

NSW POLICE FORCE SUBMISSION ON POLICE OVERSIGHT

JULY 2015

INTRODUCTION

The significant interest in police oversight is not new. In addition to recent commentary that has occurred in various forms, a briefing paper¹ prepared by the NSW Parliamentary Research Service indicates that at least five reviews of police oversight have occurred in the past decade.

That there must be oversight of policing activities is not contested. Police officers have powers that are not available to anyone else: powers to carry arms, use coercive force, enter and search premises, seize and hold property and to deprive people of their liberty. There is a very proper expectation that police act lawfully in the execution of these extraordinary functions and that safeguards exist to identify, investigate, and appropriately respond to inappropriate and/or unlawful acts.

In the first instance officers' obligation to act in a manner which 'upholds the rule of law' rests with their employer. Under Part 9 of the *Police Act 1990*, the Commissioner has power to take action on unsatisfactory conduct and performance of all sworn officers. Consistent with that responsibility, the NSW Police Force must have the ability to conduct its own internal investigations without unnecessary interference, subject to an appropriate level of oversight to ensure that the public confidence is retained.

At issue is the form and function of police oversight: what it is, who is responsible, to what matters it ought apply and when. Simple as they are, these questions have proved anything but straightforward. A system of oversight has developed with multiple agencies, overlapping jurisdictions and complex, difficult to interpret regulation. It is a system misunderstood by complainants and unsatisfactory for police, with processes slow to resolve and undertaken without full regard to their impact on the mental and physical effects of those taking part.

It is the view of the NSW Police Force that neither it nor the community is advanced by aspects of the current oversight framework. Simplification of the system of police oversight is overdue. Ideally, such simplification would clearly define the nature of 'oversight'; reduce the number of agencies involved; clarify their roles, expectations and obligations; and create a clear order of precedence for their involvement, thereby improving efficiency without adversely affecting police accountability.

¹ Lenny Roth 'External oversight of police conduct' Briefing Paper No 6/2015 NSW Parliamentary Research Service.

In practice, this would see the investigation and management of the majority of complaints being subject to existing robust and accountable internal NSW Police Force complaints handling processes. Once the internal investigation had concluded, the oversight agency would, if necessary, then conduct a review, and if deficiencies are identified, prepare a report for the consideration of the Commissioner.

Of course, in certain circumstances it would be necessary for the oversight body to conduct its own investigation into particular complaints, independently of the Police Force. Such investigations are necessarily in the public interest and are warranted where allegations of serious or systemic police misconduct are made.

The NSW Police Force recommends a single oversight body with revised powers. Whether this be a new agency, an existing agency, a combination of existing agencies, or some other model, it is imperative that its roles and responsibilities are stated clearly and concisely in empowering legislation. It is also imperative that the oversight agency be held to these: its decisions to investigate matters need to be transparent and justifiable, its investigations of the highest quality, and its findings able to withstand the closest scrutiny.

Any review of police oversight needs to keep in mind that police officers are called upon to make split second decisions in the most trying of circumstances. In situations from which many would instinctively flee, police officers are expected to intervene, to act quickly and confidently, on the basis of training and well rehearsed plans, making decisions about life and liberty. Decisions that are forced on an officer in an instant can be clinically dissected by tribunals over days, months - and sometimes years.

Accordingly, it is the view of the NSW Police Force that oversight should have organisational improvement among its aims. It should be directed at matters where the NSW Police Force has not met reasonable community expectations. Oversight should, fundamentally, point the way to how police can do their job better.

THE CURRENT SYSTEM OF OVERSIGHT

'Police oversight' is a broad and imprecise term involving one or more of: 'review', 'monitoring', 'detection', 'inspection', 'checking', 'research' or 'investigation'. Further, an oversight agency's interest can encompass the full spectrum of police misconduct from customer service complaints through to systemic, serious corruption.

Depending on the nature of a policing matter, one or more of the NSW Ombudsman, the NSW Police Integrity Commission (PIC), the NSW Coroner, WorkCover NSW, the NSW Parliament and/or the NSW Police Force will investigate or undertake inquiries, often writing reports and making recommendations.

To illustrate, it is helpful to examine the system of oversight as it now stands. In broad terms that can be divided into two streams of matters: complaint management and critical incident investigations.

Complaint Management

A police officer is held accountable for his or her action or inaction, on or off duty, in New South Wales or elsewhere and the New South Wales Police Force is responsible for the management of the conduct and performance of all its employees. Part 8A of the *Police Act 1990* sets out the NSW Police Force's legislative obligations for complaints about the conduct of police officers, and Part 9 sets out the particular management action that can be taken at the discretion of the Commissioner's powers to take reviewable and non-reviewable action against police officers who are found to have engaged in misconduct or unsatisfactory performance.

When a complaint is received, it is generally either directly from the complainant or referred from the Police Integrity Commission or the Ombudsman where that agency has received the original complaint. There is currently a mechanism allowing these agencies to retain these complaints (or part of them) and conduct their own investigations and inquiries.

If the complaint meets the assessment criteria to be a complaint, it is entered into c@tsi, a recording system accessible to the oversight bodies.

Critical Incident Investigations

A *critical incident* is an incident involving a member of the NSW Police Force which resulted in the death of or serious injury to a person:

- arising from the discharge of a firearm by the member
- arising from the use of appointments or application of physical force by the member
- arising from a police vehicle pursuit or from a collision involving a NSW Police Force vehicle
- in police custody
- arising from a NSW Police Force operation

or any other event, as deemed by a region commander, that could attract significant attention, interest or criticism from the community, and the circumstances are such that the public interest is best served through an investigation independent of the officers involved. Critical incidents are investigated in accordance with the *NSW Police Force Critical Incident Guidelines*, which set out requirements for the investigation and its management.

The current external oversight arrangements for critical incidents involving a death or deaths involve a judicial process and potentially a range of bodies each governed by primary legislation and their own legal frameworks. These arrangements are described in detail at page 10 of this report and set out the legislative basis for the involvement of the NSW Police Force, the NSW Coroner, the NSW Ombudsman, the Police Integrity Commission and the WorkCover Authority of NSW in critical incident investigations.

Problems

The number of agencies and the complexity of oversight arrangements mean that one matter can generate multiple investigations, proceedings and follow up. This can be taxing on complainants, unsatisfactory for officers and unduly onerous on the NSW Police Force. This speaks to the importance of ensuring that the definition of oversight is clearly limited in scope. In particular, the exact powers of the oversight agency, and the circumstances in which those powers are enlivened, must be defined with precision. Further, these powers must be limited to avoid unnecessary duplication with inquiries and investigations conducted by the NSW Police Force.

Existing powers granted to the oversight agencies require scrutiny. In *Baff v New South Wales Commissioner of Police* [2013] NSWSC 1205, Adamson J found the right to silence and the privilege against self incrimination were basic and substantive common law rights which had existed since 1680 AD.² Adamson relied on High Court of Australia authorities to conclude that the privileges could be abrogated by legislature only where there was 'irresistible clearness',³ as is the case in the *Police Integrity Commission Act 1996*.⁴ It is, then, somewhat perverse that the system for ensuring police act within the law arguably undermines it by allowing the use of coercive powers and denying police substantive common law rights afforded to criminal offenders. However effective they may be at exposing corruption, such powers should be used sparingly and as a last resort, applied when the organisation has not or cannot deal with a significant problem. This is in the interests of officers' common law rights and also serves to ensure that opportunities to prosecute officers are not forfeited by obtaining coerced evidence. In any event, such is the gravity of these powers that it is essential that the frequency and consistency of their use require examination by an inspectorate charged with oversight agency review (see Term of Reference 2, below).

² at [99].

³ at [56].

⁴ *PIC Act* s 28.

IMPROVING THE SYSTEM OF OVERSIGHT – TERMS OF REFERENCE

As indicated, the NSW Police Force considers that the existing system of police oversight could be streamlined by having a single oversight agency responsible for complaint management and critical incident investigations.

The NSW Police Force position is set out below under the review's seven terms of reference.

1. OPTIONS FOR A SINGLE CIVILIAN OVERSIGHT MODEL FOR POLICE IN NSW, INCLUDING IDENTIFYING MEASURES TO IMPROVE EFFICIENCY AND EFFECTIVENESS OF OVERSIGHT.

The New South Wales Police Force supports a single oversight model for complaint handling. The model should provide for high level oversight, leaving the investigation and management of complaints to the NSW Police Force. The single oversight agency should also have the remit to conduct its own investigations, which it may opt to do in conjunction with the NSW Police Force, for particular types of serious complaints, for example: those involving broad systemic corruption, corrupt activities undertaken in conjunction with other government agencies such as smuggling drugs with customs officers or selling information accessed through other government agencies, involvement with organised crime, matters involving the administration of justice, and matters involving members of the NSW Police Force senior executive. Any such investigative powers must be carefully structured and expressly limited to avoid unnecessary duplication.

Such a model would acknowledge the New South Wales Government's substantial investment over the last decade in the professionalisation of the NSW Police Force complaint handling system and the significant gains the NSW Police Force has made in upholding the professional conduct of its officers. It would recognise that the NSW Police Force's management of complaints has substantially improved, together with its practices for identifying and preventing corrupt conduct.

The NSW Ombudsman's Annual Report 2013-2014 stated that 82% of complaints were handled by the NSW Police Force in a timely and effective manner, with "delay" being the sole reason a further 9% of matters were found deficient. These results are reasons both to re-examine how often oversight of police complaint handling needs to be conducted and also to re-consider the necessity of having separate agencies concerned with overseeing complaint management (Ombudsman) and corrupt conduct (PIC), particularly given the overlap between the two.

A single oversight agency should operate in a way that minimises disruption to operational police activity. It should look to reduce duplication, crossover and confusion. Once the NSW Police Force is investigating a complaint, that complaint investigation should be

allowed to proceed without interference, with any oversight agency review conducted at the end of the investigatory process.

In circumstances where an external investigation is warranted, the oversight agency's operating model should apply strict criteria as to when it will conduct public hearings and examinations. Where a matter is not systemic but may adversely affect the reputation of individual officers, the option should remain to conduct hearings in private with a final report made either to the Commissioner of Police, or made public at its conclusion. This would build trust with police and ensure there is no unnecessary or unreasonable damage to individuals later found not to have engaged in misconduct.

2. ANY GAPS IN THE CURRENT POLICE OVERSIGHT SYSTEM

The current oversight system is characterised by duplication and overlap rather than omission. Nonetheless gaps and inconsistencies are apparent.

For example, the New South Wales Police Force increasingly participates in joint operational activities with other jurisdictions, the G20 operation in Brisbane in 2014 a recent example. In such circumstances, there is often protracted debate on the professional standards to which officers will be subject, whether these be the standards in place at the receiving jurisdiction or those applying in the officers' home jurisdiction. Further complexities arise when the one incident gives rise to a complaint involving officers from different jurisdictions or when local legislation proves an obstacle to conducting complaint investigations.

To the extent that it is possible to do so, the review should examine oversight in place in other jurisdictions with a view to the ensuring that effective oversight is maintained during interstate joint operations.

It would also be remiss were the review not to examine what further could be done to respond to the significant stress, physical and mental, police are placed under as a result of oversight processes. Quite apart from having one's performance scrutinised and the spectre of management action against them at hand, which is stressful enough, officers can also find themselves subject to adverse public coverage and commentary even prior to a finding having been made. This can and has occurred in public hearings/documents of oversight agencies and as a result of media releases, denying the officers natural justice and adversely affecting their well being. It is positive that consideration has recently been given to exempt officers affected by Operation Prospect on a case by case basis from non-disclosure orders for the purpose of obtaining medical treatment or counselling. This is in recognition that such matters, especially but not exclusively those played out in public, have potentially significant effects on officer well-being. It is an exemption that the NSW Police Force believes should be substantively in place, not one that affected police need to seek with each new inquiry.

Trial by media and/or innuendo to the effect that police are corrupt even prior to a finding of misconduct requires scrutiny on whether procedural fairness should be stipulated in the oversight agency's empowering legislation. In the interests of justice and transparency, this should occur in conjunction with setting out the criteria for the oversight agency to conduct public hearings and examinations and report on their findings (see also last paragraph under Term of Reference 1, above).

Furthermore, the oversight agency must itself be accountable. Given their public significance and implications for police officers, the oversight agency's investigations and practices, including its use of covert powers, require audit and review by a qualified and well-resourced inspectorate with powers to make findings and recommendations for change.

3. FUNCTIONAL OVERLAP BETWEEN OVERSIGHT BODIES AND IF THAT CONTRIBUTES TO INEFFECTIVENESS, UNNECESSARY COMPLEXITY, INEFFICIENCIES, OR IMPAIRS TRANSPARENCY OR POLICE ACCOUNTABILITY

At present there is substantial inefficiency caused by having multiple agencies involved in complaint management and critical incident investigations (see Annexure A). This contributes to unsatisfactory outcomes for complainants, victims and police officers.

Complaint management

In the area of complaint management:

- there are multiple ways in which complaints can be received,
- there are three points/agencies at which complaints can be assessed (NSW Police Force, Ombudsman, Police Integrity Commission), with a fresh assessment whenever a complaint is referred,
- there are three agencies which can undertake an investigation (NSW Police Force, Ombudsman, Police Integrity Commission),
- there are two agencies which can conduct an investigatory review (Ombudsman, Police Integrity Commission), and
- there are three agencies which report on complaint handling (NSW Police Force, Ombudsman, Police Integrity Commission).

In addition, the NSW Police Force, the Ombudsman and the Police Integrity Commission each undertake what could be termed 'research' into complaints or matters stemming from

complaints, and the NSW Police Force and the Police Integrity Commission engage in corruption prevention.

Problems with existing arrangements begin with Division 4 of Part 8A of the *Police Act 1990* and the referral of complaints between the various oversight agencies. For example, it directs the Police Integrity Commission, the Ombudsman, the Independent Commission Against Corruption and the NSW Crime Commission to refer complaints to the Commissioner of Police for investigation. However, the Police Integrity Commission also has an express statutory authority to refer a complaint to the Ombudsman rather than the Commissioner, or refer part of a complaint to the Ombudsman and the remainder to the Commissioner. The Ombudsman has a similar ability to refer a complaint, or part of a complaint to the Police Integrity Commission, with the remainder to the Commissioner. Alternatively, the Ombudsman may conduct the investigation into the complaint itself. The potential for confusion, duplication and wasted public resources with this system of complaint management is significant.

In circumstances where complainants do not know where their complaint may end up, the system cannot possibly be 'user friendly'. The resultant confusion and frustration may be exacerbated if a complaint is split into parts and investigated by different bodies concurrently.

Also, if a complaint is split up into parts, it will often require multiple oversight agencies and the Commissioner to work together to resolve the complaint. This also has the potential to cause confusion and frustration.

From an industrial point of view, the delay that can result from the involvement of multiple oversight agencies can have an impact on police officers, both those who are the subject of the complaint and those who are witnesses.

The environment is complex and, despite some effort among the agencies involved, little progress has been made in simplifying it and reducing duplication. This has led to problems of various sorts, the occurrence of which would be reduced were the duplication of functions minimised.

A significant example of this overlap is demonstrated in the PIC investigations process. PIC is empowered to conduct investigations and on the bases of these form assessments and recommend disciplinary action in the s 181 removal of officers or reviewable action pursuant to s 173. Despite an exhaustive process, on receipt of the recommendation the NSW Police Force needs to conduct its own investigation and make its own independent findings to enable the Commissioner to satisfy himself that management action is warranted and to determine what level of management action is to be taken, a requirement which may extend the process by months. This arises from the result in *PIC Operation Whistler* (2005) and *Alford* where PIC made misconduct findings against two officers, including for the use of

excessive force. Various appeals followed which were upheld by the PIC Inspector on procedural fairness grounds. One result was that disciplinary action that relied upon the PIC findings was ultimately abandoned after a number of years. While PIC has taken steps to resolve procedural unfairness issues, there always remains a prospect of judicial review which necessitates a complete reinvestigation by the NSW Police Force on every occasion within its own framework. The NSW Police Force cannot risk an appeal which may result in the PIC finding being quashed.

Another example is of an officer who was alleged to have engaged in fraudulent conduct in early 2007 and which came to the attention of the Commissioner later that year. It was also referred to the Police Integrity Commission given the concerns about the officer's integrity. During the course of the Police Integrity Commission's investigation, the investigation of the Part 8A complaint was suspended. The Police Integrity Commission investigation and findings did not conclude until late 2011. Following the PIC findings the Part 8A complaint investigation was resumed and, in 2014, over seven years after the first allegations of misconduct arose, the officer was removed from his employment.

While the appropriate outcome was ultimately reached, there was a lengthy period when the officer was out of the workplace suspended, for a majority of the time without pay. These delays not only lead to dissatisfaction of complainants and accused employees, but had the officer not been removed after such a long period of absence it would have been necessary to provide re-training. Further, such lengthy delays create a financial risk in that back pay may become payable if an officer were to have been reinstated (either by the Commissioner or the NSW Industrial Relations Commission).

Management action

Under Part 9 of the *Police Act 1990* the Commissioner has the responsibility and is accountable for the discipline and performance of all sworn officers.

Once an investigation under Part 8A is undertaken, and sustained findings of misconduct are made, it will then fall to the Commissioner of Police to make a decision on the appropriate management action to take against the relevant police officer under Part 9.

Management action needs to be timely, proportionate and constructive, meeting the needs of the NSW Police Force, respecting the rights of the individual officers, and, ideally, meeting the expectations of the complainant and larger public.

It is the NSW Police view that if the Commissioner takes action under Part 9, be it removal under section 181D or reviewable/non-reviewable action, then the decision of the Commissioner about the relevant action to be taken (and whether or not it is commensurate with the sustained findings made) can be the subject of review by the NSW Industrial Relations Commission and/or Supreme Court. No further oversight is required.

Oversight by a non-judicial agency should only apply when no action is taken under Part 9 or when the action taken is manifestly inadequate, for example when a Commander's Warning Notice is issued in circumstances that would ordinarily warrant an officer's removal. In such situations it is appropriate for the oversight body to have a statutory power to require the Commissioner to provide reasons why the decision was made, and to invite the Commissioner to revisit that decision, but only where the oversight agency has concerns that the decision is incommensurate with any sustained findings of misconduct that are made.

Legal interpretation of the oversight relationship

There have been unfortunate disagreements with the Office of the Ombudsman over the interpretation of Part 8A and Part 9 of the *Police Act 1990*. For example, at various points there has been debate as to whether or not a matter is a complaint; whether or not a complaint meets the test of a public interest disclosure; whether or not a particular complaint should be investigated; whether the Ombudsman has the right to access telecommunications material; whether the Ombudsman has the right to audit various documents; the meaning of s148 of the *Police Act 1990*; the operation of s170 of the *Police Act 1990*; and the Commissioner's role in adopting findings of courts and tribunals.

On occasion the advice of the Crown Solicitor has been obtained and in other cases that of the Solicitor General. This leads to lengthy correspondence and delay in resolving disagreements on interpretation.

While the interpretation of the sections has limited impact on the public, it does have a significant impact on the role played by each agency, and it is suggested that it would lead to greater efficiencies and better serve the community's interest if there was greater clarity in the statutory functions of the oversight agency. An oversight body should not engage in protracted dispute with the NSW Police Force over interpretation, but rather seek advice from the Crown Solicitor or Solicitor-General where a statutory provision or the legislative basis for a particular practice engaged in by the NSW Police Force is unclear. Further, such advice should be binding on both the NSW Police Force and the oversight agency.

The oversight of critical incidents

There are currently significant regulatory overlaps in the oversight of police critical incidents, with a range of bodies having a stake in the investigation and accompanying judicial processes. This situation has proven especially problematic for police who are required to respond to sometimes conflicting requests from the Coroner, WorkCover and the Ombudsman while attempting to compile a criminal brief of evidence.

The difficulties experienced by police are well illustrated in two recent critical incidents involving the deaths of Detective Constable William Crews and Roberto Laudisio-Curti,

relevant features of which are set out below. First, however, it is instructive to review the legislation to see how the various agencies come to have a role in proceedings.

Regulation of critical incidents

In NSW, the Coroner investigates certain deaths with a view to determining the time, date, manner and cause of death. To that end, the Coroner may (and in certain circumstances, must) hold an Inquest which is ordinarily open to the public. At the conclusion of the inquest, the Coroner has the power to make such recommendations as he or she considers necessary or desirable in relation to any matter connected with the death, including a recommendation that a matter be “investigated or reviewed by a specified person or body” (s82 *Coroners Act 2009*).

Importantly, one circumstance in which the Coroner **must** hold an inquest is where a death occurs during the course of a ‘police operation’ (as defined in s23). In recognition of the seriousness of those matters, jurisdiction to hold the inquest is only conferred on a “Senior Coroner”, being either the State Coroner or a Deputy State Coroner(s22(1)), who may then give directions to the police investigator (s51(2)). As such, **all** critical incidents which involve the death of a person are effectively conducted on behalf of the Coroner unless and until criminal proceedings are commenced. In circumstances, therefore, where the State Coroner or a Deputy State Coroner has the ability to direct the police investigation it is not necessary for that investigation to also be the subject of ‘oversight’ by another external body.

Often, however, matters which give rise to a critical incident investigation and/or a mandatory coronial inquest are also the subject of a complaint under Part 8A of the *Police Act 1990*. An investigation into a complaint under Part 8A enlivens the protection of s170 *Police Act*. That section provides that a document created for the purposes of Part 8A investigation is not admissible in any proceedings other than proceedings that concern the conduct of police officers and that are dealt with by the Commissioner, the Industrial Relations Commission or by the Supreme Court in the exercise of its jurisdiction to review administrative action. As such, when coronial proceedings are on foot, the Part 8A complaint is usually ‘suspended’.

If a Part 8A complaint is not suspended, or if the Ombudsman decides to initiate his own investigation under s13 *Ombudsman Act 1974*, s146 of the *Police Act 1990* then gives the Ombudsman an intrusive power to ‘monitor’ the investigation, including being present as an observer and conferring with investigators about the conduct and progress of the investigation. Further, s145 (1)(b) of the *Police Act 1990* then requires investigators to have regard to any matters specified by the Ombudsman as needing to be examined or taken into consideration. The issues caused by the resultant oversight of the coronial investigation are highlighted in the case study into the death of Roberto Laudisio-Curti, below.

In addition to the Ombudsman, the jurisdiction of the Police Integrity Commission may also be enlivened in respect of the same matter. For example, PIC could commence an investigation on its own initiative or upon becoming aware of a police complaint, despite any proceedings (including coronial proceedings) that may be on foot (s 21 *Police Integrity Commission Act 1996*). It would then be open to PIC to exercise a broad range of powers from passive monitoring through to conducting its own hearings.

Although not an 'oversight' agency, the WorkCover Authority of NSW has responsibility for assessing, investigating and prosecuting employers for their failure to comply with obligations under the *Work, Health and Safety Act 2011*. As such, it may also have jurisdiction to investigate matters which overlap with those which are the subject of the coronial inquiry or a criminal prosecution, and exercise their extensive coercive powers to compel production of documents and compel witnesses to answer questions, in circumstances where this compulsion expressly overrides the privilege against self-incrimination. This can and, in relation to the Crews matter did, result in a WorkCover investigation running concurrently with the investigation and prosecution of criminal charges.

CASE STUDIES:

Detective Constable William Crews

The critical incident investigation into the death of Detective Constable Crews served to exemplify not only the issues which arise when there is a functional overlap between a number of oversight bodies (Term of Reference 3, above), but also the potential impact of those parallel investigations on criminal proceedings.

The Officer in Charge of the criminal investigation against a person of interest (Nguyen) was also the Officer in Charge of the coronial investigation (which essentially also encompassed his critical incident investigation). WorkCover was also notified of the incident and it commenced its own investigation.

Unlike some other critical incident investigations, the investigation into the death of Detective Constable Crews proceeded as a criminal investigation against a known suspect (Nguyen) from the outset. In the usual course, the Coroner would suspend the inquest pending the outcome of the criminal proceedings; however, in this instance that did not occur. In addition to creating a very public disagreement between the NSW Police Force and the State Coroner (see *The Sydney Morning Herald* articles October 27 & 28, 2011), the Coroner's decision not to suspend the inquest resulted in the Officer in Charge continuing to receive requests from the Coroner (as well as WorkCover) to provide them with documents at the same time as he was investigating and preparing a criminal brief.

After receiving advice from the Director of Public Prosecutions, Nguyen was charged with manslaughter. The DPP then requested that the Officer in Charge provide all of the material

that was being requested by the Coroner and WorkCover, the existence of which they then determined had to be disclosed to Nguyen's solicitors under their disclosure obligations. Inevitably, Nguyen's solicitors issued subpoenas which called for the production of that material. Although those subpoenas were successfully resisted, the time taken and expense could have been avoided had WorkCover and the Coroner deferred their investigations until after the criminal proceedings. This point is of particular significance because both WorkCover and the Coroner can (and in the case of WorkCover, did) require police to produce draft and incomplete versions of documents. Of course, until a document is finalised, the views, observations and conclusions drawn by the author are subject to change as information and evidence is analysed and the full facts become known.

As the WorkCover investigation ran concurrently with the criminal prosecution, a situation arose where WorkCover sought to interview the involved officers at the same time as Nguyen's Committal proceedings were on foot. Although the NSW Police Force raised concerns about the timing of those interviews, given that it was already a stressful time for those involved, WorkCover nevertheless proceeded to conduct those interviews.

WorkCover also played an active role in the Coronial Inquest and put forward expert evidence, though not, despite an extension at the conclusion of the Inquest, a written submission.

Mr Roberto Laudisio-Curti

The critical incident investigation into the death of Roberto Laudisio-Curti was also significantly and negatively affected by functional overlap between a number of oversight bodies.

Although the Ombudsman does not automatically have a scrutiny function over critical incidents, his jurisdiction is enlivened when a Part 8A complaint is initiated. In the usual course, the Part 8A investigation is suspended pending finalisation of the critical incident investigation and, if relevant, the Coronial or criminal proceedings. This course of action is taken to ensure that s170 *Police Act 1990* will not operate to limit the use to which the information may be put; however, the result is that once the Part 8A investigation is suspended, the Ombudsman no longer has oversight. In the Laudisio-Curti matter, however, the Ombudsman maintained a monitoring role. This gave rise to a number of significant issues.

Visit to TASER International

To clarify data discrepancies in the timing of the firing of some of the TASERs during the course of the incident, investigators discussed with the NSW Deputy Ombudsman (Police) and the Ombudsman's Principal Investigator (OPI) their intention to travel to TASER International. The Deputy Ombudsman was opposed to that course of action on the basis of TASER International having some apprehended bias.

The view of the Ombudsman that a line of inquiry regarding a critical issue in the investigation (namely a possible functional defect in the product) not be pursued on the basis of a perceived bias failed to appreciate that evidence gathered in a Coronial investigation is tested by those assisting the Coroner and other parties to the Inquest, in open Court. It also failed to appreciate that the TASER firing data was critical objective evidence stored on an electronic device and the apparent discrepancy in the data required clarification which could not readily be provided by anybody other than the manufacturer.

The Ombudsman's view was at odds with the State Coroner and the Crown Solicitor's Office which provided a letter of instruction to the investigators to take with them when making enquiries of TASER International to ensure that the issues which they considered to be relevant were also addressed.

Had the investigators accepted the Ombudsman's view and delayed or refrained from making those enquiries, evidence would not have been available to the Coroner at the inquest and the investigators would likely have been the subject of criticism.

That the Ombudsman's principal investigator and the Deputy Ombudsman tried to dissuade investigators from obtaining critical evidence from TASER International highlights the risk of 'oversight' personnel, untrained in homicide investigations, actively involving themselves in evidence gathering.

Additional investigation conducted by the Ombudsman's Principal Investigator

The Ombudsman's principal investigator was present at a crime scene review attended by the Government Pathologist, Crime Scene Officers, Strike Force personnel, Weapons & Tactics Policy & Review personnel, and Professional Standards personnel. The Government Pathologist showed slides depicting patterned injuries found upon the deceased at the post mortem examination. The cause of these injuries was discussed at length and it was concluded that the most likely cause of the injuries was a specific fitting on the load bearing vests worn by police officers or some type of metal grate that may have been on the ground within the crime scene area.

Officers from the Weapons & Tactics Policy & Review Unit agreed the patterned injuries could have been caused by a fitting on the load bearing vest and arrangements were made for a vest to be supplied to the Government Pathologist for comparison with the injuries.

At that meeting, the Senior Crime Scene Officer stated that she had examined closely all of the metal grates within the crime scene area and had not observed any grate that was likely to have caused the patterned injury. The injuries were circular and all of the metal grates found within the boundaries of the crime scene area were rectangular. Nevertheless it was decided that these grates would be re-inspected to conclusively eliminate them as the cause of the injury. The Senior Crime Scene Officer subsequently returned to the crime scene

location and reviewed all of the crime scene photographs and other notes and could not locate any circular metal grate that was likely to have caused the injuries.

The Ombudsman's principal investigator, however, conducted his own inquiries. He stated that he had attended the site where he understood Mr Laudisio-Curti had died and photographed circular metal grates that he believed had been overlooked by the Crime Scene Officers and Critical Incident Investigators. He subsequently sent those photographs through so that they could be further considered.

Two days later, in a meeting at the State Coroner's Court, Glebe with the State Coroner, Government Pathologist, the Ombudsman, Deputy Ombudsman, the Ombudsman's principal investigator, Critical Incident Investigators and the Commander of the Homicide Squad, the Government Pathologist provided details of the post mortem examination and possible explanation of the injuries suffered by the deceased. It was considered the circular patterned injuries were consistent with the TASER fitting on the police load bearing vest.

Later that day the Ombudsman's principal investigator sent another email to the Senior Critical Incident Investigator which referred to circular metal plates that he had observed on the footpath. As a result of that email, the Officer in Charge returned to the crime scene and video recorded the entire footpath and roadway where police had interacted with the deceased during the critical incident. This further examination of the crime scene did not locate any circular metal grates, or the grate depicted in the OPI's photograph.

The following week, Investigators conducted walk through interviews with eight civilian witnesses. The Ombudsman's principal investigator was present at those interviews and acknowledged that he had observed the wrong area and that the plates he had referred to were in an unrelated area.

Given that a considerable amount of time had already been expended pursuing this line of inquiry, a decision was made to conduct no further enquiries in respect of the metal grate. At the Inquest it was established that the injuries could only have been caused by the load bearing vest worn by an identified involved officer.

Concerns with the current arrangements: duplication, sequential oversight and inefficiency

In his 2013 report to the Premier on the oversight of critical incidents, the Hon Robert McClelland expressed concerns that the current arrangements involved duplication, sequential oversight and inefficiency, the blurring of the lines between monitoring or oversight and influencing investigations, confusion and conflicting directions, and the loss of confidence in current oversight bodies and arrangements.

Problems were also identified by Freiberg (2010, p.40):

“Due to the complexity of the regulatory space, and the variety of regulators and levels of government that exist, there are instances where multiple regulators seek to regulate the same conduct in the same place. This can result in regulatory ‘forum shopping,’ overlap, conflict or inconsistency, leading to poor regulatory outcomes, inefficiency, and unnecessary restrictions on individuals and organisations.”

So, too, the Acting State Coroner, whose submission to the McClelland review stated “We think that duplication (or multiplication) of bodies overseeing such investigations is likely to lead to inefficiency, confusion, conflict and unnecessary expense.” (McClelland, 2013, p.67)

And from a somewhat different perspective, the Police Association of NSW:

“each stage alone is a traumatic experience for all involved and when a single matter is subject to all of these overlapping investigations, it is impossible to say that justice is being served for the community, the complainants or the police officers.” (Police Association of NSW, 2013, p. 11)

The NSW Wales Police Force shares these views. There is no doubt that oversight bodies with overlapping roles and responsibilities for critical incidents have tended to get in one another’s way, wasting resources, complicating investigations and frustrating all involved.

Critical incidents: The NSW Police Force position

When a person dies in the course of a police operation, the incident must be investigated. An independent, transparent and comprehensive investigation is owed to deceased persons and their families, as well as to the general public whose confidence in its police force is paramount. But the NSW Police Force’s accountability extends beyond this. It has a similar duty to its officers who have been involved in traumatic events and whose performance is under the microscope, and to the broader body of police to ensure that investigations are objective, thorough and accurate.

In matters where there is so much at stake – for the public and for private interests – critical incident investigations must be conducted in the most professional way. For this to occur there needs to be agreement among judicial authorities, oversight agencies and the NSW Police Force on the priority to be accorded the various interests. This is not to deny the legitimacy of any of oversight agencies’ work but rather to recognise that to maintain its focus, an investigation cannot afford to have multiple, fragmented objectives.

On this matter the NSW Police Force is **fully** in accord with Recommendation 4 of the McClelland Report. It agrees that a *Framework for Cooperation* among key agencies is required to establish the order of precedence for oversight issues in critical incidents and that, further, a critical incident investigation owes its first duty to the courts and then to oversight agencies. It is imperative that judicial processes are not compromised by pre-emptive oversight, however well intentioned.

To assert the primacy of judicial proceedings in critical incident matters, McClelland gave consideration to amending the Coroner's Act to require oversight bodies, including WorkCover, to suspend their jurisdictions during the course of a Coronial inquest. The NSW Police Force is in favour of such a course and believes that a modification to the same effect is warranted for critical incidents that do not involve a death but which result in serious injury to a member of the public or a NSW Police Force officer.

As such, it is the view of the NSW Police Force that when a critical incident gives rise to a coronial inquest, the coroner is appropriately and ideally placed to monitor the progress of the investigation and to direct further investigative steps if necessary, such that there is no need for any additional external oversight.

It is also the view of the NSW Police Force that to avoid duplication and reduce the likelihood of conflicting requirements on investigators that the commencement of any regulatory investigation be deferred until after the conclusion of the coronial proceedings.

Further, to avoid the possibility of prejudicing criminal proceedings, it is the view of the NSW Police Force that that the commencement of any regulatory investigation be deferred until after the conclusion of the criminal proceedings.

4. BEST PRACTICE MODELS FROM AROUND THE WORLD, INCLUDING THE UK INDEPENDENT POLICE COMPLAINTS COMMISSION AND THEIR APPLICABILITY AND ADAPTABILITY TO NSW

While the NSW Police Force supports the examination of best practice systems from around the world, it cannot support a United Kingdom styled Independent Police Complaints Commission (IPCC). The IPCC has been the subject of serious criticism by the United Kingdom Parliament and government, and has generated public and police dissatisfaction in its performance.

In 2013 the United Kingdom House of Commons, Home Affairs Committee published a report into the IPCC and was scathing of its police complaints and oversight system, stating, *"The public do not fully trust the IPCC and without faith in the Commission, the damaged public opinion of the police cannot be restored. Unfortunately, too often the work of the Commission seems to exacerbate public mistrust, rather than mend it."*

Without being prescriptive, the NSW Police Force broadly favours a model that allows it to find its own solutions to problems while providing for assistance and guidance from the oversight agency where imperative. Such an approach entails the NSW Police Force maintaining responsibility for the investigation of complaints and critical incidents rather than ceding this to an independent civilian agency.

On this point, if all investigations were to be undertaken or even directed by an independent agency, there would be potentially significant resource implications. Care would also need to be taken lest such a course introduce different standards to those investigating police are normally required to uphold.

A best practice model of oversight would necessarily enjoy the acceptance of police and of the wider community.

5. A RECOMMENDED MODEL FOR POLICE OVERSIGHT INCLUDING GUIDANCE ON ITS DESIGN, STRUCTURE, COST AND ESTABLISHMENT.

The NSW Police Force position is that there should be a single agency responsible for the oversight of police complaints. This could be a new agency, an existing agency, a combination of existing agencies, or some other model.

The operations of the single oversight agency should be reviewed by a qualified and well resourced inspectorate with powers to make findings and recommendations.

Oversight functions should not be added. The focus should be on reducing duplication and clearly articulating in legislation its role, expectations and obligations.

The model should mandate that the investigation and management of the majority of complaints remain the responsibility of the NSW Police Force.

The single oversight agency would have a remit to conduct its own investigations for complaints of particular types of a higher order of seriousness. That oversight agency may opt to do those investigations in conjunction with the NSW Police Force.

Such investigations should generally be conducted in private with a final report made either to the Commissioner of Police, or made public at its conclusion.

There should be an agreed final arbiter for resolving disputes arising from disagreements over interpretation of Part 8A and Part 9 of the *Police Act 1990*.

The model should reconcile various statutes so that police officers are only subject to one investigation. Furthermore, the model should seek to maximise the extent to which the evidence collected is admissible in the various jurisdictions.

In recognition of the increasing frequency of cross-border policing, the model should seek to harmonise complaint handling and critical incident investigation across jurisdictions.

There be an agreed *order of precedence* for involvement in critical incident investigations, particularly those involving the NSW Coroner, in the terms set out in Recommendation 4 of the *McClelland report on the review and oversight of police critical incidents*.

6. ANY IMPLICATIONS FOR MAINTAINING OVERSIGHT OF THE NSW CRIME COMMISSION ARISING FROM THE RECOMMENDED MODEL OF POLICE OVERSIGHT, WHILE AIMING TO MINIMISE UNNECESSARY DUPLICATION AND OVERLAP.

Many NSW Police officers are inducted members of the NSW Crime Commission and the NSW Police Force often works with Crime Commission on joint investigations. Therefore, it is the NSW Police Force view that the New South Wales Crime Commission should also be subject to the same expectations and oversight as the NSW Police Force.

7. THE REVIEW WILL NOT CONSIDER:

- a. MATTERS RELATING TO PARTICULAR DECISIONS TO INVESTIGATE, NOT TO INVESTIGATE, OR TO DISCONTINUE INVESTIGATION OF A PARTICULAR COMPLAINT; OR FINDINGS, RECOMMENDATIONS, DETERMINATIONS OR OTHER DECISIONS IN RELATION TO A PARTICULAR INVESTIGATION OR COMPLAINT.**
- b. ISSUES RELATING TO WORKCOVER THAT DO NOT INVOLVE OVERLAP WITH THE POLICE OVERSIGHT SYSTEM.**

Nil comment.

ANNEXURE A: AGENCY OVERLAP

Role	Overlap	Inefficiency
Complaint receipt function.	<p>Complaints are received by</p> <ul style="list-style-type: none"> • PIC • Ombudsman • NSWPF • Minister 	<p>Complaints are transferred between agencies (PIC and Ombudsman may receive complaints ‘on line’) and duplicate complaints are searched for within the system. One central online complaint repository would be more efficient and in line with Service NSW objectives. The oversight agency and the NSW Police Force would have access to the repository.</p>
Complaint assessment function.	<p>Assessing whether a complaint meets requirements of Part 8A. Depending upon the recipient of the complaint, this assessment is performed by:</p> <ul style="list-style-type: none"> • PIC • Ombudsman • NSWPF 	<p>When complaints are referred, a new assessment is conducted. Sometimes there is variance between organisations as to whether a matter is a complaint or not. This is confusing for all involved, including those who complain. There should be a central repository with one single assessment determining whether a matter is a complaint or not.</p>
Hearing function.	<p>Both the Police Integrity and the Ombudsman can investigate the NSWPF and conduct hearings. Only PIC can conduct hearings in public. Also, in respect of deaths resulting from police operations, the Coroner has an inquest function, which often results in hearings.</p>	<p>Duplicate hearings at the Coroner and for example, PIC tend to confuse both those involved and the public in general. This is especially so when jurisdictions have different rules of evidence. Material from a Part 8A investigation cannot be used in Coroner’s hearing unless privilege under S170 is waived. Are statements</p>

		made in one jurisdiction truly admissible in another? This duplication of roles tends to undermine the rights of individuals against self-incrimination as determined by the Supreme Court in <i>Baff</i> . One hearing is more appropriate – Coroner or oversight agency – not both. There needs to be a clear delineation of roles and responsibilities. Additional complications in some matters are Workcover investigations which cross all boundaries.
Review function – investigation.	Both the Ombudsman and PIC review police internal investigations into allegations of misconduct, although for different purposes. In the main, investigation reviews are conducted by the Ombudsman.	The Ombudsman determines whether individual NSWPF complaint investigations are deficient. There are no set legislative or other criteria for deficient investigations and much depends upon the subjective views of the reviewer. The Ombudsman review function is akin to an ongoing audit of the quality of police investigations. PIC also reviews but for more strategic investigative purposes. One single agency could utilise a single oversight and quality criteria for review of investigations.
Review function – management action – industrial.	The NSWPF conduct investigations oversighted by PIC and Ombudsman. Should a matter be the subject of appeal to the Industrial Relations Commission, especially	Complaint investigations which result in reviewable action (and have been the subject of oversight of PIC and/or Ombudsman), are still the subject of a completely fresh hearing, testing the

	<p>under S173 (reviewable action) or S181D of the Act, the IRC conducts a hearing <i>de novo</i>, rather than reviews whether the decision of a Commander or the Commissioner is beyond power, harsh, unreasonable or unjust.</p>	<p>evidence to the <i>Brigginshaw</i> standard, rather than reviewing the decision of the Commander or Commissioner. This usurps the purpose of Part 8A of the Act, which is not written as a disciplinary system, but rather a management system (for example, officers are removed under S181D, not dismissed). A single oversight agency, ensuring the efficacy of police investigations should result in changes to the way the IRC approaches reviews.</p>
<p>Research and suggested intervention function.</p>	<p>Both PIC and the Ombudsman conduct research and make recommendations.</p>	<p>Dealing with these often subjective views takes an inordinate amount of time of the NSWPF. The NSWPF has now developed its own research function within Professional Standards. A single oversight agency, with joint aims for research with the NSWPF would save resources and ensure a joint focus. Alternatively, this function should be removed from oversight agencies.</p>
<p>Audit function.</p>	<p>The Ombudsman conducts audits under S160 of the Act, mainly to determine whether the NSWPF is complying with Part 8A. PIC also conducts audits, although not as regularly, such as auditing compliance with CARA guidelines and ongoing audit of targeted drug tests.</p>	<p>Audit of the one system by two separate oversight agencies is inefficient in the extreme. System compliance audits should be conducted by a single agency.</p>

Reporting function.	Each agency collects its own statistics in relation to complaint handling and each agency prepares its own reports.	If there is a central repository for complaint receipt, a single agency could report upon all complaint handling
Officer involvement in investigations.	<p>Officers may be interviewed by (in the one matter):</p> <ul style="list-style-type: none"> • NSWPF internal investigators • PIC investigators/hearings • Ombudsman investigators/hearings • The Coroner • WorkCover NSW • Solicitors representing NSWPF officers in various tribunals. 	This is both extremely inefficient and stressful for police officers. One single agency should be responsible for the investigation of an incident – and there should be no cross-over.