LECC
Law Enforcement
Conduct Commission

OPERATION EACHAM

A report under section 132 of the *Law Enforcement Conduct Commission Act 2016,* dealing with indifference to an Aboriginal man's self-harm in custody

June 2025

LECC
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Conduct Commission

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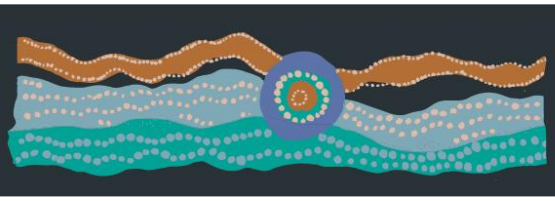
The Law Enforcement Conduct Commission acknowledges and pays respect to the Traditional Owners and Custodians of the lands on which we work, and recognises their continuing connection to the lands and waters of NSW. We pay our respects to the people, the cultures, and the Elders past and present.



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Office of Commissioner

23 June 2025

The Hon Ben Franklin, MLC
President
Legislative Council
Parliament House
SYDNEY NSW 2000

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

Dear Mr President and Mr Speaker

Operation Eacham

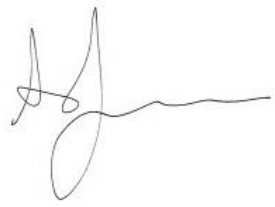
In accordance with s 132(3) of the *Law Enforcement Conduct Commission Act 2016* (the LECC Act), the Commission provides you with a copy of its Report:

> Operation Eacham
>
> A report under section 132 of the *Law Enforcement Conduct Commission Act 2016,* dealing with indifference to an Aboriginal man's self-harm in custody.

I presided at the private examinations held in aid of the investigation.

In accordance with s 142(2) of the LECC Act, I recommend that this report be made public immediately.

Yours sincerely



Anina Johnson
Commissioner

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Executive Summary

At 8.30 one morning, the New South Wales Police Force declared a Critical Incident Investigation as a result of a head injury sustained by an Aboriginal man (CAE) whilst in police custody in a Regional Town overnight. CAE is an Aboriginal man who police knew had serious mental health conditions and a past history of self-harm in custody.

The critical incident was revoked three days later. Revoking the critical incident allowed the Commission to investigate whether there had been any attempt to call an ambulance for CAE whilst he was in custody, and if not, why this was not done.

The Commission had access to police documents, CCTV footage and conducted 2 private examinations.

The evidence before the Commission was that during his 3 hours in the dock, CAE sustained visible injuries. These injuries were incurred when CAE banged his head against the metal bench in the dock and banged his head and punched the dock door and wall.

CAE's banging was loud enough to be heard in other parts of the police station. Yet the custody manager, Officer EAC1 made little attempt to stop it. Other officers considered that an ambulance was needed, and this was raised with Officer EAC1. He did not request an ambulance.

By 1 am, CAE's temple had developed a large lump which was clearly visible in the photos taken in custody. Officer EAC1 decided that it was still appropriate to transport CAE to a City Police Station in the back of a police caged vehicle – a drive of 1 ½ hours.

Officer EAC1's decision not to call an ambulance was influenced by the fact that he thought CAE was 'bunging on' his self-harm in an attempt to be taken to hospital and not into correctional custody. Officer EAC1's view was that Aboriginal people in the Regional Town community often attempted to manipulate the system in this way.

The Commission found that Officer EAC1's conduct amounted to serious misconduct.

The Commission recommends statutory amendment to extend the timeframe for bringing charges under s 201 *Police Act 1990* (NSW).

The Commission also reviewed the mental health and Aboriginal cultural awareness training that Officer EAC1 had undertaken. The Commission does not recommend any changes to that training but expects that the very recent events documented in this report will be considered by the NSW Police Force as they develop further training on these topics.

1. The Role of the Commission

1.1. This matter began when a critical incident was declared by an Assistant Commissioner. A critical incident is an incident involving a police officer or member of the NSW Police Force that results in the death or serious injury of a person as a result of a number of specified police actions or whilst a person is in custody: s 110 *Law Enforcement Conduct Commission Act 2016* (NSW) (LECC Act).

1.2. Under Part 8 of the LECC Act, the Commission can monitor a police critical incident investigation. However, the Commission may not investigate allegations of police misconduct that might have occurred during a critical incident, while the police investigation is still on foot: s 44(1)(d) of the LECC Act.

1.3. Three days later, the critical incident investigation was revoked on the basis that there was no evidence CAE had sustained a serious injury. Once the critical incident investigation was revoked, the Commission was permitted to investigate the circumstances surrounding CAE's time in custody.

1.4. By the end of that month, the Commission decided that the matter should be investigated by the Commission under Part 6 of the LECC Act.

1.5. The other relevant provisions of the LECC Act are set out in Appendix 1 of this Report.

1.6. The Commission does not sit as a criminal or civil court. It does not determine the rights of any person. However, the Commission may make findings which are adverse to persons and their reputation. The standard of proof to be applied by the Commission in making findings of fact is the civil standard of proof, proof on the balance of probabilities, being qualified having regard to the gravity of the questions to be determined. The test is whether the facts have been proved to the reasonable satisfaction of the Commission.

1.7. An important function for the Commission is to determine whether any police officer has engaged in 'serious misconduct' as defined in s 10 of the LECC Act. In addition, the Commission may make findings, express opinions or make recommendations under s 133 of the LECC Act.

1.8. The Commission has decided that this report should be tabled in Parliament under s 132 of the LECC Act, but that pseudonyms should be used to protect the identity of those involved in these events. It has also taken steps to de-identify the town where these events occurred. In adopting this approach, the Commission had regard to the Guidelines on the use of pseudonyms and non-publication orders in Commission reports published by the Commission in November 2023.

1.9. The Commission has made orders protecting the identity of the people involved in this report. Those orders are set out in Appendix 2 to this report.

2. The Commission's Investigation

CAE

2.1. CAE is a First Nations man. He is a Regional Town local, whose family also live in the town. He is a father, a son, a brother and a cousin.

2.2. CAE frequently crossed paths with police, both in the context of criminal allegations and when police were called to respond to concerns for his welfare. His police profile highlights issues which might pose a risk to arresting police as well as past attempts at self-injury and thoughts of suicide.

2.3. The Commission attempted to contact CAE for comment during the investigation but was unsuccessful. Regrettably this report was therefore prepared without the voice of CAE.

Officers on duty

2.4. There were 4 officers on duty at Regional Town Police Station on the evening in question:

- Officer EAC2 was a constable, with about 2 years of service as a police officer. He had been stationed at Regional Town Police Station throughout his 2 years.
- Officer EAC1 had been a police officer for 16 years, working in both metropolitan and regional New South Wales. He had been a senior constable for about 10 years and had been working as a police officer in the Regional Town area for about 4 years.
- Officer EAC3 was a probationary constable at the time of the event and had been working at Regional Town Police Station for his whole period of service.
- Officer EAC4 had been appointed as a senior constable about 6 months prior to the event. He had been stationed at Regional Town Police Station for about 5 years.

2.5. Officers EAC1 and EAC2 gave evidence in private examinations before the Commission on 19 and 20 November 2024. Officer EAC4 provided evidence to the Commission in the form of answers to a statutory notice. On the basis of the evidence provided to the Commission by Officers EAC1, EAC2 and EAC4, the Commission determined that evidence was not required from EAC3.

2.6. Officers EAC1 and EAC2 were asked about what they knew of CAE before the night in question. Both said that they had had previous dealings with him. However, they were also generally aware of him through conversations with other police at the station.[1]

[1] Private examination ZMS at T18; Private examination VKD at T24-25.

2.7. Officer EAC2 knew that CAE was an Aboriginal man, local to Regional Town. He was aware of CAE's criminal record and that CAE had a significant history of domestic violence offences. He was aware that CAE had an extensive mental health history and that he had previously been taken to hospital by police.[2]

2.8. As at the date of arrest, Officer EAC1 knew that CAE was an Aboriginal man, local to Regional Town and that he had family who lived in the town. Officer EAC1 was aware that CAE was subject to an apprehended domestic violence order. He was aware that CAE had a lengthy criminal record, a history of drug use and that he had a background of multiple mental health issues. In particular, Officer EAC1 knew that CAE had a diagnosis of schizophrenia and history of self-harm, which had previously required police to call for an ambulance and to assist with transporting CAE for a mental health assessment. Officer EAC1 knew that CAE had a history of hurting himself when in police custody, including by banging his head on the dock in the Regional Town Police Station.[3]

Background to CAE's arrest

2.9. About 2 months before CAE's arrest, CAE went to the home of his former partner in breach of an apprehended domestic violence order. He smashed items in the home, physically assaulted his former partner and made threats against her. His former partner reported this to police about 2 weeks later. His former partner told police that she believed CAE was using illicit substances and had stopped taking his mental health medication.[4]

2.10. For the remainder of the month, the police system notes that police made regular attempts to locate CAE, with police contacting and visiting a number of addresses and speaking with CAE's friends and family.[5]

Arrest of CAE

2.11. On the night of CAE's arrest, Officer EAC2 received information that CAE was at a particular address in Regional Town. Officer EAC2 knew that police were trying to locate CAE and that he had a number of mental health conditions.[6] Before arranging to go to the nominated address, Officer EAC2 checked the police system to make sure that police were justified in arresting CAE. He noted reference to CAE's mental health conditions on the police system.[7]

2.12. Officer EAC2 went with Officer EAC3 and Officer EAC4 to the nominated address to arrest CAE.

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[2] Private examination ZMS at T16-18.
[3] Private examination VKD at T17-21.
[4] Exhibit ZMS 3C at 46.
[5] Exhibit ZMS 3C at 46.
[6] Private examination ZMS at T36.
[7] Private examination ZMS at T35; Exhibit ZMS 4C.

2.13. Body worn video footage[8] shows that police entered the house where CAE was sitting on the kitchen floor with his head on his forearms. Upon entry, police had a taser drawn, but CAE was cooperative and was handcuffed to the rear without any use of force. CAE almost immediately began to whimper and sob. He continued to whimper while walking to the caged police vehicle. The officers asked CAE why he was crying and he told the officers that he was on medication. Officers asked what medication he was on, but the conversation moved on without an answer. The officers offered to get CAE a t-shirt from the house as he got into the back of the caged truck, but he said he did not have one.

2.14. As he sat in the back of the caged truck, CAE banged his head twice against the vehicle, loudly enough for the bangs to be captured on the body worn video. He protested that, "I haven't done nothing wrong." The officers said, "don't [CAE]". CAE stopped. The officers asked if he had taken any drugs and CAE told them that he had been clean for a month. As the door to the truck closed, Officer EAC2 said to the other 2 officers, "He does this every time. He hits his head."

2.15. In his evidence, Officer EAC2 explained that he knew that CAE had a history of harming himself by banging his head and that this awareness came from his prior interaction with CAE and from conversations with other police about CAE.[9]

2.16. The officers then drove 2-3 minutes to Regional Town Police Station.[10] Officer EAC2 said that during the drive, CAE laid down on the seat in the caged truck and continued to sob.

Entering CAE into custody

2.17. CAE was placed into a Perspex dock inside the Regional Town Police Station at 10.52 pm. The Perspex dock had a metal bench, which was long enough for CAE to lie down on with his knees bent.

2.18. Responsibility for CAE was transferred to Officer EAC1, who was the custody manager for that shift. The time of his entry into custody is formally recorded as 10:55 pm.[11] Officer EAC1 was already aware of CAE and the reasons for his arrest before he was brought into the police station. However, in his evidence EAC1 said he was not aware that CAE had banged his head in the caged truck when he was taken from the scene of arrest by other officers.[12]

2.19. After CAE was placed in the dock, Officer EAC1 completed the custody management record, under Part 9, Div 3 of the *Law Enforcement (Powers and Responsibilities) Act 2002*. Officer EAC1 recorded that CAE identified as an Aboriginal or Torres Strait Islander person. CAE also disclosed that he had

[8] Exhibit ZMS 6C.
[9] Private examination ZMS at T37-38.
[10] Private examination ZMS at T42.
[11] Exhibit VKD 3C.
[12] Private examination VKD at T43.

previously tried to kill himself by overdose. He disclosed that he had many mental illnesses including anxiety, depression and schizophrenia and that he was currently receiving medication for those illnesses.[13] Officer EAC1 gave evidence that he did not know a lot about schizophrenia but knew that it was a mental illness that could prompt a person to have sudden changes in behaviour and mood.[14]

2.20. Officer EAC1 said that whilst CAE was answering his questions, he was crying and curled up in the dock.[15] Officer EAC1 set the inspection frequency at 60 minute intervals, which is the maximum time allowed by the custody management system.[16]

CAE's time in custody

2.21. Officer EAC1 said that he heard CAE banging the dock up to 40 times in the 30 minutes after he entered custody.[17] Although he could hear the noise, Officer EAC1 said that his view of the dock was obscured. He could see CAE's leg moving and he initially presumed that CAE was hitting the dock with his foot.[18] CCTV footage showed that CAE repeatedly hit the right side of his head against the metal bench.

2.22. At 11.01 pm, Officer EAC1 entered a comment in the custody management system which said, "appears highly emotional, at times gently banging his head on the dock seat." The date stamp on the custody record suggests that by this time, Officer EAC1 was aware that CAE was hitting his head and not his foot against the bench. However, Officer EAC1 told the Commission that he could not remember when he became aware the noises were made by CAE's foot.[19]

2.23. Officer EAC1 said that his custody desk was 3 to 4 metres from the Perspex dock. His view was partially obscured by an open door leading to the custody loading area. A modest movement would have allowed him full view of CAE.[20] Officer EAC1 accepted that he was not paying a great deal of attention to CAE that evening.[21]

2.24. By 11:11 pm, CCTV footage of the custody area shows CAE facing the wall and lying in a curled position, whilst banging his head against the dock seat over and

[13] Exhibit VKD3C; Private examination VKD at T35-37.
[14] Private examination VKD at T38.
[15] Private examination VKD at T53.
[16] Private examination VKD at T60.
[17] Private examination VKD at T45.
[18] Private examination VKD at T41-43.
[19] Private examination VKD at T42.
[20] Private examination VKD at T55.
[21] Private examination VKD at T47.

over again. At 11:15 pm, CCTV records that Officer EAC1 went to the dock. Officer EAC1 said that he told CAE to stop banging.[22]

2.25. At 11:29 pm, the CCTV footage shows CAE getting to his feet and forcefully banging his head against the Perspex door of the dock 3 times, before punching the Perspex door more than 12 times. Officer EAC1 can be seen on the telephone with his hand over his ear, presumably to limit the noise being made by CAE.

2.26. Officer EAC4 said that at this time, he was in the muster room with Officers EAC3 and EAC2. He could hear CAE banging and yelling. He presumed that it was CAE banging his head. When the noise continued Officer EAC4 said to the other officers "Is [Officer EAC1] going to do something?" and went into the custody room.[23]

2.27. CCTV footage shows Officer EAC4 entering the custody room 15 seconds after CAE first punched the dock.[24] CAE forcefully banged his head against the Perspex door another 2 times. Officer EAC4 opened the dock door and held CAE down. Officer EAC1 then moved across from the custody desk and stood at the open door to the dock. Officer EAC4 appeared to be talking to CAE, as did Officer EAC1. Officer EAC4 then let CAE sit back up and continued to talk to him. Officer EAC4 spoke to CAE a little more, then moved out of the dock, with Officer EAC1 closing the dock door. CAE then sat upright in the dock with his head in his hands.[25]

2.28. Following their interaction with CAE, Officer EAC4 and Officer EAC1 left the custody area together.

The need for an ambulance is identified

2.29. Officer EAC4 said that when he walked out of the custody room, he told Officer EAC1 that an ambulance should be called.[26]

2.30. Officer EAC2 recalled that shortly after Officer EAC4 intervened to stop CAE hitting the walls of the dock, there was a discussion between Officers EAC2, EAC3 and EAC4 in the muster room. They all agreed that an ambulance should be called to the police station.[27] Officer EAC2 thought that Officer EAC4 (as the most senior officer of the 3) was going to raise the issue with Officer EAC1. Officer EAC2 remembered Officer EAC4 reporting back that Officer EAC1 had decided not to call an ambulance.[28]

[22] Private examination VKD at T43-44.
[23] Exhibit RTL1C.
[24] Exhibit ZMS 8C; Exhibit VKD8C.
[25] Exhibit ZMS 8C; Exhibit VKD8C.
[26] Exhibit RTL1C.
[27] Private examination ZMS at T52-53.
[28] Private examination ZMS at T55-58.

2.31. Officer EAC1's evidence was that one of the other officers on shift may have suggested that an ambulance should be called for CAE, but that he did not remember who.[29]

2.32. Officer EAC2 and Officer EAC4 have a slightly different recollection about the timing of the suggestion of an ambulance, but the substance of their evidence is the same. The Commission is satisfied that after restraining CAE at about 11.30 pm, Officer EAC4 made a strong recommendation to Officer EAC1 that an ambulance should be called. Officer EAC1 declined to call an ambulance. Officer EAC4 reported the effect of this conversation to Officers EAC2 and EAC3.

2.33. In answering questions put by counsel assisting the Commission, Officer EAC1 agreed that he should have called an ambulance at this point.[30]

2.34. Officer EAC2's evidence was that he was not aware of any difficulties in getting an ambulance to the Regional Town Police Station.[31]

CAE continues to self-harm

2.35. Less than a minute later, at 11:32 pm, CAE stood up in the dock and violently hit his head against the Perspex door of the dock and then twice hit his head against the brick wall inside of the dock. He drew his arm back and repeatedly punched the Perspex door of the dock with force. He then head butted the Perspex door of the dock about 18 times. Officer EAC1 is standing at the charge counter and moves only after CAE has been hitting the Perspex and brick wall for 45-55 seconds. As Officer EAC1 walks across to stand at the dock door, CAE lies back down on the metal seat, and Officer EAC1 returns to his charge counter.[32]

2.36. Officer EAC1 said that even at this stage he had a limited awareness of which body parts CAE was using in order to punch the Perspex door and brick wall of the dock.[33] Officer EAC1 told the Commission that he could not see any blood on CAE when he conducted his visual inspection and the idea that CAE may have broken bones when he punched the wall and door did not occur to him.[34] Officer EAC1 accepted that he should have been checking on CAE more frequently than he was, and certainly more than the 60 minute intervals that he had entered into the custody management record.[35]

2.37. In submissions received from Officer EAC1's legal representative it was noted that Officer EAC1 inspected CAE more frequently than in 60 minute intervals.[36] The

[29] Private examination VKD at T68.
[30] Private examination VKD at T94.
[31] Private examination ZMS at T15, T80.
[32] Exhibit VKD9C.
[33] Private examination VKD at T54-57.
[34] Private examination VKD at T57-59.
[35] Private examination VKD at T60.
[36] Officer EAC1's Submissions on Draft Report at para 9.

Commission acknowledges that there were occasions when Officer EAC1 conducted observations of CAE, which were at less than 60 minute intervals. These include the occasion on which CAE was escorted out of his cell for the purpose of taking fingerprints and photographs, and when significant incidents occurred. These are documented in further detail below.

2.38. At 12:01 am, Officer EAC1 recorded in the custody management record that CAE was "annoyingly banging on the dock seat with his hand".[37] Officer EAC1 did not approach the dock to conduct his inspection, but simply guessed that it was CAE's hand and not his head which was the source of the banging.[38] This is despite Officer EAC1 admitting that from about 11.30 pm he was aware that CAE was hitting his head against the dock wall.[39] Officer EAC1 agreed that given the continual banging, he should have made an effort to observe CAE closely.[40]

2.39. The only record of this conduct in the custody management record is at 11.33 pm when Officer EAC1 records that CAE was "punching the dock and hitting his head against the dock wall." Officer EAC1 told the Commission that he simply recorded the actions of CAE at the 60 minute intervals prompted by the custody management system, rather than documenting these significant incidences as they occurred.[41]

2.40. By 12:46 am, CCTV footage shows that CAE had a significant and easily visible lump on the right side of his forehead.[42] That footage also shows that Officer EAC2 and Officer EAC3 had also walked past the dock and were looking in the dock. Officer EAC3 appears to talk to CAE. A few minutes later, the CCTV footage shows Officer EAC2 giving CAE water in a paper cup.

Custody photos

2.41. At 1:14 am, Officer EAC4 opened the dock door for the purpose of arranging for CAE to have his custody photos and fingerprints taken. At 1.22 am, CCTV footage shows Officer EAC1 giving instructions to CAE in relation to taking his custody photos. Officer EAC1 takes 4 photos of CAE. CAE was calm during this process. CAE stood while the photos were taken and then helped himself to some water from the sink in the corner of the charge room before opening the dock door and lying back down on the bench.

2.42. The 4 charge photos show that by this time, CAE had a very prominent lump on his right forehead, which distorts the shape of his forehead. The lump is impossible to miss. Officer EAC1 acknowledged that at this point he must have

[37] Exhibit VKD3C at 6.
[38] Private examination VKD at T70.
[39] Private examination VKD at T65.
[40] Private examination VKD at T66.
[41] Private examination VKD at T64-65.
[42] Exhibit ZMS 9C; Exhibit VKD10C.

contemplated that the banging sounds that he had heard throughout CAE's time in custody could have related to his head, rather than his foot or hand.[43]

2.43. Officer EAC1 accepted that by 1:20 am, when he had taken the custody photos, the extent of CAE's physical injuries was clear to him. He was also aware of the volatile nature of CAE's behaviour during his 2 ½ hours in custody. Officer EAC1 said that he did not call an ambulance, because CAE had been cooperative in taking the custody photos and appeared to have a relatively clear mind, despite the significant lump on his forehead.[44] In answering questions put by counsel assisting the Commission, Officer EAC1 agreed that he should have called an ambulance for CAE at this point.[45]

The decision to transport CAE in a caged truck

2.44. Regional Town Police Station is not a 24-hour station. Anyone who is remanded in custody when the station is closing has to be moved to City Police Station. CAE had been refused police bail and was therefore remanded in custody to be taken before the Local Court the following morning.[46] The journey from the Regional Town to the City takes about 1 hour and 20 minutes.[47]

2.45. As custody manager, Officer EAC1 accepted that it was his duty to seek medical attention if he had concerns about a detained person's mental or physical condition.[48] In addition to CAE's observed behaviours on the night in question, Officer EAC1 was also aware that CAE had a number of other factors, which the Standard Operating Procedures identifies as risk factors for people in custody, in that he:

- is an Aboriginal person;
- has a past history of mental health issues;
- has a history of drug and alcohol use;
- has a past history of suicide attempts; and
- has a past history of self-harm in police custody.[49]

2.46. Indeed, headbanging in custody was specifically mentioned in the Standard Operating Procedures as a behavioural indicator of distress and a warning sign that the person in custody is at risk of self-harm.[50]

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[43] Private examination VKD at T69-70.
[44] Private examination VKD at T77.
[45] Private examination VKD at T74.
[46] Private examination ZMS at T59.
[47] Private examination VKD at T74.
[48] Private examination VKD at T71.
[49] Private examination VKD at T72-73.
[50] Exhibit VKD13C at 20.

2.47. If an ambulance had been called, and the paramedics assessed that CAE needed medical care, then he would have been transported to a hospital and not to a police station. If some form of restraint were required, he could have been given a sedative and/or restrained on the ambulance gurney.[51] There was also the option of transporting CAE in a police vehicle to the Regional Town Hospital, which was only a few minutes down the road from the police station.[52]

2.48. However, if a person in custody is transported to a hospital for assessment and treatment, then transporting police officers are required to remain at the hospital to provide a police guard. That guard will continue until relieved by other police officers. Transporting CAE to hospital rather than the City Police Station on the night CAE was in custody, would have meant that the officers from the Regional Town would be required to remain on guard until late the next morning. Transporting CAE to City Police Station (even taking into account a return journey of approximately 3 hours) was a considerably quicker and more convenient option.[53]

2.49. Officer EAC1's decision not to call an ambulance meant that the only method of transporting CAE was in a caged police vehicle, with or without handcuffs as a restraint.[54]

Transporting CAE

2.50. CAE was handcuffed and placed into the back of a caged police vehicle at 1:40 am. Officer EAC2 said that CAE was calm until that point. Once the cage door was closed, CAE began to hit himself in the head with the handcuffs. Officer EAC2 then opened the caged door and removed the handcuffs, with Officer EAC1 standing beside him. Officer EAC1 knew that CAE was now distressed to the point of hitting himself in the head with the handcuffs. At this point, the vehicle was still parked at Regional Town Police Station.[55]

2.51. Officer EAC2 said that once the door was closed again, CAE began to hit his head against the side wall of the caged vehicle. He started to do this before the vehicle left Regional Town Police Station. This is supported by the CCTV footage of the van dock which shows the vehicle physically moving from side to side whilst parked.

2.52. The CCTV shows the police vehicle leaving Regional Town Police Station at 1:44 am. Officer EAC2 made a call to VKG (police radio) at 1:44.11 am, saying that the vehicle was leaving Regional Town to transport a prisoner who had been bail refused. The Commission has the recording of that VKG call.

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[51] Private examination VKD at T75.
[52] Private examination VKD at T76.
[53] Private examination VKD at T78-79.
[54] Private examination VKD at T75.
[55] Private examination ZMS at T62; Private examination VKD at T84; Exhibit ZMS13C.

2.53. Whenever the police radio is switched through to Officer EAC2, there are audible bangs in the background. Those bangs can be heard about once a second during the period when the radio channel is open for Officer EAC2 to speak.[56] Officer EAC2 agreed with counsel assisting's suggestion that at this point, it was still possible for police to take CAE to the Regional Town Hospital, which was only a 1-2 minute drive away.[57]

2.54. Officer EAC1 said that he did not consider changing his decision to transport CAE to the City Police Station. His view was that CAE was prepared to "do whatever he can, not to go to [City Police Station]". He considered that CAE was attempting to manipulate police decision-making by self-harming in an effort to prompt police to take him to a hospital rather than into police custody.[58]

2.55. Officer EAC2 said that the banging continued fairly constantly for the first 10 minutes of the trip. Officer EAC1's evidence was that the banging continued for the first 20 minutes of the journey. Officer EAC1 said that CAE was hitting his head with such force that it shook the police vehicle, whilst the vehicle was travelling at 110km along the highway.[59]

2.56. After a period of time, the noise stopped. Officer EAC2 said that CAE lay down in the back of the truck and Officer EAC2 had to crawl out of his seat to be able to conduct observations.[60] Officer EAC2 gave evidence that he discussed the need for an ambulance again with Officer EAC1 during this trip.[61]

2.57. Officers EAC1 and EAC2 both gave evidence that before they arrived at the City, Officer EAC1 contacted the custody manager at the City Police Station to explain that CAE had head injuries after hitting his head in the truck. Officer EAC1 asked that an ambulance meet their vehicle at the City Police Station. [62]

2.58. Officer EAC1 gave evidence that this phone call was made when the officers stopped after about 45 minutes to check on CAE's condition.[63] Officer EAC1 said that CAE was conscious at that point.[64] Officer EAC1 said that it was not possible to make a phone call before they stopped as there was no phone reception.[65]

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[56] Exhibit ZMS 12C.
[57] Private examination ZMS at T72.
[58] Private examination VKD at T85-86.
[59] Private examination ZMS at T64; Private examination VKD at T88.
[60] Private examination ZMS at T64.
[61] Private examination ZMS at T68.
[62] Private examination ZMS at T70 – 71; Private examination VKD at T100; Exhibit VKD14C.
[63] Private examination VKD at T87.
[64] Private examination VKD at T87.
[65] Private examination VKD at T101.

2.59. The custody manager at the City Police Station told them to take CAE directly to the City Hospital. The change of plan was reported to VKG about 10 minutes before their arrival into the City.[66]

2.60. When pressed by counsel assisting, Officer EAC1 acknowledged that despite CAE's calm demeanour when taken out of the dock for charge photos, there was a real risk that he would self-harm on the drive from the Regional Town to the City.[67] Officer EAC1 acknowledged that CAE's behaviour had fluctuated significantly throughout the night, from highly agitated to calm. He appeared to be most calm when talking to the officers on duty. When deciding whether to transport CAE, Officer EAC1 said he only considered CAE's behaviour in the half hour prior to placing him in the truck.[68]

2.61. Officer EAC1 acknowledged that he placed more weight on his physical observations of CAE as his photo was being taken than he did on CAE's history of self-harm, including on the evening in question, whilst previously in police custody and in the community.[69] Officer EAC1 also knew that CAE had a diagnosis of schizophrenia which could make a person unpredictable in their behaviour.[70]

2.62. Officer EAC1 acknowledged that if CAE had been transferred to a hospital, either in a police vehicle or in an ambulance, then the Regional Town Police Station police officers would be required to keep him under police guard until relieved by an incoming shift. The quicker and more convenient option for him and his fellow officer was to transfer CAE to police custody in the City.[71]

2.63. Officer EAC1 acknowledged that in deciding to transport CAE to the City Police Station he exposed CAE to an unjustifiable level of risk.[72]

Obvious risk to CAE

2.64. In answers to questions put by counsel assisting the Commission, Officer EAC1 conceded that there were a number of points during that evening when he should have sought medical attention for CAE:

- From 11:30 pm, when CAE first stood up and began to punch and head-butt the Perspex walls of the dock, he should have called an ambulance.[73]

[66] Private examination ZMS at T70-71; Private examination VKD at T90, T100; Exhibit VKD14C.
[67] Private examination VKD at T77-78.
[68] Private examination VKD at T82.
[69] Private examination VKD at T77-78.
[70] Private examination VKD at T83.
[71] Private examination VKD at T78-79.
[72] Private examination VKD at T83.
[73] Private examination VKD at T73.

- At 1.20 am the next morning when Officer EAC1 took the custody photos, and the significant injury to CAE's head was obvious.[74]
- At the time that police left the Regional Town Police Station and CAE immediately began to self-harm in the caged police vehicle, when there was the option of driving to the Regional Town Hospital rather than to the City Police Station.[75]

2.65. In any Commission investigation, the Commission must be mindful of the effect of hindsight bias, which is the tendency to assume that events are more predictable or foreseeable than they really were to those involved in the situation as it developed.[76]

2.66. The Commission's concerns about Officer EAC1's failure to fulfil his obligation to seek medical attention for CAE is not a question of hindsight bias. It was apparent to other officers involved in events on the night.

2.67. The Regional Town Police Station does not appear to have been busy on the night CAE was in custody. There was one other person in custody, who was released in the early hours of the next morning at about 12:55 am. CCTV footage shows Officer EAC1 at the custody desk and 2 - 3 other officers walking in and out of the charge room, without any apparent haste. No other pressing issues were identified by Officer EAC1 in his evidence to suggest that he was unable to attend to CAE on the night.

2.68. In submissions received from Officer EAC1's legal representative,[77] it was noted that whilst it cannot excuse Officer EAC1's lack of attention that he paid to CAE whilst Custody Manager, Officer EAC1 was attending to multiple duties as Custody Manager in addition to the (admittedly paramount) task of monitoring CAE's safety such as:

1. Completing CAE's Custody Management Record;

2. Contacting the Aboriginal Legal Service (NSW/ACT) Limited in order to ensure that CAE's legal entitlements were met under s 112(1)(b) of *the Law Enforcement (Powers and Responsibilities) Act 2002* and s 37 of *the Law Enforcement (Powers and Responsibilities) Regulation 2016*; and

3. Performing his role as Custody Manager in respect of another person in custody, including the process around the movement of that other person from out of the custody of the Police Station.

[74] Private examination VKD at T74.
[75] Private examination VKD at T76.
[76] Hugh Dillon and Marie Hadley, *The Australasian Coroners Manual* (Federation Press, 2015) 10.
[77] Officer EAC1's Submissions on Draft Report at para 6.

This submission is accepted by the Commission and is relevant in assessing the conduct of Officer EAC1.

2.69. Officer EAC1 said that his view of the dock was obscured and this prevented him from being aware that CAE was banging his head and not some other part of his body. However, the distance from the charge counter to the dock was 3-4 metres. It was only obscured by a partly open door that could have been easily pushed to one side. CAE's banging was forceful enough to be heard in the adjacent muster room and to prompt Officer EAC4 to come in to see why there was so much noise. Officer EAC2 and Officer EAC3 also checked on CAE.

2.70. There was no good reason preventing Officer EAC1 from checking on CAE and the source of the banging.

2.71. By 11.30 pm, Officer EAC4 considered that an ambulance was needed for CAE. Officer EAC2 said that he and Officer EAC3 shared this view, given what they had heard from the muster room. Officer EAC4 made this suggestion to Officer EAC1 and was told that an ambulance would not be called.

2.72. When Officer EAC1 called the custody manager at the City Police Station, en route to the City Police Station, and described a situation where CAE had been self-harming in the back of the police vehicle during the drive, the custody manager immediately directed Officer EAC1 to go to the City Hospital. This appears to have been the obvious course to the City Police Station custody manager, despite having more limited information than was available to Officer EAC1.

2.73. The Commission notes that Officer EAC2's knowledge of the available options for obtaining mental health care for a person in custody in the Regional Town Police Station was significant and nuanced. He was able to articulate the various legal and practical options available, despite his more junior rank and only 2 years' service as a police officer. He was firm in his evidence that had the decision been his, an ambulance would have been called for CAE. [78]

Critical incident

2.74. A critical incident was declared when a computed tomography (CT) scan at the City Hospital showed that CAE had a bleed on the brain.[79] The Commission was notified of the critical incident investigation and a Commission critical incident investigation monitoring team member attended the Regional Town and was briefed about the investigation.

[78] Private examination ZMS at T66-67.
[79] Exhibit RTL8C.

2.75. Three days later, the critical incident decision was revoked. The Commission was advised that the reason for the critical incident decision being revoked was that there was no evidence that CAE had sustained a serious injury.[80]

Legal and Police policy obligations

2.76. Section 129 of the *Law Enforcement (Powers and Responsibilities) Act 2002* provides:

> **129 Right to medical attention**
>
> The custody manager for a detained person or protected suspect must arrange immediately for the person to receive medical attention if it appears to the custody manager that the person requires medical attention or the person requests it on grounds that appear reasonable to the custody manager.

2.77. It was apparent to Officers EAC2, EAC3 and EAC4 that CAE required medical attention. It should have been apparent to Officer EAC1.

2.78. Both the Police Handbook and the NSW Police Force Charge Room and Custody Management Standard Operating Procedures (the SOPS) provide guidance on how to respond to people in mental distress when they are in police custody.

2.79. The SOPS[81] set out guidance for custody managers when dealing with persons in custody with mental health conditions or who may be at risk of self-harm.

2.80. The SOPS point out that warning signs for potential self-harm or suicide can be subtle and include weeping, agitation, anger or aggression or being emotionally out of control.

2.81. The SOPS include a bold warning - **Do not ignore these indicators**.

2.82. The SOPS say:

> The first step in preventing suicide in custody, or illness, is identifying the risk. No single sign will necessarily indicate a PIC [person in custody] is contemplating suicide, however a combination of factors might indicate a greater potential.... A PIC might show several warning signs.....The confinement of a PIC combined with other factors should increase a Custody Manager's concern.
>
> Some signs will only be detected with careful observation and questioning. Custody Managers should take the time necessary to make a proper assessment. If you recognise any of the signs, take steps to reduce the

[80] Exhibit RTL9C.
[81] Exhibit VKD12C, Exhibit ZMS11C.

> opportunity for self-injury and arrange for any illness to be treated. Continue to assess the person throughout custody.....
>
> Base your assessment of potential self-harm on the general pattern which develops after making observations, questioning the PIC and asking the arresting police the background information.
>
> Common behavioural indicators of distress are pacing up and down in cells or docks, **headbanging** and vocalising negative thoughts about themselves.
>
> ...
>
> In the case of PICs suffering a mental illness and/or making threats of self-harm, the Mental Health Crisis Team can be contacted on your local mental health line and will assist in assessing the PIC whilst he/she remains in custody. If not available, contact NSW Ambulance and request assistance. (emphasis added)

2.83. If Officer EAC1 had followed the SOPS on this occasion, he would have:

- made closer observation of CAE;
- identified that CAE was exhibiting a number of warning signs for suicide/self-harm risk, including weeping, agitation and headbanging; and
- arranged for assessment through an ambulance.

2.84. In April 2025, the Charge Room and Custody Management Standard Operating Procedure was updated (the April 2025 SOPS). In the April 2025 SOPS update, the bolded warning no longer exists. Instead, there is a framework of factors which needs to be 'considered', in assessing whether a PIC is mentally disturbed.[82]

The first two dot points of that Framework are:

- In assessing a PIC, a custody manager should consider all relevant Information provided by arresting police, observe any signs and symptoms, behaviour, and consider factors such as history of self-harm or suicide, and or a known mental health diagnosis. The custody environment itself can exacerbate an existing condition, trigger heightened emotions, anxiety, or a crisis response. If a PIC is experiencing these behaviours, they should be considered at risk of self-harm or suicide.
- Custody managers should take the time necessary to make a proper assessment of the PIC, some signs and symptoms may only be detected with

[82] Exhibit RTL11C, chapter 8.

observation and questioning. If you recognise any signs or symptoms, take steps to mitigate the risk for self-injury.

2.85. The Framework then provides:

> To assist in assessing whether a PIC is mentally ill or mentally disturbed, the custody manager should consider applying the STATE acronym.
>
> S – Signs and symptoms that Indicate an abnormal mental state - may include;
>
> – Delusions - the person has fixed beliefs that something Is true, despite evidence to the contrary.
>
> – Hallucinations - the person may hear, smell, see, touch, or feel things that are not there.
>
> – Psychosis - a person may present Illogical thoughts, disorganised or Impulsive, non sensical speech, Impaired communication skills, staring Into nothing or at you.
>
> T – Thoughts that Indicate delusions, suicidal Ideas, hallucinations, or paranoid thinking
>
> A – Appearance (dishevelled, unkept)
>
> T – Threats or acts by the person that are potentially harmful to self or others
>
> E – Emotions of the patient that Indicate feelings of sadness, distress, anger, or hopelessness.

2.86. The reference to 'headbanging' is not explicitly mentioned in the April 2025 SOPS. Paragraph 5.5 of the April 2025 SOPS now require that a person with an obvious or stated mental illness, or where there are concerns about self-harm or suicide, should be assessed every 15 minutes for the first 2 hours in custody.

2.87. Had the April 2025 SOPS been in place at the time of this event, they would not have changed Officer EAC1's obligations. If anything, those obligations would have been stricter.

2.88. The NSW Police Force Handbook (the Handbook)[83] refers to the 2018 Memorandum of Understanding between the NSW Police Force and the NSW Ambulance dealing with the transfer of people with mental illness. It states that transportation should be the least restrictive under the circumstances and not be dependent upon expediency.

[83] Exhibit RTL10C.

2.89. The Handbook suggests that family, Community Mental Health, PACER (if applicable) and ambulance vehicles should be used to transport someone with a mental illness. Police vehicles should only be used where there is a demonstrated significant risk to the mentally ill person or others. Police may also escort persons transported in ambulance vehicles.

2.90. The Commission acknowledges that given the time of night and the fact that CAE had been bail refused, the only viable alternative mental health transport was an ambulance. Neither Officer EAC1 nor Officer EAC2 suggested there were any difficulties with access to an ambulance on the night in question.

2.91. Police policies clearly directed Officer EAC1 to keep CAE under close observation and call an ambulance for him when his distress escalated to the point of inflicting self-harm.

The impact of unconscious racism[84]

2.92. At the conclusion of his evidence, Officer EAC1 said that he thought that CAE was attempting to manipulate the system to go to hospital rather than into custody. He was asked about whether this view of CAE's behaviour was influenced by his experiences working with the Aboriginal community in the Regional Town over the previous 4 years.

2.93. Officer EAC1's evidence was:[85]

> Q. To what extent was your attitude to [CAE's] potentially bunging it on, on this night, to escape the - as you saw it, to try and avoid the need to go to [City] and perhaps engineer a pathway to hospital? To what extent was it influenced by the things that you knew about his family as well?
>
> A - it was certainly influenced.
>
> Q. In what way?
>
> Just - I guess just knowing that he's been, you know, arrested numerous times and he always seems to be back out in the community very shortly after. It just seems that a realistic way forward to stop him breaching the AVO was just refuse him bail and send him to court the next day rather than worrying about taking him to hospital and going through that route.
>
> Q. Did you have a perception that he and his family - that the Aboriginal community - were kind of inclined to bung things on, to use the system, to avoid going into custody where they could?

[84] Unconscious racial bias is a term used by the Judicial Commission of NSW in its Equality before the Law Bench Book at 1.4 and in the chapter titled "Actual or apprehended bias and unconscious bias" in the Handbook for Judicial Officers.
[85] Private examination VKD at T97–98.

A. In a way, yes. And sort of the last four years that I've been at [Regional Town], I've noticed a larger proportion of the Aboriginal community will, you know, make some claims to get their own way. And whether it's, you know, bunging it on or just making false allegations, seems to happen quite often.

Q. False allegations?

A. Just like, you know, they might say that, "Oh, police hit me, and that's why, you know, I should be out", or something along those lines.

Q. And in your experience or in your view, rather, so in your opinion, do you think that the Aboriginal community are perhaps more likely to claim a mental health condition to try and get out of going to custody?

A. Yes.

Q. And is it more likely that they will claim a mental health condition as a way of getting an order under the Forensic Provisions Act so that they don't get a conviction?

A. I believe so, yes.

Q. So you were inherently sceptical about claims of mental illness, cognitive impairment, mental health impairments from a member of the Aboriginal community; is that fair?

A. It seems more often than not that a lot of them have claims of mental illness. It's not saying they don't have it, but just seems a large proportion of the community does have it, which I guess makes me a little sceptical about it, yes.

2.94. A report by the University of New South Wales, *A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system* documents the way in which police and other government service providers can view the behaviour of Aboriginal people with a mental health and/or cognitive impairment through the prism of institutional racism rather than disability.[86] The Report's authors write:[87]

> For Aboriginal people with a [Mental Health Disability and Cognitive Disability (MHDCD)], the negative effects of these legacies [of the intergenerational impact of colonisation, trauma, grief and loss, and the lack of funding and support for culturally appropriate services and support in Aboriginal communities] were described as particularly acute. Actions that should be understood in the context of an individual Aboriginal person's cognitive impairment or mental illness are regularly

[86] E Baldry, R McCausland, L Dowse and E McEntyre, *A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system* (Report, University of New South Wales, 2015) at 12.
[87] *A predictable and preventable path* n 86, at 98.

perceived by police as attention seeking or bad behaviour requiring punitive intervention and often custody. Many interviewees in regional towns reported witnessing police targeting Aboriginal people with MHDCD, particularly once they have a history of contact with the criminal justice system.

2.95. The authors report that for Aboriginal people, it has become normal that disadvantage and disability are dealt with in the criminal justice system rather than through social support. Behaviour that in others would be seen as the sign of a mental health or cognitive impairment, such as yelling or swearing in court, is perceived as 'bad behaviour' or somehow typical of Aboriginal people. It is met with punishment rather than a therapeutic intervention.[88]

2.96. The Commission acknowledges that the NSW Police Force is not a social service agency nor is it responsible for the multiple disadvantages facing many Aboriginal people in today's community. However, the experiences reported by Aboriginal people and documented in the University of New South Wales Report are closely mirrored by the evidence that Officer EAC1 gave to the Commission. It is a demonstration of the way in which an unconscious racism can permeate police decision making.

2.97. Although he had undertaken cultural awareness training, Officer EAC1 could not describe that training nor relate how the intergenerational disadvantage and trauma faced by Aboriginal people might lead to a greater level of mental health impairments or cognitive impairments within the Aboriginal community of the Regional Town.

2.98. Officer EAC1's view was that in his experience, Aboriginal people were more likely to report having a mental health impairment than non-Aboriginal people. He was inherently sceptical about an Aboriginal person's claim to have a mental health impairment. Officer EAC1 considered it likely that many of the Aboriginal people he encountered as a police officer, were fabricating their impairment. Officer EAC1 considered that the behavioural disturbances of Aboriginal people he dealt with were a deliberate strategy to get an easier path, rather than the behaviour of someone with a genuine mental health or cognitive impairment.

2.99. As a result, Officer EAC1 did not respond appropriately to CAE's ongoing self-harm. He did not call an ambulance because he thought that CAE was in control of his own actions and malingering.

2.100. CAE suffered serious self-inflicted injuries. It is fortunate that those injuries were not fatal. The need to seek help for CAE was overlooked in part because he was an Aboriginal man.

[88] *A predictable and preventable path*, n 86, at 108-109.

Mental health and cultural awareness training

2.101. Officer EAC1 had completed a number of relevant training programs prior to the incident in question. They included:

- NSW Police Force Mental Health 2023-2024;
- Advanced Custody Management; and
- Engaging with Aboriginal Communities.

2.102. The Commission has received a hard copy of the NSW Police Force Mental Health 2023-2024 training and the Engaging with Aboriginal Communities training, as well as 3 videos which form part of the training. These documents give a sense of the online training experience but do not replicate it.

2.103. The NSW Police Force Mental Health training is new and covers skills such as building empathy and de-escalation. It incorporates scenarios and encourages officers to reflect on their own practices. In 2024/2025, the Mental Health training is a 2.5-hour face-to-face session which includes critical discussion, case studies, role play exercises and presentations from those with lived experience.[89]

2.104. The Engaging with Aboriginal Communities training covers issues of unconscious bias. It has elements of truth telling, and incorporates videos where Aboriginal people talk about their experiences of racism and being part of the Stolen Generations. Interestingly, the training also suggests that safe custody practices are to check on Aboriginal detainees every 30 minutes.[90] The Corporate Sponsor Aboriginal Engagement has advised that the NSW Police Force continues to deliver its Aboriginal Cultural Awareness Training online and in person.[91]

2.105. From the Commission's review, both courses, which are delivered online, should have given Officer EAC1 the knowledge to respond appropriately to CAE's situation.

2.106. Delivering training that will impact the actions of thousands of police officers is a challenge. The training on engaging with Aboriginal people and people with mental health conditions clearly did not achieve the goal of impacting Officer EAC1's response. Officer EAC1 had a limited memory of the training and its content. His actions did not reflect the guidance that he had been given in the two training modules.

2.107. Online training is flexible to deliver and can be widely rolled out to a Force that operates across the State. However, face to face training may have more impact for nuanced topics such as how to better engage with people with mental health

[89] Letter Assistant Commissioner to Director, Oversight Investigations 20 May 2025.
[90] Exhibit RTL3C.
[91] Letter Assistant Commissioner to Director, Oversight Investigations 20 May 2025.

difficulties, and improving officers understanding of the experiences of Aboriginal communities.

2.108. Ideally face to face training on cultural awareness and mental health experiences would also involve local community members and be tailored to local issues. This may be more readily absorbed by busy police who already have a significant training load. The Commission understands that these options are already being explored by the NSW Police Force.

2.109. As noted above, the Commission is aware that the NSW Police Force are reviewing and updating their training on responding to people with mental health conditions and engaging with First Nations communities. The NSW Police Force are delivering face to face mental health training for all officers in 2024/2025.

2.110. The Commission expects that the very recent events documented in this report will be considered by the NSW Police Force as they continue to develop that training. However, the Commission does not consider that a formal recommendation is needed.

3. Submissions Received

3.1. The Commission provided a draft copy of this report to EAC1's legal representative, as well as the NSW Police Force, for the purpose of making submissions. In response, submissions were received from the legal representative of EAC1 and some comments were made by an Assistant Commissioner of the NSW Police Force in relation to training. These responses have been adopted where appropriate and incorporated into the report.

4. Findings

4.1. When tabling a report under s 132 of the LECC Act, the Commission must consider whether it should take further steps or recommendations as a result of its findings against any "affected person", that is, any person who has been the subject of substantial allegations during the course of the examination: s 133(3) LECC Act. The Commission must set out whether consideration should be given to:

- obtaining the advice of the Director of Public Prosecutions (DPP) with respect to the prosecution of the person for a specified criminal offence;
- taking action against the person for a specified disciplinary infringement;
- taking action including the making of an order under s 181D of the *Police Act 1990* (NSW) (the Police Act) against the person as a police officer on specified grounds, with a view to dismissing, dispensing with the services of, or otherwise terminating the services of the police officer; and

- taking reviewable action within the meaning of s 173 of the Police Act against the person as a police officer.

4.2. The Commission's approach to these questions is elaborated on in Appendix 1 to this Report.

Officers EAC2, EAC3 and EAC4

4.3. The NSW Police Force is strongly hierarchical. Officer EAC1 was the most senior officer on duty and had specific responsibilities as a custody manager. Officer EAC4 suggested that an ambulance should be called and was told no. He advised the other officers that Officer EAC1 had declined to call an ambulance. In circumstances where Officer EAC1 was by far the most experienced officer and also the most senior officer, the Commission does not criticise Officers EAC2, EAC3 or EAC4 for not raising the issue again.

4.4. Indeed, Officer EAC2 impressed the Commission with his thorough and thoughtful knowledge of the options available to police to facilitate mental health care for a person experiencing mental distress.

4.5. The Commission makes no adverse findings against Officers EAC2, EAC3 or EAC4, and does not make any recommendations in relation to these officers.

Officer EAC1

4.6. The Commission finds that Officer EAC1 failed to comply with his obligation under s 129 of LEPRA and with the Charge Room and Custody Management SOPS. He conceded as much in his evidence before the Commission.

- He failed to undertake the observation and assessment of CAE that would have allowed him to identify signs of CAE's distress. Officer EAC1 was 3-4 metres from where CAE was in the dock. A small movement would have given him a clear line of sight. The noise of CAE's self-harm was so loud that other officers in the muster room could hear him. Officer EAC1 can be seen on CCTV covering his ear while on a phone call, apparently to be able to hear over the noise.
- He failed to call an ambulance when the need was obvious at several points during the night:
    - At 11.30 pm, CAE twice stood and punched the dock door and forcefully hit his head. CAE's mental distress was clearly apparent. He was clearly exhibiting a number of the behaviours flagged in the Charge Room and Custody Management SOPS, namely headbanging, weeping, agitation, anger or aggression or emotionally out of control. The need for an ambulance was also apparent to Officer EAC4 and the other officers at the station.

- At 1.20 am, when the custody photos were taken CAE had a large and obvious lump on his forehead. He had clearly sustained a head injury of some kind from his self-harm.
- As the police vehicle left the Regional Town Police Station at 1.40 am, CAE was banging his head against the metal cage so forcefully that it shook the truck and could be heard on the VKG recording. There remained the option of deviating to the Regional Town Hospital and getting medical support from an ambulance.

4.7. A custody manager exercises important protective functions inside the police station concerning persons in custody. They have responsibility for the welfare of vulnerable people who are detained in their care and control and away from the public eye. The role of custody manager calls for proactive attention and action in the discharge of duties under LEPRA, including the obligation to seek medical attention under s 129.[92]

4.8. Officer EAC1's breaches of the Charge Room and Custody Management SOPS were serious. They were deliberate. They could have been life-threatening. They warrant serious disciplinary action. The Commission is satisfied that a finding of serious misconduct should be made against Officer EAC1.

4.9. The Commission has also considered whether Officer EAC1's conduct was criminal conduct, warranting a referral to the DPP. One offence which the Commission considers was available is neglect of duty, which is an offence again s 201 of the Police Act. There are no NSW cases, of which the Commission is aware, which deal with what might be required to prove a neglect of duty under s 201, although the issue has been considered in a similar context in the United Kingdom: *R v Dytham* [1979] QB 722; *Attorney General's Reference (No 3 of 2003)* [2004] EWCA Crim 868.

4.10. In any event, the issue is irrelevant as there is a statutory time limit of 6 months to bring a prosecution under s 201 of the Police Act.[93] That timeframe expired when Officer EAC1's conduct was still under investigation by the Commission. A charge under s 201 of the Police Act is not a serious indictable offence and so Officer EAC1's conduct cannot be considered serious misconduct on that basis: s 10(2) LECC Act.

4.11. Six months is a short period of time within which to establish and charge neglect of duty. The Commission notes that another summary offence under the Police Act has a 2 year statutory timeframe: s 167A.

[92] See Commission's comments to the same effect in *Operation Pamir: A report under section 132 of Law Enforcement Conduct Commission Act 2016 concerning the arrest, charging and prosecution of a vulnerable person, including issues arising from his detention in custody*, October 2024, at para 3.98.
[93] Sections 6(1)(c) and 179(1) *Criminal Procedure Act 1986.*

4.12. The Commission has also considered whether Officer EAC1's conduct reaches the demanding threshold of misconduct in public office. Elements of this offence include demonstrating a wilful neglect of duty. The misconduct must be deliberate or wilfully reckless rather than accidental: *Obeid v R* [2015] NSWCCA 309 at [133], [145]; *R v McDonald; R v Maitland (No 8)* [2022] NSWSC 1421 at [7]–[10].

4.13. The evidence of Officer EAC1 was given under objection and cannot be relied on in considering whether there is sufficient evidence to establish the offence.[94] The admissible evidence includes the CCTV footage, VKG recording and the evidence given by other officers. This evidence establishes that CAE was banging his head repeatedly, gave himself visible injuries and that Officer EAC1 did not call an ambulance, even when the suggestion was made to him. However, there is no firm admissible evidence as to why Officer EAC1 made that decision.

4.14. The Commission has considered whether the admissible evidence is sufficient to warrant advice being sought from the DPP in relation to the commencement of proceedings against Officer EAC1 for wilfully neglecting his duties as custody manager. The Commission considers that there are limited prospects of success. The Commission is conscious that referring a matter to the DPP for advice is likely to delay consideration of any disciplinary action for Officer EAC1, although the Commission's view is that this should not be the case.[95]

4.15. Where there are limited prospects of success and prompt disciplinary action is desirable, the Commission is of the opinion that it is not appropriate to seek the DPP's advice concerning possible prosecution of Office EAC1 for misconduct in public office under s 133(2)(a) of the LECC Act.

4.16. The Commission was also very concerned by Officer EAC1's evidence that he dismissed CAE's clear distress because he considered it to be 'bad behaviour' typical of Aboriginal people who often attempt to manipulate the system. Officer EAC1's views are contrary to the NSW Police Force's stated aim of calling out racism, discrimination and bias.[96] They are also contrary to the NSW Police Force's statements in their Aboriginal Strategic Direction[97] that:

- the NSWPF understand unconscious bias, the impacts of trauma; and
- Aboriginal people in custody are provided appropriate support and are safe.

4.17. His attitude contributed to CAE being exposed to an unacceptable risk of serious injury. His conduct failed his first obligation as a NSW Police Force employee under the NSW Police Force Code of Conduct and Ethics which is to:

[94] See discussion at para 15 of Appendix 1.
[95] See comments made in Operation Venti at 8.26 and following.
[96] NSW Police Force, Aboriginal Strategic Direction (2024) 15.
[97] NSW Police Force, Aboriginal Strategic Direction (2024) 15, 17.

behave honestly and in a way that upholds the values and the good reputation of the NSW Police Force whether on or off duty.

5. Recommendations

Officer EAC1

5.1. The Commission is not bound to recommend that the Commissioner of Police should take action under s 173 or s 181D of the Police Act. In this instance, the question is finely balanced.

5.2. Officer EAC1 expressed remorse when giving his evidence and said that he had learnt a lot by reflecting on his conduct. However, he was the most senior officer on duty in a regional town with a significant Aboriginal community. His conduct did not model the behaviour that the NSW Police Force should expect from its officers.

5.3. The Commission recommends that, at the very least, Officer EAC1 should be the subject of reviewable action under s 173 of the Police Act.

5.4. The Commissioner of Police will need to decide whether additional training and supervision, particularly in the context of engaging with Aboriginal communities, could lead Officer EAC1 to behave at the standard that the public expects of the NSW Police Force. If not, it is open to the Commissioner to take action under s 181D of the Police Act.

5.5. The legal representative for Officer EAC1 made the following submissions that are relevant to the question above to be determined by the Commissioner of Police.[98] These submissions are supported by the Commission.

1. While it is accepted that the NSW Police Force Mental Health 2023-2024 and Engaging with Aboriginal Communities online courses should have given Officer EAC1 the knowledge to respond appropriately to CAE's situation, the evidence was that Officer EAC1 had a limited memory of the training and its content, and his actions did not reflect the guidance that he had been given in the two online training modules.

2. It appears that the Commission has identified that cultural awareness and mental health training could be improved by including local community members and by being tailored to local issues; such training might be more readily observed by busy police; the Police Force is already exploring such options; and the Police Force is reviewing and updating its training in these areas, including by incorporating face to face training.

[98] Officer EAC1's Submissions on Draft Report at para 11.

3. Officer EAC1's frank admission of unconscious racism (and lack of recall that 30-minute observation intervals are appropriate for Aboriginal persons in custody) clearly identifies a training gap. It is submitted that it would not be unrealistic to hypothesise that if Officer EAC1 were delivered the improved training discussed above – especially face to face interactions with local community members who could help dispel Officer EAC1's subscription to the misconceived notion of a generalised tendency of local Aboriginal communities to malinger mental health systems for a collateral purpose – the provision of such additional training to Officer EAC1 could in fact lead the Police Commissioner to form a view that Officer EAC1 is capable of behaving at the standard that the public expects of the NSW Police Force, meaning taking action under s 181D of the Police Act would not be the most appropriate course to take.

5.6. Further, the legal representative for Officer EAC1 made the following submission in relation to Officer EAC1's character and complaint history.[99]

> Significantly, no additional evidence was presented in the private examination which criticised Officer EAC1's service to the State for the past 16 years as a Police Officer. It follows that no evidence was presented in the private examination that Officer EAC1's misconduct on the occasion in question represented a pattern of behaviour. It follows that Officer EAC1 ought to enjoy the benefit of this prior professional good character, which should manifest itself in a conclusion that Officer EAC1 is capable of professional rehabilitation, particularly within the context of further appropriate training and/or supervision.

The Commission accepts that there was no evidence which suggests that Officer EAC1's conduct on the night in question represents a pattern of behaviour.

5.7. Finally, on behalf of Officer EAC1 it was submitted that he made appropriate concessions during his private examination which, without being exhaustive, included the following:[100]

1. Officer EAC1 accepted the possibility that CAE was initially banging his head in the dock rather than kicking it;[101]

2. Officer EAC1 accepted that that misunderstanding meant he was not keeping much of an eye on CAE;[102]

3. Officer EAC1 accepted that CAE wasn't "gently" banging his head as per his entry on the Custody Management Record (CMR);[103]

[99] Officer EAC1's Submissions on Draft Report at para 12.
[100] Officer EAC1's Submissions on Draft Report at para 13.
[101] Private examination VKD at T42.
[102] Private examination VKD at T47.
[103] Private examination VKD at T45.

4. Officer EAC1 accepted that despite not observing CAE's physical injury when walking to check him after he'd been banging against the brick wall, there still could have been invisible injuries at that point;[104]

5. Officer EAC1 accepted he should have entered on the CMR earlier than midnight that CAE was also hitting his head;[105]

6. Officer EAC1 accepted that it was not good enough as a custody manager to not investigate the banging noises;[106]

7. Officer EAC1 accepted that when CAE was banging his head at 11:30 pm, there was a need to call an ambulance;[107]

8. Officer EAC1 accepted that when he saw CAE's head injury when taking custody photographs, he should have called an ambulance;[108]

9. Officer EAC1 accepted he knew there was a risk of continued self-harm in driving CAE from Regional Town Police Station to City Police Station in the caged vehicle;[109]

10. Officer EAC1 accepted he made a pragmatic decision to take CAE to the City instead of the Regional Town Hospital;[110]

11. Officer EAC1 accepted he exposed CAE to unjustifiable risk;[111]

12. Officer EAC1 accepted that the discharge of his responsibilities as custody manager were not up to the expected standard,[112] and that it was not a reasonable performance of his duties;[113]

13. Officer EAC1 accepted he was required to call an ambulance from 11:30 pm[114] and when he saw CAE's physical condition when taking custody photographs at 1:30 am;[115]

14. Officer EAC1 accepted there was no proper justification for deciding to transport CAE in the caged vehicle and this exposed CAE to an

[104] Private examination VKD at T58-59.
[105] Private examination VKD at T63.
[106] Private examination VKD at T66.
[107] Private examination VKD at T73.
[108] Private examination VKD at T74.
[109] Private examination VKD at T77.
[110] Private examination VKD at T80.
[111] Private examination VKD at T83.
[112] Private examination VKD at T93.
[113] Private examination VKD at T93.
[114] Private examination VKD at T93.
[115] Private examination VKD at T94.

unacceptable level of risk and this was the wrong decision;[116]

15. Officer EAC1 accepted he bore primary responsibility for creating the set of circumstances that led to the outcome.[117]

The Commission accepts these concessions were made during officer EAC1's private examination.

5.8. In relation to the above concessions, the following was submitted.[118]

> The breadth of those concessions and Officer EAC1's willingness to express them speak to Officer EAC1's prior professional good character and capacity to reflect on his misconduct and unhesitatingly and accept responsibility for them without qualification. These qualities, in addition to Officer EAC1's apparently otherwise unblemished 16-year career in service of the State of NSW as a Police Officer, speak to his capacity for rehabilitation, which support disciplinary action being taken short of a decision under s 181D of the Police Act.

5.9. Whilst these concessions in one sense highlight Officer EAC1's negligence in the duty he owed CAE, the Commission accepts that it also demonstrates an acceptance of responsibility and accountability for his actions.

5.10. Furthermore, the Commission accepts the following submission that Officer EAC1 showed genuine contrition and remorse for his actions (and omissions).[119]

> In this vein, it is submitted that Officer EAC1's expression of remorse below provides strong evidence of genuine contrition, acceptance of responsibility and insight into his own misconduct:
>
> > Q: Have you learned anything?
> >
> > A: I've learnt a lot.
> >
> > Q: What have you learnt?
> >
> > A: To not be worried about, you know, calling the ambos for somebody in custody, calling at the first available opportunity, just looking after that person is more important than, you know, filling out the paperwork or anything like that. Yeah. I mean, I should have called the ambos a lot earlier. But I didn't.

[116] Private examination VKD at T94.
[117] Private examination VKD alt T95.
[118] Officer EAC1's Submissions on Draft Report at para 14.
[119] Officer EAC1's Submissions on Draft Report at para 15.

General recommendation

5.11. There is a 6 month time limit for bringing proceedings under s 201 of the Police Act. Section 201 makes it an offence for a police officer to neglect or refuse to obey any lawful order or carry out any lawful duty. As neglect of duty involves an omission, it is possible that neither the Commission nor the police will become aware of it immediately. If proceedings can only be commenced within 6 months of the act occurring, there is a risk that the offence will become statute barred.

5.12. For this reason, the Commission recommends that the timeframe for bringing proceedings under s 201 of the Police Act should be extended to 12 months. The Commission notes that there are other summary offences under the Police Act where the time period for laying charges has been extended: see for example ss 167A and 206 of the Police Act.

Recommendation: The Commission recommends to the Minister for Police and Counter-terrorism that s 201 *Police Act 1990* should be amended to provide that the time period for commencing proceedings under s 201 is at least 12 months.

5.13. Finally, and although not the subject of a formal recommendation, the Commission encourages the NSW Police Force to continue to explore options to provide face to face training on cultural awareness and mental health experiences involving local community members and tailored to local issues.

Appendix 1 - The Commission's Statutory Functions

1. The *Law Enforcement Conduct Commission Act 2016 (*the LECC Act) lists among the Commission's principal functions the detection and investigation of serious misconduct and serious maladministration: s 26.

2. Section 10 of the LECC Act defines 'serious misconduct':

> (1) For the purposes of this Act, **serious misconduct** means any one of the following:
>
> (a) conduct of a police officer, administrative employee or Crime Commission officer that could result in prosecution of the officer or employee for a serious offence or serious disciplinary action against the officer or employee for a disciplinary infringement,
>
> (b) a pattern of officer misconduct, officer maladministration or agency maladministration carried out on more than one occasion, or that involves more than one participant, that is indicative of systemic issues that could adversely reflect on the integrity and good repute of the NSW Police Force or the Crime Commission,
>
> (c) corrupt conduct of a police officer, administrative employee or Crime Commission officer.
>
> (2) In this section:
>
> **serious disciplinary action** against an officer or employee means terminating the employment, demoting or reducing the rank, classification or grade of the office or position held by the officer or employee or reducing the remuneration payable to the officer or employee.
>
> **serious offence** means a serious indictable offence and includes an offence committed elsewhere than in New South Wales that, if committed in New South Wales, would be a serious indictable offence.

3. 'Officer maladministration' and 'agency maladministration' are both defined in s 11 of the LECC Act. 'Officer maladministration' is defined in s 11(2) in these terms:

> (2) **Officer maladministration** means any conduct (by way of action or inaction) of a police officer, administrative employee or Crime Commission officer that, although it is not unlawful (that is, does not constitute an offence or corrupt conduct):
>
> (a) is unreasonable, unjust, oppressive or improperly discriminatory in its effect, or

(b) arises, wholly or in part, from improper motives, or

(c) arises, wholly or in part, from a decision that has taken irrelevant matters into consideration, or

(d) arises, wholly or in part, from a mistake of law or fact, or

(e) is conduct of a kind for which reasons should have (but have not) been given.

4. The conduct of an officer or agency is defined as "serious maladministration" if the conduct, though not unlawful, is conduct of a serious nature which is unreasonable, unjust, oppressive or improperly discriminatory in its effect or arises wholly or in part from improper motives: LECC Act, s 11(3).

5. The Commission may hold an examination for the purpose of an investigation into conduct that it has decided is (or could be) serious misconduct or serious maladministration: s 61 (a).

6. Section 29 provides the authority for the Commission to make findings and express opinions:

(1) The Commission may:

(a) make findings, and

(b) form opinions, on the basis of investigations by the Commission, police investigations or Crime Commission investigations, as to whether officer misconduct or officer maladministration or agency maladministration:

(i) has or may have occurred, or

(ii) is or may be occurring, or

(iii) is or may be about to occur, or

(iv) is likely to occur, and

(c) form opinions as to:

(i) whether the advice of the Director of Public Prosecutions should be sought in relation to the commencement of proceedings against particular persons for criminal offences against laws of the State, or

(ii) whether the Commissioner of Police or Crime Commissioner should or should not give consideration to the taking of other action against particular persons, and

(d) make recommendations as to whether consideration should or should not be given to the taking of action under Part 9 of the Police Act 1990 or under the Crime Commission Act 2012 or other disciplinary action against, particular persons, and

(e) make recommendations for the taking of other action that the Commission considers should be taken in relation to the subject-matter or opinions or the results of any such investigations.

(2) Subsection (1) does not permit the Commission to form an opinion, on the basis of an investigation by the Commission of agency maladministration, that conduct of a particular person is officer maladministration unless the conduct concerned is (or could be) serious maladministration.

(3) The Commission cannot find that a person is guilty of or has committed, or is committing or is about to commit, a criminal offence or disciplinary infringement.

(4) An opinion or finding that a person has engaged, is engaging or is about to engage in:

(a) officer misconduct or serious misconduct or officer maladministration or serious maladministration (whether or not specified conduct), or

(b) specified conduct (being conduct that constitutes or involves or could constitute or involve officer misconduct or serious misconduct or officer maladministration or serious maladministration), and any recommendation concerning such a person is not a finding or opinion that the person is guilty of or has committed, or is committing or is about to commit, a criminal offence or disciplinary infringement.

(5) Nothing in this section prevents or affects the exercise of any function by the Commission that the Commission considers appropriate for the purposes of or in the context of Division 2 of Part 9 of the *Police Act 1990*.

(6) The Commission must not include in a report under Part 11 a finding or opinion that any conduct of a specified person is officer misconduct or officer maladministration unless the conduct is serious misconduct or serious maladministration.

(7) The Commission is not precluded by subsection (6) from including in any such report a finding or opinion about any conduct of a specified person that may be officer misconduct or officer maladministration if

the statement as to the finding or opinion does not describe the conduct as officer misconduct or officer maladministration.

7. This report is made pursuant to Part 11 of the LECC Act. Section 132(1) provides that the Commission may prepare reports 'in relation to any matter that has been or is the subject of investigation under Part 6'.

8. Section 133 (Content of reports to Parliament) provides that:

(1) The Commission is authorised to include in a report under section 132:

(a) statements as to any of the findings, opinions and recommendations of the Commission, and

(b) statements as to the Commission's reasons for any of the Commission's findings, opinions and recommendations.

(2) The report must include, in respect of each affected person, a statement as to whether or not in all the circumstances the Commission is of the opinion that consideration should be given to the following:

(a) obtaining the advice of the Director of Public Prosecutions with respect to the prosecution of the person for a specified criminal offence,

(b) the taking of action against the person for a specified disciplinary infringement,

(c) the taking of action (including the making of an order under section 181D of the Police Act 1990) against the person as a police officer on specified grounds, with a view to dismissing, dispensing with the services of or otherwise terminating the services of the police officer,

(d) the taking of reviewable action within the meaning of section 173 of the *Police Act 1990* against the person as a police officer,

(e) the taking of action against the person as a Crime Commission officer or an administrative employee on specified grounds, with a view to dismissing, dispensing with the services of or otherwise terminating the services of the Crime Commission officer or administrative employee.

Note. See section 29 (4) in relation to the Commission's opinion.

(3) An "**affected person**" is a person against whom, in the Commission's opinion, substantial allegations have been made in the course of or in connection with the investigation (including examination) concerned.

(4) Subsection (2) does not limit the kind of statement that a report can contain concerning any affected person and does not prevent a report from containing a statement described in that subsection in respect of any other person.

9. In considering any factual conclusions to be reached in a report, the Commission will apply the civil standard of proof, namely whether the relevant factual matters have been proved to the reasonable satisfaction of the Commission.[120] Accordingly findings can form the basis of opinions and recommendations, even if they do not reach the standard of beyond reasonable doubt.

Considerations under s 133(2) of the LECC Act

10. Section 133(1) authorises the Commission to include in a s 132 report statements as to any findings, opinions and recommendations of the Commission together with statements of the Commission's reasons for any findings, opinions and recommendations.

11. As noted earlier in this Report (at paragraph 2.3), an important function for the Commission is to determine whether any police officer has engaged in 'serious misconduct' as defined in s 10 of the LECC Act. Relevantly, s 10 defines 'serious misconduct' as conduct of a police officer that could result in prosecution of the officer for a serious offence or serious disciplinary action against the officer for a disciplinary infringement. 'Serious disciplinary action' is defined as action against any officer by terminating the employment, demoting or reducing the rank, classification or grade of the office or position held by the officer or reducing the remuneration payable to the officer.

12. For practical purposes, 'serious disciplinary action' for a police officer involves action to terminate the officer's employment under s 181D of the *Police Act 1990* or reviewable action under s 173 of the *Police Act 1990*. If the conduct could result only in non-reviewable action as defined in s 173(1) and Schedule 1 of the *Police Act 1990*, then the conduct would not constitute 'serious misconduct'.

13. Section 133(2) requires the Commission to include in a report, in respect of each affected person, a statement as to whether or not in all the circumstances the Commission is of the opinion that consideration should be given (relevantly) to the following:

[120] *Briginshaw v Briginshaw* [1938] 60 CLR 336; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170.

(a) obtaining the advice of the Director of Public Prosecutions (DPP) with respect to the prosecution of the person for a specified criminal offence;

(b) the taking of action against the person for a specified disciplinary infringement;

(c) the taking of action including the making of an order under s 181D of the *Police Act 1990* against the person as a police officer on specified grounds, with a view to dismissing, dispensing with the services of, or otherwise terminating the services of the police officer; and

(d) the taking of reviewable action within the meaning of s 173 of the *Police Act 1990* against the person as a police officer.

14. Some observations should be made about the various steps contained in s 133(2).

15. Firstly, it is mandatory that the Commission give consideration to such measures in s 133(2) as may be relevant to the particular affected person.

16. Secondly, in considering whether to obtain advice of the DPP under s 133(2)(a), it is necessary for the Commission to disregard evidence given under objection by the person being considered for referral. The evidence of that person is not admissible in any criminal proceedings against that person: ss 57, 74, 75 LECC Act. Evidence given under objection should not be provided to the DPP in the event of a s 133(2)(a) referral. However, the evidence given under objection by one person may be taken into account by the Commission in determining whether another person should be referred to the DPP for advice as to prosecution under s 133(2)(a).

17. Thirdly, in considering whether a s 133(2)(b) recommendation ought to be made, regard should be had to the definition of 'disciplinary infringement' in s 4(1) LECC Act:

> **disciplinary infringement** includes any misconduct, irregularity, neglect of duty, breach of discipline or substantial breach of a code of conduct or other matter that constitutes or may constitute grounds for disciplinary action under any law.

18. The term 'disciplinary infringement' is used in ss 9 and 10 of the LECC Act. The Commissioner of Police may issue instructions to members of the NSW Police Force with respect to the management and control of the NSW Police Force. Instructions to members of the NSW Police Force under s 8(4) of the *Police Act 1990* may include instructions and guidelines with respect to the exercise of police officers of functions conferred under LEPRA. The terms 'misconduct', 'neglect of duty' and 'breach of discipline' in the definition of 'disciplinary infringement' are capable of picking up alleged breaches of Commissioner's Instructions issued under the *Police Act 1990*.

19. Fourthly, the various steps in s 133(2) are not mutually exclusive. They are not expressed as alternatives although, as noted earlier, not all will be capable of application in a particular case. Clearly, s 133(2)(e) has no application in the case of a police officer.

20. Fifthly, the Commission is not bound to select one or other of the steps contained in s 133(2)(c) and (d). They are not expressed as alternatives. In some cases, a s 133(2)(c) recommendation for action under s 181D of the *Police Act 1990* may be the clear course of action to be recommended. In other cases, action under s 173 of the *Police Act 1990* may seem the clearly appropriate course to be recommended. There will undoubtedly be cases where factors may bear upon the exercise of judgment by the Commissioner of Police in the choice between s 181D or s 173 action, and those factors may not be fully known to the Commission. Reviewable action under s 173 of the *Police Act 1990* involves more serious disciplinary action falling short of dismissal from the NSW Police Force.

21. It is open to the Commission under s 133(2) to state that consideration be given to the taking of action under s 181D or s 173 with an opinion being expressed that one of these steps is supported more strongly than the other. The Commission's reasons given under s 133(1)(b) will explain the thought processes which have led to the s 133(2) steps being addressed in this way.

Appendix 2 – Use of Names of Witnesses or Pseudonyms in this Report

1. The Commission has made a determination to protect the identities of all persons involved. Accordingly, all persons/places will be referred to by codenames in this report.

2. There is to be no publication of the name or image of any of the codenamed persons/places in relation to the evidence given in the Operation Eacham investigation or included in this report without further order of the Commission.

3. In accordance with the statutory requirements, a copy of this report will be provided to the complainant, the Commissioner of Police and the Minister for Police and Counter-terrorism. There is to be no publication of the actual name of any person referred to in this report in relation to the conduct discussed in this report, without order of the Commission.

LECC
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Conduct Commission