Submission of the State Coroner to the Review of Police Oversight

The State Government has commissioned Mr Andrew Tink AM to review aspects of the current system for civilian oversight of police action and to report on options for a single agency oversight model, among other things.

I have been invited to make a submission to the review because any change to current arrangements has the potential to impact upon the way fatal "critical incidents" – deaths connected with police action – are investigated. As such deaths must be subject to an inquest, any changes could impact on the coroner's jurisdiction.

Summary of State Coroner's response

Based on my experience[1], for the reasons set out below and subject to certain qualifications, I am of the view that following a fatal critical incident: -

- Experienced Homicide Squad detectives, properly supported and resourced, are best placed to gather the evidence needed to establish who did what, to whom, where and when.

- Because of their understandable empathy for the police officers involved in such incidents, homicide detectives and over-viewing police officers may have difficulty objectively assessing whether what was done by the police officers involved was reasonable and/or necessary.

- An independent expert agency with authority to monitor and overview these investigations as they occur with a mechanism for quickly addressing shortcomings is highly desirable.

- The various agencies with responsibility for responding to such incidents need to work collaboratively while maintaining their independence and utilising agreed protocols to resolve conflicts.

- The management principle that the Chief Executive Officer (CEO) of an organisation has primary responsibility for oversighting the performance of the staff of the organisation must yield to the public interest in independent fact finding and assessment of that performance when serious misconduct is alleged or suspected.

Critical incident deaths vs deaths in police custody

The New South Wales Police Force (NSWPF) Critical Incident Investigation Guidelines (the Guidelines) stipulate how critical incident deaths should be investigated. The requirements differ depending upon whether the death is categorised as a level 1 or level 2 critical incident.

Immediately a level 1 critical incident death is reported an officer from the Homicide Squad, State Crime Command is appointed as the Senior Critical Incident Investigator (SCII) to lead the Critical Incident Investigation Team (CIIT). The SCII promptly travels to the relevant location and takes control of the investigation. In the meantime, a senior officer in the Local Area Command (LAC) where the death occurred is responsible for taking all necessary steps to preserve evidence and to secure the scene.

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[1] The author has been involved in investigations, oversight of police and research into and tertiary teaching of policing for 25 years: 1988 – 90 RCADIC; 1991 – 2000 Criminal Justice Commission; 2000 – 2003 Head, School of Justice QUT; 2003 – 2013 State Coroner Qld.

The state coroner is also notified immediately. He or she makes contact with the SCII to ensure all preliminary steps to preserve the integrity of the investigation have been/will be taken and to arrange to attend the scene if necessary.

A death resulting from a level 2 critical incident is investigated by a CIIT comprised of officers from an LAC or Command different from that in which the incident occurred and the involved officers serve.

The state coroner or a deputy state coroner is notified immediately. He or she makes contact with the SCII to ensure all preliminary steps to preserve the integrity of the investigation have been/will be taken and to arrange to attend the scene if necessary.

If a death falls within s23 of the Coroners Act it must be the subject of an inquest presided over by the state coroner or a deputy state coroner. So far as is relevant to the issues here under consideration, that section deals with deaths in police custody and deaths in a police operation. Neither term is comprehensively defined and the definitions do not coincide with the critical incident categorisations or definitions. Some s23 deaths will fall within level 1 and some level 2. The issue is usually resolved by negotiation between the state coroner or deputy state coroner and the Local Area Commander where the death occurs. However the uncertainly is unnecessary and unhelpful.

Concern

The imprecision of the definition of s23 deaths and the disjuncture between those deaths and the categorisation of critical incident deaths risks the critical incident investigation and the coronial investigation being uncoordinated. Further, in some cases it is difficult to determine whether a death falls within s23 because of the incomplete definitions in that section.

Recommendation 1 – Consistent comprehensive definitions

It is recommended that the Coroners Act and the Critical Incident Guidelines be amended so that deaths which are connected to police action, inaction or custody and in which inquests are mandatory are consistently and comprehensively defined in both instruments. The precise terms should be arrived at following consultation between the state coroner and the Commissioner NSWPF.

Why oversight critical incident investigations

Once it is determined a death is a death in police custody or a death in a police operation the investigation of it proceeds in accordance with the Critical Incident Guidelines.

Among other things, those guidelines direct that a Review Officer is to be appointed to monitor and review the probity of the investigation but the Review Officer does not become involved in the investigation or set its direction.

The coroner is authorised by s51(2) of the Coroners Act to give a police officer directions concerning investigations to be carried out for the purposes of proposed coronial proceedings.

The coroner is assisted by independent counsel during the preparation of a matter for inquest. That counsel is usually briefed by the Crown Solicitors Office.

Pursuant to s146 of the Police Act the Ombudsman may monitor the investigation but only if a complaint has been made about some aspect of police conduct and the Commissioner of Police does not suspend the investigation. That monitoring may include officers from the Ombudsman's office conferring with the SCII and attending interviews undertaken by the SCII and those working with him/her.

Concern

Most critical incident deaths do not prompt an official complaint because those connected to the deceased are not aware of sufficient information on which to base a complaint and/or do not know of their right to make one. Accordingly, most critical incident deaths are not monitored by the Ombudsman's office.

The state coroner or deputy state coroner to whom the death has been reported could in theory monitor the investigation but it is not practical for that to occur in more than a general sense for a variety of reasons.

In matters which are identified as contentious from the outset counsel assisting is appointed at an early stage and he/she meets with the SCI and has input into the framing of issues to be investigated etc but this is a fairly arms' length process. Further, counsel assisting has no authority to direct police as to how the investigation should be undertaken. In practice, if counsel assisting becomes concerned that something is not being done which should be done or is not being done in an appropriate manner he/she can raise those concerns with the coroner who can issue a direction to the investigators. However, this is a convoluted process and in many instances investigative steps are time critical.

Further, in many cases the circumstances of a death may seem relatively benign when first reported. In such cases the coroner receives an initial telephone briefing, and then only receives periodic updates. In such cases counsel assisting is not briefed until the investigation report is finalised and provided to the coroner. However, the initially reported "facts" frequently change as an investigation proceeds.[2] These changes are frequently not brought to the coroner's attention. He/she is then left with having to rely on the investigators responding appropriately. In most cases that occurs but the risks are significant.

On occasions, police officers may have difficulty objectively assessing the reasonableness of the operational activities of other officers when a death has apparently resulted from the involved officers' actions.

It is not suggested police officers investigating deaths that occur in an operational setting deliberately seek to "cover-up" misconduct or "run dead". Rather, in my experience, the understandable empathy more senior officers feel for the junior officers usually involved in these incidents can undermine the impartiality of investigators and internal review officers. Because the primary victim frequently precipitates the deadly interaction by aberrant behaviour, there is a tendency to characterise the involved officers' actions as a matter of operational judgment that can't be validly critiqued. On occasions searching questioning of the involved officers and other witnesses is appropriate. Once the opportunity to do that is

[2] In 1995, the author was told by the then Deputy Police Chief of Loss Angles that he had found that invariably a material "fact" reported at the time of a police related death was found to be wrong by subsequent investigation.

missed it is often irretrievable and can negatively impact on other aspects of the investigation.

Consequently, in my view, for the assessment of the compliance with police policies to be independent and rigorous, it needs to be undertaken by an agency external to the NSWPF.

Similarly, if the testing of the findings and substance of the investigation is to be independent that also needs to be undertaken by an external agency, notwithstanding those matters will be further considered during the inquest.

To mitigate the risk of evidence being lost or degraded as a result ofthe occasional reluctance of police investigators to critically examine the actions and motivations of involved officers, real time monitoring of the investigation by an independent agency is essential.

In those cases where counsel assisting is appointed at an early stage, he/she should also be kept informed about the progress of the investigation. If counsel assisting becomes concerned about the manner in which matter is progressing, or if he/she concludes that a different or another investigative stagey is appropriate those concerns will be drawn to the attention of the coroner who will decide whether a direction to the SCII under s51 of the Coroners Act is warranted. In any event, the interaction between the state coroner, the oversighting agency and the NSWPF should be the subject of protocol negotiated between those three parties.

Recommendation 2 - Real time oversight by an independent agency

Coroners need a mechanism which ensures the quality and integrity of the investigation of fatal critical incidents and that causes them to be notified immediately if that is jeopardized so that remedial action can be taken. In order that the public and the coroner can have confidence that the investigation is being effectively monitored it needs to be undertaken by an expert independent agency with as of right access to all information gathered during the investigation as it comes to hand. I recommend such an agency be created or an existing agency empowered.

Which agency should oversight?

Currently, the investigation, oversight and monitoring of complaints of police misconduct can be undertaken by the Ombudsman or the Police Integrity Commission. In practice, neither agency undertakes many investigations. The Ombudsman oversights about a third of all complaints investigated by the NSWPF by reviewing the proposed investigation and the outcome. This is of limited utility in my view: once an investigation is compromised or evidence is not secured early, recovery is unlikely. Very few are contemporaneously monitored. The external oversight of fatal critical incidents is usually absent until a report is presented to the coroner months or even years after the event. Fatal police shootings and police pursuits are examples of this.

The current arrangements are consistent with the principle that a CEO of an organisation is primarily responsible for monitoring and correcting the performance of the staff of the organisation. However, the unique nature of police powers and the impact their exercise may have on individual members of the public and public confidence in the NSWPF justifies a departure from that principle when serious misconduct is alleged or suspected. Similarly, when a police related death occurs.

In such cases the need to ensure the investigation is independent and that the facts are rigorously pursued should take precedence over the general management responsibility principle. Complaints about more minor matters involving quality of service can provide an organisation with valuable feedback from its customer or consumers that should lead to an improvement in that service. However, allegations or suspicions of serious misconduct need a response most likely to establish what precisely occurred if aberrant behavior is to be corrected and/or unsuitable officers removed from the Force. In such cases justice for those impacted by the questionable conduct and public confidence in the independence of the investigation must be given a higher priority.

A difficulty in implementing an arrangement whereby only serious matters are considered by an external agency is that in many cases the seriousness of an incident cannot be assessed until at least some investigation is undertaken. Further, looking at a complaint in isolation from other intelligence about the subject officer or his/her associates can lead to an underestimation of the significance of the complaint. Similarly, an increase in the prevalence of a particular type of allegation or an increase in the number of complaints being made in relation to an individual officer or the officers of a particular unit or region, even if the allegations themselves are relatively minor, can flag a failure of management or the existence of more serious on-going misconduct that has not been detected.

In my view, all of these concerns can be addressed by the creation of an agency that:-

- is notified of all complaints and serious incidents involving police officers;
- is staffed by police investigators answerable to civilian team leaders and a civilian executive;
- has own motion power to undertake investigations;
- assesses all complaints and intelligence about police misconduct; and
- in accordance with protocols negotiated with the Commissioner of the NSWPF:-
    - investigates matters itself;
    - refers other matters back to the NSWPF for investigation; and
    - monitors and/or reviews investigation being undertaken by the NSWPF.

This proposal cannot be impeached on the basis that it would involve police officers investigating police accused of serious misconduct because that it what is already occurring. This proposal would add the stringency of direct civilian oversight of those investigations.

Nor can it cogently be argued that such an arrangement would jeopardize the confidentiality of corruption investigations: the NSWPF has procedures for maintaining security of covert operations that could be readily adopted and adapted.

Another advantage of an organisation structured along these lines is the shared consensus that should develop between the seconded police officers and the civilian employees. The civilians can develop a more realistic appreciation of the practical challenges of policing and the police officers will have greater insight into how civilians can be aggrieved by police actions. Officers in the field are more likely to accept critiques informed by the views of experienced officers working for the oversight agency. The mistrust and animosity towards

the agency will diminish as more and better officers undertake secondments to the agency and return to the force.
Generally, police officers are no less ethical than members of the general population. On the contrary, it is easy to demonstrate by countless examples that most officers regularly demonstrate impeccable integrity. However, for a variety of reasons, perhaps more so than the general population, police officers are influenced by peer group pressure. This can be result in altruism and bravery; but it can also lead to unwillingness to hold colleagues accountable. However, if an officer's workmates and supervisors are civilians demonstrably committed to improving police performance and vindicating good police work those civilians can equally influence officer behavior, in my experience.

Concerns that high profile complaints about quality of service might starve less visible but more serious corruption investigations can be addressed by a budget committee with power to quarantine the funding of the latter function, or vice versa.

Such an agency would turn out to all deaths in police custody or deaths in a police operation to ensure the initial assessment could provide the coroner with a sound basis on which to form a preliminary judgment of the seriousness of any police misconduct that might be involved. Depending upon that assessment, the agency would calibrate its on-going oversight of the investigation. Protocols developed between the state coroner, the head of the agency and the police commissioner would avoid unnecessary duplication of investigative effort and would provide a mechanism for material to be disseminated to the NSWPF expeditiously if remedial action was called for.

Recommendation 3 – Creation of a single police oversight agency
For the reasons detailed above, I recommend that all complaints and serious incidents involving police officers be assessed by a single agency that has power to investigate or oversight the investigation of such matters as its charter and operational protocols provide for. That should extend to oversighting the investigation of deaths in police custody or those that occur in a police operation.

M A Barnes
NSW State Coroner
10 July 2015