LECC
Law Enforcement
Conduct Commission

Review of 29 NSW Police Force critical incident investigations

June 2019

Law Enforcement Conduct Commission
Level 3, 111 Elizabeth Street
Sydney NSW 2000
email: *contactus@lecc.nsw.gov.au*

Postal address
GPO Box 3880
Sydney NSW 2001
Phone: (02) 9321 6700
Toll free: 1800 657 079
Fax: (02) 9321 6799

Hours of operation
08:30am to 4:30pm Monday to Friday (excluding public holidays)

ISBN 978-1-74003-009-0

LECC
Law Enforcement
Conduct Commission

Review of 29 NSW Police Force critical incident investigations

June 2019

CONTENTS

RECOMMENDATIONS

1. OUR REVIEW

A critical incident is an incident involving a police operation that results in death or serious injury to a person. The NSW Police Force is required to investigate the actions of its members involved in a critical incident.[1] The Law Enforcement Conduct Commission ('the Commission') monitors the investigation of critical incidents from the time of the incident until the completion of the investigation by police, to provide assurance to the public that police investigations into critical incidents are conducted in a competent, thorough and objective manner.

The NSW Police Force has guidelines in place which set out how police are to conduct critical incident investigations, including how the investigations should be documented.[2]

When the Commission commenced operations in July 2017, the NSW Police Force already had a number of critical incident investigations on foot. We decided to review 29 of those critical incident investigations (also known as strike forces). The purpose of our review was to –

(1) measure and benchmark compliance by the NSW Police Force with their critical incident guidelines;
(2) establish whether the finalisation of certain critical incident investigations has been unreasonably delayed by the NSW Police Force;
(3) identify whether there had been any agency maladministration in relation to compliance and delay issues; and
(4) make recommendations to the NSW Police Force to increase compliance with critical incident guidelines, reduce delays in finalising matters, and prevent misconduct and maladministration.

One of the first issues we identified was that some key investigation records could not be located in the NSW Police Force investigations management system, e@gle.i. This system is where police are required to keep all documents created as a result of critical incident investigations.[3] The absence of records impacted on our ability to properly assess compliance of the NSW Police Force with some of the procedural requirements set out in its critical incident guidelines. Clearly it would also inhibit the NSW Police Force's own capacity to ensure the critical incident guidelines are being followed.

Our review also identified very low levels of compliance by the NSW Police Force in relation to two key procedural requirements of the guidelines. These were the requirement to conduct mandatory alcohol testing within desired timeframes of two hours[4] and the requirement to prepare an interim report prior to the completion of a coronial inquest.[5]

The Commission also identified a number of investigations where it appeared that there may have been unreasonable delays on the part of the NSW Police Force in finalising these investigations.

These deficiencies are significant because they impact on the consistency and quality of the critical incident investigations that police undertake. We are particularly concerned by the inadequacy of the conflict of interest form currently being used to identify and keep account of the way that conflicts of interest are managed in critical incident investigations, as outlined in

[1] Section 113(1) Law Enforcement Conduct Commission Act 2016.
[2] There are two sets of guidelines relevant to the critical incident investigations we reviewed. These are the NSW Police Force, *Critical Incident Guidelines*, August 2012 ('2012 Guidelines') and the NSW Police Force, *Critical Incident Guidelines*, January 2016 ('2016 Guidelines').
[3] NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 29. A similar requirement is included in the 2012 Guidelines, p. 28.
[4] NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 35; NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 27.
[5] NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 15. The 2012 Guidelines did not require the completion of an interim report.

Part 3.1 of this report. We are also concerned that a number of critical incident investigations remain open without any or adequate reasons being provided. This is discussed in Part 4 of this report.

We have made three recommendations to assist the NSW Police Force to improve its compliance with the critical incident guidelines –

(1) It is recommended that the NSW Police Force revises the current *P1103 Critical incident – conflict of interest declaration* form to be more similar in form and content to the *MARA Part B – Disclosure of conflict by Investigator/Resolution Manager* form.

(2) It is recommended that NSW Police Force Critical Incident Guidelines include a hyperlink and/or reference to NSW Police Force Procedures for Managing Conflicts of Interest.

(3) It is recommended that NSW Police Force Critical Incident Guidelines require the senior critical incident investigator to record reasons explaining why any mandatory testing event occurred outside the desired two hour timeframe.

In its response to the Commission's draft report the NSW Police Force indicated that it supports these recommendations and has implemented recommendation 2. To this end, they informed us that –

- the current P1103 form has been amended to incorporate the Commission's recommendation. Each member of the critical incident investigation team must complete the amended Conflict of Interest Declaration Form on e@gle.i.[6]

- the critical incident guidelines will include a hyperlink to the NSW Police Force Procedures for Managing Conflicts of Interest, and

- the NSW Police Force has taken action to ensure that senior critical incident investigators are provided with instructions about the need to make records of the reasons for any delays associated with the completion of tests.

Our draft report also contained a preliminary recommendation that the critical incident guidelines should clarify the requirements relating to the completion of interim reports, including the role and purpose of interim reports, when interim reports should be completed, what should be contained in the interim reports and who is expected to complete them. The NSW Police Force advised us that police are now required to provide a preliminary report to the Senior Coroner and Crown Solicitor no later than eight weeks after a senior coroner has determined jurisdiction under section 23 of the *Coroners Act 2009* concerning deaths in custody or as a result of police operations. The critical incident guidelines will include details of the requirement. As the preliminary report to the Coroner will contain essentially the same information that we would have expected to see in an interim report, we have withdrawn the preliminary recommendation.

While the NSW Police Force has undertaken to address the above issues in its revised critical incident guidelines, it is worth noting that the NSW Police Force has been reviewing the 2016 Critical Incident Guidelines for nearly two years. At the time of publication of this report, the Commission has not yet seen the finalised version.

[6] The NSW Police Force commenced using the amended Conflict of Interest Declaration Form on 7 May 2019.

1.1 THE COMMISSION'S CRITICAL INCIDENT MONITORING TEAM

When the Commission commenced operations on 1 July 2017, it had the power to independently oversee and monitor the investigation of critical incidents by the NSW Police Force when the Commission decides it is in the public interest to do so. Section 115(1) requires the NSW Police Force and the Commission work co-operatively in the exercise of their respective functions to ensure that critical incidents are investigated in a competent, thorough and objective manner. Formal arrangements have been made between the two agencies to give substance to this requirement.

The Commission's Critical Incident Monitoring Team ('CIMT') monitors critical incident investigations in real-time, including attending critical incident scenes, observing interviews conducted by police, and analysing evidence such as body worn video and witness statements. To date, the Commission has monitored every critical incident investigation initiated by the NSW Police Force since 1 July 2017.

During the course of an investigation, the Commission may provide advice to police where it is considered that the investigation is not being conducted in a competent, thorough or objective manner. The Commission can share its views with police if it becomes concerned that an investigation is or might not being fully and properly conducted (s 116). At the conclusion of the critical incident investigations monitored by the Commission, we must advise police whether we consider the investigation was properly conducted and whether any aspect of a critical incident investigation was inappropriate. We can also make recommendations to the Commissioner of Police (s 117). At the conclusion of the critical incident investigation, if it is in the public interest to do so, the Commission may make our final advice to police public.[7]

At the time of writing, three of the critical incident investigations that commenced after 1 July 2017 have been finalised by police.

[7] Part 8 of the *Law Enforcement Conduct Commission Act 2016* (NSW) empowers the Commission to monitor critical incident investigations conducted by the NSW Police Force where it is in the public interest to do so. Sections 114, 116(a)(b), 117(1)(6)(8) apply.

2. METHODOLOGY

We conducted this review pursuant to section 27 and Part 8 of the *Law Enforcement Conduct Commission Act 2016* ('the LECC Act').

Section 27 of the LECC Act confers on the Commission administrative functions relating to education and prevention of officer misconduct. These functions give the Commission the capacity to assess and make recommendations about programs and procedures that the NSW Police Force has in place to deal with officer misconduct or maladministration, and agency maladministration, including programs and procedures to prevent such misconduct or maladministration, or which educate the staff of the NSW Police Force about such misconduct or maladministration.[8]

Under Part 8 of the LECC Act the Commission has the power to independently oversight and monitor the investigation of critical incidents by the NSW Police Force if it decides that it is in the public interest to do so.

In July 2017, the Commission wrote to the NSW Police Force requesting information for all critical incident investigations open as at 18 July 2017.[9] According to the NSW Police Force, 81 critical incident investigations were open as at that date.

The Commission selected 29 of the 81 critical incidents on the basis that they –

- involved level 1 critical incidents,[10] or
- involved death in police custody, or
- involved persons from the community who were considered 'vulnerable', or
- involved discharge of a police firearm, or
- were linked to complaint investigations under Part 8A of the *Police Act 1990*.[11]

For each of the 29 critical incident investigations we reviewed the investigative records stored on e@gle.i. We reviewed, where available, the following documents that we considered to be key to a critical incident investigation (given the requirements set out in the critical incident guidelines) –

- conflict of interest declaration forms
- mandatory drug and alcohol testing results, and
- interim reports.

We also examined –

- records attached to e@gle.i to find out if the finalisation of some critical incident investigations were unreasonably delayed, and

[8] Section 27 of the *Law Enforcement Conduct Commission Act 2016* also gives the Commission the same functions with regard to the NSW Crime Commission.
[9] Correspondence from Director Investigation – Oversight, Law Enforcement Conduct Commission, to Assistant Commissioner NSW Police Force, Professional Standards Command, 18 July 2017.
[10] Both the 2012 and 2016 Guidelines define level 1 critical incidents as follows: the homicide of a police officer; any death or imminent death resulting from the discharge of a firearm by a police officer; any death or imminent death arising from use of police appointments; any death or imminent death as a result of the application of physical force by a NSW police officer. (NSW Police Force, *Critical Incident Guidelines*, January 2016, pp. 7-8; NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 10). The Commission determined not to consider the critical incident investigation into the death of Roberto Laudisio Curti as it has already been the subject of significant scrutiny.
[11] Part 8A of the *Police Act 1990* deals with complaints about the conduct of police officers and administrative employees of the NSW Police Force.

- whether a critical incident was linked to a Part 8A investigation.

In a number of matters we reviewed the above significant records were not located on e@gle.i. We acknowledge that records may have been created during the critical incident investigation but not uploaded to e@gle.i.

In conducting this review, we have taken into account the previous work of the Police Integrity Commission ('PIC') on critical incident investigations. In particular, we have considered the PIC's report of May 2017 – 'Project Harlequin, Audit of the NSW Police Force investigations into 83 critical incidents occurring between 1 January 2009 and 30 June 2012'. The PIC's report focussed on the NSW Police Force's compliance with its critical incident guidelines.[12]

While Project Harlequin had a broader scope than our review, some of the issues identified in Project Harlequin are present in the 29 critical incident investigations we have reviewed. This suggests that more work may need to be done by the NSW Police Force to improve important elements of the way critical incident investigations are carried out.

[12] The Project Harlequin report is available at: www.opengov.nsw.au.

3. COMPLIANCE WITH THE CRITICAL INCIDENT GUIDELINES

The NSW Police Force has developed guidelines that set out the processes for critical incidents to be investigated, reviewed and managed by its officers. The 29 critical incident investigations reviewed by the Commission are governed by two iterations of guidelines – the NSW Police Force Critical Incident Guidelines, August 2012, ('2012 Guidelines')[13] and the NSW Police Force Critical Incident Guidelines, January 2016, ('2016 Guidelines').[14]

3.1 IDENTIFICATION AND MANAGEMENT OF CONFLICTS OF INTEREST

In recent years a number of critical incidents and their subsequent investigation have been the subject of intense media and public scrutiny. Public perceptions of how these matters are handled by the NSW Police Force are important and it is essential that any conflicts or risks, whether actual, potential or perceived, are carefully managed by the NSW Police Force.

A conflict of interest occurs where there is a conflict between a person's official duties and private or personal interests, which might affect the performance of the person's official duties and responsibilities. Conflicts can involve gaining personal advantage or avoiding personal disadvantage and may involve financial or material benefits, or benefits relating to private interests such as personal relationships, or involvement or affiliations with groups or organisations that could influence the way a person makes decisions in their official capacity.[15] It is important that the NSW Police Force properly manages both actual and perceived conflicts of interest in order to uphold the integrity of its investigations, and also to avoid damage to the reputation of the NSW Police Force, or a loss of trust in the capacity of the NSW Police Force to carry out an impartial investigation.

Our review identified three issues in the way conflicts of interest were identified and managed in the 29 critical incident investigations –

(1) the template form used to document conflicts of interest was not always filled out, or was not filled out at the relevant point in time to assist the investigation;
(2) the form used by the NSW Police Force to document conflicts of interest and how they are managed is unclear and unhelpful;
(3) the strategies for dealing with identified conflicts, or perceived conflicts, were sometimes inadequate.

The NSW Police Force *Procedures for Managing Conflicts of Interest* provide the policy and procedural framework for identifying and managing such conflicts.[16] These procedures include strategies for commanders and supervisors about how to treat and manage conflicts of interest effectively –

> To manage conflicts of interest effectively commanders/managers and supervisors must -
>
> - provide advice and guidance when a conflict of interest is identified;

[13] The 2012 Guidelines were in force from August 2012 to 1 January 2016.
[14] The 2016 Guidelines commenced on 1 January 2016. They are, as of writing of this report, being reviewed by the NSW Police Force.
[15] NSW Police Force, *Procedures for Managing Conflicts of Interest*, December 2017
[16] NSW Police Force, *Procedures for Managing Conflicts of Interest*, December 2017.

- on receiving a report of a conflict of interest, record the conflict of interest and make appropriate enquiries to allow a thorough risk assessment to occur;
- assess the risks associated with the conflict of interest;
- consult with the individual involved and identify strategies appropriate to the risk level;
- manage the conflict of interest with the cooperation of the individual involved;
- monitor the conflict of interest while they have management responsibility for the individual, or until it is resolved.[17]

These procedures require that treatment strategies for conflicts of interest must be 'properly recorded, implemented and monitored'.[18] These procedures are not referenced in the critical incident guidelines. The critical incident guidelines contain their own procedures for managing conflicts of interest. The critical incident guidelines set out the following steps –

- Conflicts should be declared and documented utilising the P1103, Critical incident – conflict of interest declaration form which is attached to the guidelines.
- Each member of the critical incident investigation team must complete or sign the conflicts of interest declaration form, regardless of whether a conflict is declared.
- If a conflict or risk is declared, the senior critical incident investigator (SCII) must develop and implement a strategy to manage the declared conflict or risk and record the strategy on the form.
- If a potential conflict involving the SCII is declared, the SCII is to immediately advise the review officer who will determine a treatment strategy.
- Upon completion of the form, the SCII is to provide a copy of the form to the review officer.
- The completed conflict of interest form is to be recorded on e@gle.i.[19]

We assessed –

- whether a conflict of interest form was attached to e@gle.i;
- whether the conflict of interest form was signed and dated by each member of the critical incident investigation team ('CIIT') at a relevant time for the investigation;
- whether the content of the conflict of interest form used by NSW Police Force is adequate; and
- for instances in which a conflict of interest was declared, whether a strategy to manage the declared conflict or risk had been devised and the strategy was recorded on the conflict of interest form.

We found deficiencies under each of these criteria in the critical incident investigations we reviewed.

3.1.1 WAS A CONFLICT OF INTEREST FORM FOUND IN THE INVESTIGATIVE RECORDS?

The question of whether a conflict of interest form was attached to e@gle.i (being the relevant location of all investigative records) addresses issues of record keeping and transparency. The conflict of interest form is the measure of how the NSW Police Force is making itself accountable for the way it identifies and manages conflicts of interest in the conduct of a

[17] NSW Police Force, *Procedures for Managing Conflicts of Interest*, December 2017, p. 19.
[18] Ibid, p. 19.
[19] NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 28; NSW Police Force, *Critical Incident Guidelines*, January 2016, pp. 20-21.

critical incident investigation. The form sets out how the NSW Police Force has considered the important issue of impartiality in the conduct of the critical incident investigation.

E@gle.i contained a conflict of interest form in only 19 of the 29 critical incident investigations we reviewed. That is, in 34% of matters no conflict of interest forms were attached to e@gle.i.

Of the ten investigations which did not have a conflict of interest form attached to e@gle.i, we determined that for seven there were no satisfactory reasons for failing to complete a conflict of interest form.[20]

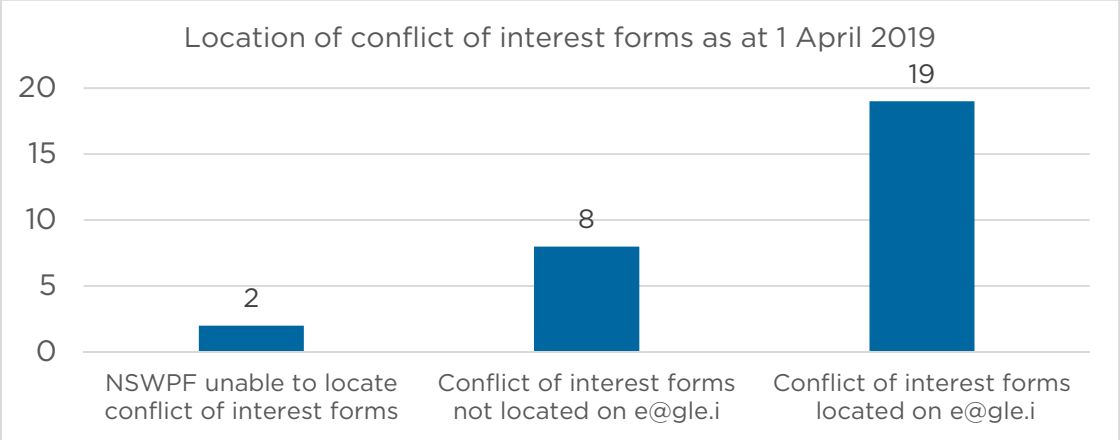
For one investigation, strike force Fellows, the NSW Police Force informed us that they did not complete conflict of interest forms as this incident 'involved voluminous staff' and 'the completion of conflict of interest forms would have been an unduly time-consuming process and it would have taken personnel away from completing investigation tasks'.[21] That critical incident investigation, which commenced in 2015, investigated the death of a police employee. The subsequent investigation involved a large number of police officers[22] from a range of different commands.

We acknowledge that completing an assessment of conflict of interest risks for all of the 70-odd involved officers would be time consuming, and that some officers may have only had a peripheral role in the investigation. However the e@gle.i investigation file contains no indication that the SCII had considered whether or not any of the officers involved in the critical incident investigation may have some conflicts of interest. We are of the view that the SCII should have at least considered the risks of conflicts of interest for those officers who had a major role in investigating this incident.

For the remaining two investigations (strike forces Barnet and Berith) the NSW Police Force advised us that it was unable to locate conflict of interest forms.

Chart 1.1 provides information about the location of conflict of interest forms as at 1 April 2019.

Chart 1.1: Location of conflict of interest forms as at 1 April 2019.



[20] Strike forces Begrinda, Buteo, Tabit, Edison, Kotari, Leawill and Magarra. For strike force Kotari there is an e@gle.i record that indicates that a conflict of interest declaration form for five officers is attached. However, there are no conflict of interest forms attached to e@gle.i as at 1 April 2019.
[21] NSW Police Force, Memorandum from Inspector, PSM, North West Metropolitan Region to A/Assistant Commissioner, PSC, 23 April 2018.
[22] Our research identified over 70 officers involved in this investigation. E@gle.i records do not provide information if all of these officers were part of the critical incident investigation team.

3.1.2 WAS THE FORM COMPLETED CONTEMPORANEOUSLY?

In addition to the absence of conflict of interest forms we found deficiencies in the content of the forms. Only 11 of the 19 conflict of interest forms that were contained in e@gle.i complied with the content requirements of the critical incident guidelines.

On the 19 March 2018 we requested information from the NSW Police Force for documents we were unable to locate on e@gle.i.[23] This request included conflict of interest forms. In response the NSW Police Force attached four conflict of interest forms to e@gle.i. However, the conflict of interest forms were not completed at the time the critical incident occurred. Instead, it appears the forms were created in response to our queries about the location of the forms, a considerable time after investigations into the critical incidents commenced –

(1) The critical incident (investigated under strike force Clemton) occurred on 19 January 2016. Members of the CIIT completed and signed the conflict of interest form on 28 March 2018 and attached it to e@gle.i that same day.
(2) The critical incident (investigated under strike force Pettit) occurred on 9 September 2015. On 27 March 2018 the SCII completed and signed the conflict of interest form on behalf of all members of the CIIT and attached it to e@gle.i that same day.
(3) The critical incident (investigated under strike force Ladera) occurred on 25 April 2017. Members of the CIIT completed and signed the conflict of interest form on 26 March 2018 and attached it to e@gle.i that same day.
(4) The critical incident (investigated under strike force Appenine) occurred on 28 April 2016. Members of the CIIT completed and signed the conflict of interest form on 5 April and 16 April 2018 and attached it to e@gle.i on 23 May 2018.

While the guidelines do not explicitly state that the conflict of interest form must be contemporaneous, it is reasonable to imply that it should be. The form is supposed to be used to manage risks that may arise while the investigation is conducted. The four conflict of interest forms that the NSW Police Force attached to e@gle.i in March and May 2018 were not created at the time of, or immediately after, the incidents occurred. Therefore, these forms provide no assurance that potential conflicts of interest were adequately considered by members of the CIIT or, in instances where officers declared conflicts, successfully managed by the SCII during the critical incident investigation.

In a further four investigations the conflict of interest forms were incomplete. Two investigations (strike forces McElroy and Deer) included the signatures of each member of the CIIT on the conflict of interest form. However, in those investigations some signatures were undated. In one investigation (strike force Mayberry) one officer signed his signature on behalf of all the members of the CIIT instead of each member signing for themselves. In another investigation (strike force Roeland), only one member of the CIIT had signed and dated the conflict of interest form. As already mentioned the guidelines require that each member of the CIIT must complete and sign a conflict of interest form, regardless of whether a conflict is declared. In instances where one officer signs on behalf of all the other team members, or where only one officer has completed the conflict of interest form, it is not possible for the NSW Police Force, or any other external review process, to assess if the officers involved in a critical incident investigation have declared and considered all potential conflicts at the time they were investigating the critical incident.

[23] Correspondence from Senior Project Officer, Law Enforcement Conduct Commission, to Senior Project Officer, NSW Police Force, PSC, 19 March 2018.

In the interests of transparency and accountability it is imperative that conflict of interest forms are contemporaneous records that include the signature of each member and contain sufficient information that conflicts were considered and, where applicable, appropriately managed by the NSW Police Force.

The Commission's CIMT monitors all critical incident investigations that have commenced since 1 July 2017. Since that time, the NSW Police Force has complied with its critical incident guideline requirements to upload conflict of interest forms for all officers with a significant role in the CIIT. We are able to ensure that the conflict of interest forms are being completed contemporaneously to the investigations.

3.1.3 IS THE CONTENT OF THE CONFLICT OF INTEREST FORM ADEQUATE?

Our review also identified shortcomings with the *P1103 Critical incident – conflict of interest declaration* form which police are required to use to record conflicts of interest in relation to critical incidents. This form consists of a blank table with the following four headings – 'Investigating officer', 'Potential/ declared conflict', 'Treatment strategy' and 'Investigator's signature and date'. One of its weaknesses is that it does not provide investigators with examples of what types of conflict of interest they should consider.

While most officers would be familiar with conflicts of interest that relate to personal relationships with any party involved in the matter that is being investigated there are other types of conflict that are less obvious and that officers may not be aware of when completing the form. By contrast, the Misconduct Matter Allocation Risk Appraisal (MARA) *Part B - Disclosure of Conflict of Interest by Investigator/ Resolution Manager* form ('MARA Part B form') which is used by police to identify and manage any disclosed conflicts of interest arising in the investigation of complaints under Part 8A of the Police Act is a more comprehensive template. This form consists of ten examples of conflicts of interest. It requires investigators to consider each type of conflict and disclose any issues which could affect their ability to conduct the investigation in an effective and objective manner. Some of the examples of conflicts of interest included in the Mara Part B form are –

> 5. Could you be influenced by factors including personal values, religion, culture, social, secondary employment, political views etc.?
>
> 6. Do you have any personal or professional bias that may lead others to believe that you would not investigate the matter appropriately?
>
> 7. Have you been directly involved in developing or approving policies, procedures or practices that form part of the subject of this matter?
>
> 8. Are you involved in study, volunteer work, secondary employment or other activities that might affect your impartiality and / or objectivity? …[24]

The benefit of the Mara Part B form is that it prompts investigators to consider a number of different conflict of interest scenarios that otherwise they may not have considered.

Given the MARA Part B form is more complete and more instructive, the Commission considers that it would be beneficial for the form used to identify conflicts of interest in critical incidents to be amended to be more like the MARA Part B form.

RECOMMENDATION 1: It is recommended that the NSW Police Force revises the current *P1103 Critical incident – conflict of interest declaration* form to be more similar in form and content to the *MARA Part B – Disclosure of Conflict of Interest by Investigator/Resolution Manager* form.

[24] NSW Police Force, P690, MARA Part B Disclosure of Conflict of Interests by Investigator/Resolution Manager – Mandatory.

3.1.4 HOW TREATMENT STRATEGIES WERE DOCUMENTED IN THE CONFLICT OF INTEREST FORMS

The NSW Police Force critical incident guidelines state that if a conflict or risk is declared, the SCII must develop and implement a strategy to manage the declared conflict or risk and record the strategy on the form.[25] In addition, the guidelines require the review officer to review any treatment strategies suggested by the SCII to address declared conflicts and risks.[26] However, the guidelines provide no direction about the type of treatment strategies the SCII or the review officer can or should apply.

There are a range of ways that police can try to mitigate the risks posed by conflicts of interest, such as appointing a different investigator or restricting officers with actual or perceived conflicts from involvement in the investigation.

The NSW Police Force *Procedures for Managing Conflicts of Interest* include detailed treatment strategies for managing conflicts of interest. However, there is no reference to those procedures in the NSW Police Force critical incident guidelines. If police are required to follow those procedures in the handling of critical incident investigations, at a minimum the critical incident guidelines should refer to the procedures explicitly.

Our review identified six investigations (strike forces Scouller, Padman, Barnier, Roeland, Rosslyn and Clemton) where officers declared a potential conflict of interest. We identified a number of issues with four of the six conflict of interest forms (in strike forces Rosslyn, Barnier, Roeland and Clemton) –

- The forms included insufficient information about the declared conflicts or risks.
- The listed treatment strategies included insufficient information that the NSW Police Force had conducted proper risk assessments or implemented suitable strategies for managing and monitoring these conflicts effectively.
- None of the conflict of interest forms included a plan of action to effectively mitigate the risk of the conflict of interest, nor were there any corresponding documents contained in e@gle.i which could be described as a plan to avoid the potential for any declared conflict of interest interfering with the investigation.

Table 1.1 replicates information recorded in the six conflict of interest forms reviewed by us. For confidentiality reasons, this information has been de-identified.

[25] NSW Police Force, *Critical Incident* Guidelines, January 2016, p. 20; NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 27.
[26] NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 41; NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 37.

Table 1.1 Information recorded on six conflict of interest forms

Strike force name	Potential/declared conflict	Treatment strategy
Barnier	Previously worked with [one involved officer] at a [regional command]	Nil conflict
	Previously worked with [one involved officer] at a [regional command]. Is a close friend.	No direct contact with officer for investigation.
	Formerly worked at LAC. No conflict with review	
Rosslyn	[Metropolitan command] staff Region Commander (husband)	Informed by Region Commander to continue as SCII as [Metropolitan command] officers only witnesses. Region Commander declared no conflict.
	[Metropolitan command]	As above
	[Metropolitan command]	As above
	[Metropolitan command]	As above
	[Metropolitan command]	As above
	[Metropolitan command]	As above
	[Metropolitan command] and [Specialist command] staff	As above
	[Metropolitan command]	As noted by SCII [Metropolitan command] staff witnesses only. Also on call record response. Asked to assist by Inspector.
Roeland	Associated with [one involved officer] – Police Football 2002-2004	Not to speak to [involved officer].
Padman	Yes. Former Co-workers involved.	Tasks not to involve direct dealing with involved officers or police statements.
	Stationed at [Metropolitan command] from 2010-2014. Knowledge of both involved officers/ offender.	Used to work at [Metropolitan command] – no interviewing police – task canvassing at markets.
	Station @ [Metropolitan command] 2003-2011 know officer involved	Involved officers not present, canvassing at markets and independent witness statements only.
Clemton	Wife works at station.	No interaction with police – canvass only.
	Previously worked with [one of the involved officers].	Nil interaction with [involved officer].
Scouller	Previously worked with [involved officer] at [Metropolitan command] in 2012.	No current contact and no contact for numerous years. Not to have direct contact with [involved officer] or inquiries directly related with [involved officer].

In strike force Barnier one member of the CIIT declared that he had previously worked with one of the involved officers and that they were 'close friends'. The recorded treatment strategy was – 'No direct contact with officer for investigation'. There was no information about the way the NSW Police Force would monitor and manage the close relationship between these two officers.

Simply stating that there should be no direct contact between the two officers without providing specific strategies of how this will be achieved does not, in the Commission's view, constitute an effective or practical treatment strategy in the circumstances. The Commission would have expected a more in-depth assessment of the potential risks and a number of treatment strategies which could include, among other things, restricting access to information and sensitive documents, separating the officer from parts of the activity or process, withdrawing the officer from discussions of involved officers and any decision-making processes, or, as a last resort, removing the officer from the investigation altogether. A second member of the CIIT also declared the following conflict of interest: 'previously worked with [involved officer] at a [regional command]. Under the heading 'treatment strategy' the SCII had recorded 'nil conflict'. It is unclear how this amounts to a treatment strategy to address the historical working relationship identified as a potential conflict. The documentation contains insufficient information to reassure anyone that the potential conflict of interest was properly addressed and managed by the NSW Police Force.

In strike force Rosslyn, eight members of the CIIT had declared a potential conflict of interest. However, the conflict of interest form did not include enough information to explain what the conflicts were or how they would be managed.

In strike force Roeland one officer declared that he had associated with one of the involved officers in the past. The treatment strategy for this potential risk was simply 'not to speak to [involved officer]'. This is not an acceptable treatment strategy as there is no information as to how this would be achieved. As outlined above in the discussion of the 'treatment strategies' in strike force Barnier, the Commission would have expected a more thorough assessment of the potential risks posed by the identified conflict and specifically tailored treatment strategies to show how the NSW Police Force would manage the risks that this association may pose to the integrity of the investigation.

In strike force Clemton, one officer declared that his 'wife works at station'. The treatment strategy was: 'No interaction with police – canvass only'. The documentation lacks detail to show precisely what the nature of the risk was and how it would be managed. Presumably the declared conflict is that the officer's wife works at the station of the involved officer. In such circumstances, the Commission would have expected some specific strategies detailing how the NSW Police Force proposed to manage the risk of a married couple discussing aspects of the investigation or discussing with officers known to them and who were also involved in the critical incident. A second officer declared that he had previously worked with one of the involved officers. The treatment strategy was that the officer was not to interact with the involved officer. The documents in e@gle.i contain insufficient information to show that this would be effective and practical as an approach to manage the potential conflict.

Conflicts of interest have the potential to jeopardise the actual or, just as important, perceived integrity of an investigation. It is imperative that they are disclosed by officers and managed effectively so that officers perform their functions fairly and impartially. Appropriately tailored and recorded risk treatment strategies for officers who have declared conflicts of interest demonstrate accountability and transparency in critical incident investigations. Conflicts of interest are not wrong in themselves. However, it is how they are being dealt with that is

important. The existence of a proper risk assessment and detailed treatment strategies will demonstrate that the NSW Police Force has considered the declared conflict of interest carefully and taken steps to manage, mitigate or eliminate any risks associated with it.

RECOMMENDATION 2: It is recommended that NSW Police Force Critical Incident Guidelines include a hyperlink and/or reference to NSW Police Force Procedures for Managing Conflicts of Interest.

3.2 MANDATORY DRUG AND ALCOHOL TESTING

According to the critical incident guidelines, officers "directly involved" in a critical incident may be required to undergo mandatory drug and alcohol testing according to section 211A of the *Police Act 1990* (NSW).[27]

Section 211A (2A) of the *Police Act 1990* states –

> An authorised person must-require any police officer directly involved in a mandatory testing incident to:
>
> a) undergo a breath test, or submit to a breath analysis, for the purpose of testing for the presence of alcohol, and
>
> b) provide a sample of their urine or hair (or both) for the purpose of testing for the presence of prohibited drugs
>
> in accordance with the directions of the authorised person and the regulations.

The following categories of critical incidents require mandatory drug and alcohol testing –

> Death or imminent death resulting from discharge of a firearm by police.
>
> Death or imminent death from use of police appointments (not firearm).
>
> Death or imminent death as a result of the application of physical force by a police officer.
>
> Death or serious injury arising from a NSW police operation where a person was being detained by police or was in police custody.
>
> Death or serious injury to a person in police custody.
>
> Death or serious injury of a person arising from a police vehicle pursuit or from a collision involving a NSW police vehicle.
>
> Serious injury from the discharge of a firearm by a police officer.
>
> Serious injury from the use of police appointments.
>
> Serious injury as a result of the application of physical force by a police officer.[28]

Sixteen of the 29 critical incidents fell into one of these categories.

We assessed whether –

- mandatory drug and alcohol testing took place
- mandatory testing results were attached to e@gle.i, and
- mandatory testing occurred within recommended timeframes.

[27] NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 12; NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 11.
[28] NSW Police Force, Critical *Incident Guidelines*, January 2016, p. 52.

3.2.1 MANDATORY DRUG TESTING

The critical incident guidelines do not provide specific timeframes in which mandatory drug testing should take place. However, NSW Police Force Drug and Alcohol Testing Procedures state that 'Mandatory drug testing can only be carried out by authorised persons (non-sworn) attached to [Drug and Alcohol Testing Unit] as soon as reasonably practicable after the incident, and preferably within 24 hours'.[29]

In addition, section 211A (4A) of the *Police Act 1990* stipulates –

> A requirement pursuant to subsection (2A) to undergo a test or to provide a sample is to be made by an authorised person as soon as practicable after the mandatory testing incident concerned.

Table 1.2 sets out our analysis of compliance with mandatory drug testing requirements.

Table 1.2: Drug testing

	Mandatory testing incident	Not a mandatory testing incident	Total number of investigations
	16	13	29
Drug testing of involved officers undertaken within 24 hours	14		
Information not available concerning times when involved officers were drug tested	1		
Drug testing for some involved officers within 24 hours and for some outside 24 hours	1		
Total	16	13	29

Of the 16 critical incident investigations where drug testing was mandatory, our review found that 14 critical incident investigations (87.5%) **complied** with the desired timeframes.[30]

In strike force Dobbin records from the NSW Police Force Drug and Alcohol Testing Unit ('D&ATU') state that 'reports have been received advising that the tests were negative to illicit drugs of abuse'. However, these reports were not attached to e@gle.i and we were unable to determine the times and outcomes of these tests.

In strike force Kotari four of the six involved officers were drug tested within 24 hours of the incident. The fifth officer was drug tested, but not within the desired timeframe. For the sixth officer we were unable to locate mandatory drug testing results on e@gle.i.

According to NSW Police Force records located on e@gle.i all officers who participated in mandatory drug testing returned a negative result.[31]

[29] NSW Police Force, *Drug and Alcohol Testing Procedures*, Drug and Alcohol Testing Unit, Professional Standards Command, January 2018, p. 27.
[30] Strike forces Pettit, Buteo, Scouller, Barnier, Tabit, Edison, Deer, Magarra, Chusan, Edges, Berith, Clemton, Roeland and Fellows.
[31] The Commission was unable to verify this for two investigations; one investigation caveated this information and the NSW Police Force provided us with the date and times when the drug testing took place and stated that 'no positive results being returned'; for the second investigation there were no records of the actual drug testing taking place, but only a letter from the NSW Police Force Drug and Alcohol Testing Unit stating that reports on drug testing had been received and that the results were negative to illicit drugs.

3.2.2 MANDATORY ALCOHOL TESTING

As indicated above, section 211A (4A) of the *Police Act 1990* states that testing for drugs and alcohol after a mandatory testing incident is to occur 'as soon as practicable after the mandatory testing incident concerned'. In relation to timeframes for alcohol testing, the guidelines state that alcohol testing is 'best completed within 2 hours of the incident'.[32]

Table 1.3 sets out our analysis of compliance with mandatory alcohol testing requirements.

Table 1.3 Alcohol testing

	Mandatory testing incident	Not a mandatory testing incident	Total number of investigations
	16	13	29
Alcohol testing of involved officers undertaken within 2 hours	0		
Involved officers alcohol tested but **not** within 2 hours	10		
Information not available concerning when involved officers were alcohol tested	4		
Alcohol testing for some of the involved officers occurred within 2 hours and for some officers outside 2 hours	1		
Results for alcohol testing available for some involved officers but not all	1		
Total	16	13	29

Of the 16 critical incident investigations where alcohol testing was mandatory, our review found that in ten investigations mandatory alcohol testing was undertaken more than two hours after the critical incident had occurred. Timeframes ranged from just over two hours to more than seven hours after the incident happened.[33]

In four critical incident investigations[34] records from the D&ATU stated that 'all officers were breath tested on Alcolizers [...] each recording a 0.000 result'. However there were no records on e@gle.i providing the times when officers were breath tested.

In strike force Kotari alcohol testing results for all involved officers were attached to e@gle.i. The results indicate that half of the officers were tested within the desired timeframe of two hours; the other half were tested more than two hours after the critical incident had occurred.

In strike force Barnier mandatory alcohol testing results were attached to e@gle.i for two of the four involved officers. One officer was tested within two hours of the critical incident occurring. The second officer was tested more than five hours after the incident had occurred.

[32] NSW Police Force, Critical *Incident* Guidelines, 2012, p. 28; NSW Police Force, *Critical Incident Guidelines,* 2016, p. 35.
[33] Strike forces Pettit, Scouller, Tabit, Edison, Chusan, Edges, Berith, Fellows, Roeland and Dobbin.
[34] Strike forces Buteo, Deer, Magarra and Clemton.

In summary, in investigations where mandatory alcohol testing results were available, 94% of directly involved officers were tested outside the desired timeframe of two hours. Only 6% of officers were tested within the recommended two hours timeframe.[35] We acknowledge that the desired timeframe of two hours within which the tests are to be completed are not always practicable. The difficulty is that an officer may be directly involved in a critical incident but because of the two hour timeframes nothing useful is gained from any testing. For instance, where there is a delay in declaring a matter to be a critical incident, where there is delay in the arrival of the testing unit or where there is a delay in identifying an officer as being directly involved the test may be delayed and rendered uninformative. The Commission's CIMT is monitoring a number of mandatory drug and alcohol testing incidents. The CIMT provided an example where alcohol testing was conducted but where there was little utility in doing so. Records on e@gle.i indicate that mandatory alcohol testing was conducted more than 40 hours after the incident had occurred and more than 21 hours after the critical incident had been declared. The reason for the delay in declaring the critical incident was attributable to the fact that police were not aware that the person of interest had sustained injuries which met the requirements for mandatory drug and alcohol testing. In these circumstances it would be difficult for NSW Police Force to make any conclusions in relation to whether any involved officer was alcohol and/or drug affected at the time when the critical incident occurred. Nevertheless, while legislation requires NSW Police Force to conduct mandatory testing of officers involved in critical incidents police have no choice in the matter.

We acknowledge that the NSW Police Force has identified a need to improve compliance with desired timeframes for alcohol testing, and are taking steps to address this. We suggest that the NSW Police Force continues to liaise with the Commission's CIMT to increase compliance with alcohol testing requirements.

Where mandatory alcohol testing does not occur within the desired timeframe of two hours, the NSW Police Force should ensure that the reasons for testing outside that timeframe are clearly recorded. It is apparent that the width of definition of "involved officer" and the necessity to conduct mandatory drug and alcohol testing where there can be no reason to think it would be relevant needs to be reconsidered given the substantial waste of resources in this regard.

RECOMMENDATION 3: It is recommended that NSW Police Force Critical Incident Guidelines require the senior critical incident investigator to record reasons explaining why any mandatory alcohol testing event occurred outside the desired two hour timeframe.

3.3 INTERIM REPORTS

Critical incident investigations occurring after 1 January 2016 which involve a coronial inquest are required to include an interim report –

> Prior to the completion of any coronial inquest, the region commander is to ensure that an interim report, detailing the outcomes of the investigation, is provided to the NSW Police Force Executive so any matters arising can be dealt with.[36]

The effect of this guideline is that, when the brief of evidence has been submitted to the Coroner, the NSW Police Force should be in a position to complete the interim report. It would be highly desirable for the interim report to be completed once a brief of evidence has been

[35] The results in Project Harlequin were slightly higher, at 12%.

[36] NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 15. The 2012 Guidelines did not include this requirement.

provided to the Coroner. Given that coronial inquests and criminal proceedings can take years before they are finalised, the interim report completed at this juncture would serve to –

- summarise the investigative actions and evidence that may otherwise be contained in hundreds of documents;
- present preliminary findings which may be used by officers supervising involved officers, or if appropriate, be conveyed to involved officers on a provisional basis;
- suggest operational or other practices requiring urgent or, at least, reasonably prompt action; and
- propose, where appropriate, disciplinary or managerial action that needs prompt action.

Responsibility for an investigation may change hands over time or, even in cases where it does not, the intervening period will almost certainly adversely affect the investigating officer's recall of salient issues. As such, an interim report may well assist officers who take carriage of the investigation at the conclusion of coronial or criminal proceedings.

An investigation left open for a lengthy period may also give rise to welfare issues for involved officers awaiting the finalisation of matters.

Of the 29 critical incident investigations reviewed, 18 involved a coronial inquest. Nine (50%) of these were governed by the 2016 Guidelines. It was expected that an interim report would have been completed for these nine investigations. However, interim reports could not be located for four investigations (strike forces Ladera, Barnier, Appenine and Clemton) on e@gle.i as at 1 April 2019 even though the NSW Police Force had provided briefs of evidence to the Coroner from eight to 26 months before this date.

A document was located on e@gle.i that was classified as 'Interim Report' for strike force Tabit. However this is a status report and does not provide any information on the outcomes of the investigation. It can only be surmised that the NSW Police Force incorrectly categorised this document as interim report.

In strike forces Barnet and Chusan, interim reports were attached to e@gle.i. However, the interim report in strike force Barnet was completed after the inquest.

In strike force Rosslyn the NSW Police Force recorded the following comments on e@gle.i: 'Nil interim report the matter is still before the criminal court. Coronial proceedings suspended until criminal matter finalised'.

In strike force Mayberry the NSW Police Force attached the following comments on e@gle.i – 'Our Region Commander has never insisted on an interim report as he is of the view that it is not appropriate to pre-empt the findings of the coroner and to wait until after the inquest. This view is/was shared by other Region Commanders'.

The results of the review show that there is some confusion within the NSW Police Force as to the purpose of an interim report. The guidelines do not provide enough information as to the stage at which an interim report should be prepared and what type of information should be included in such a report. The guidelines state that the region commander 'must ensure' that an interim report is provided to the NSW Police Force Executive so any 'matters arising' can be dealt with. This must occur prior to the completion of any coronial inquest. However, the guidelines do not specify if an interim report must also be prepared in instances where no 'matters arising' have been identified prior to the completion of an inquest.

Our review located one interim report (strike force Barnet) that was completed after the coronial inquest. Comments made in another two investigations (strike forces Mayberry and Rosslyn) indicate that some region commanders are waiting for the completion of coronial inquests and/or criminal proceedings before preparing the interim report. This is not only contrary to what is stated in the 2016 Guidelines but also adds to potential delays in completing interim reports.

The Commission's draft report made a preliminary recommendation that the NSW Police Force clarify its instructions around the use of interim reports, including the role and purpose of interim reports, the time at which they should be completed, the information that should be included in interim reports and who is responsible for completing the interim reports.

The NSW Police Force, in its response to the draft report, indicated that, during the course of the review of the Critical Incident Guidelines, the State Coroner issued Coroner's Practice Note 2 of 2018 ('CPN 2018'). CPN 2018 creates a requirement for the SCII to provide a preliminary report to the Senior Coroner and the Crown Solicitor, no later than eight weeks after a Senior Coroner has determined jurisdiction under s 23 of *the Coroners Act 2009*, outlining the following:

- the background of the report death (the known circumstances based on information currently available at the time of the report);
- the current status of the investigation;
- identified issues arising from the investigation;
- identified New South Wales Police Force policies or operational guidelines relating to the investigation;
- the status of the brief of evidence including items outstanding; and
- the proposed date when the brief of evidence will be completed.

The Commission is satisfied that the completion of a preliminary report pursuant to CPN 2018 would serve the same purpose as an interim report, and the expected content of the preliminary report to the Coroner reflects the information previously suggested for inclusion in the guidelines in relation to interim reports. Accordingly, the use of such preliminary reports is welcomed.

The NSW Police Force informed the Commission that the revised guidelines have been amended to include these requirements contained in CPN 2018. However, the review of the 2016 Guidelines has not been finalised as of writing of this report. The Commission has not reviewed this document and is in no position to comment on its content.

4. TIMELINESS OF CRITICAL INCIDENT INVESTIGATIONS

One of the aims of our review was to establish if the finalisation of some critical incident investigations had been unreasonably delayed by the NSW Police Force. We identified eight out of 29 critical incident investigations (six coronial[37] and two[38] non-coronial) where, based on the records attached to e@gle.i, it appeared that there may have been unreasonable delays on the part of the NSW Police Force in completing these matters.

The NSW Police Force critical incident guidelines do not provide police with a clear indication of timeframes in which a critical incident investigation should be completed.

The 2012 Guidelines simply state that 'the SCII should be cognizant of the need for timeliness in conducting investigations'.[39] There is no further direction about how long a 'timely' investigation should take. The 2016 Guidelines include no reference at all about the timeliness of conducting the investigation.

There may be a range of reasons why a critical incident investigation could be open for a considerable length of time, including the complexity of the investigation and delays caused by criminal or civil matters that may have an impact on the investigation. Additionally, timeliness considerations may differ for coronial and non-coronial matters. While we acknowledge that CPN 2018 has imposed timeliness requirements for critical incident investigations we are nonetheless of the view that the guidelines should include additional guidance about timeframes for conducting critical incident investigations. The timeframes for completing critical incident investigations could be similar to those for evidence based investigations of complaints under Part 8A of the Police Act. Those are to be completed within 90 days of the date the complaint is received by the NSW Police Force.[40] Similarly, the timeframe for completing a critical incident investigation could be within 90 days of the critical incident being declared. For any critical incident investigations that have exceeded the desired timeframe, the guidelines should require that a monthly status report is completed outlining the reason for delays. This will allow for appropriate consideration of whether an extension should be granted and any other circumstances that are likely to impact on the timeliness of the investigation.

Table 1.4 provides an overview of the number of coronial and non-coronial critical incident investigations we reviewed.

Table 1.4 Overview of coronial and non-coronial critical incident investigations reviewed

Number of critical incident investigations reviewed		
Coronial matters	Non-coronial matters	**Total**
18	11	**29**

[37] Strike forces, Appenine, Pettit, Barnet, Leawill, Magarra and Begrinda.
[38] Strike forces McElroy and Deer.
[39] NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 33.
[40] NSW Police Force, *Complaint Handling Guidelines*, February 2016, p. 47.

4.1 CORONIAL MATTERS

If a person dies in police custody or in the course of a police operation, a coronial inquest is mandatory. Section 23 of the *Coroners Act 2009* sets out the Coroner's jurisdiction concerning the deaths in custody or as a result of police operations.

> (1) A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the Coroner that the person has died (or that there is reasonable cause to suspect that the person has died):
>
> (a) while in the custody of a police officer or in other lawful custody, or
>
> (b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or
>
> (c) as a result of police operations, ...[41]

A 'police operation' means any activity engaged in by a police officer while exercising the functions of a police officer other than an activity for the purpose of a search and rescue operation.[42]

A 2016 report by the Coroner explains the Coroner's role in inquests relating to police operations –

> ...in relation to police operations and other forms of detention the Coroner will investigate the appropriateness of actions of police and officers from other agencies and review standard operating procedures. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist, and if so, ensure, as far as possible, that remedial action is taken.[43]

The NSW Police Force is under a statutory obligation to report deaths that occurred in police custody or deaths that occurred as a result of, or in the course of, a police operation to the Coroner. Ordinarily, reports of deaths come from police officers in a Form P79A 'Report of death to the Coroner'.[44]

Deaths that occurred in police custody or as a result of a police operation result in mandatory inquests and the Coroner must order a full investigation. Section 51 of the *Coroners Act 2009* gives the Coroner the power to order a police investigation. In these matters the officer in charge of the critical incident investigation must prepare a brief of evidence for submission to the Coroner. The Coroner's brief is not complete until the police investigation brief and the medical evidence, especially the post mortem report, are gathered. If the Coroner decides that the matter should go to inquest, the file with the brief and post mortem report are sent either to a police advocate or, in appropriate cases, the Crown Solicitor who will then review the material, analyse the issues and prepare it for inquest.[45]

Where criminal charges are being laid, the NSW Police Force forwards the police investigation brief to the Office of the Director of Public Prosecutions ('ODPP'). The Coroner is still required to review the brief for his/her purposes, and conduct an inquest, regardless of whether the

---

[41] While police operation is defined in the Coroner's Act, a death which occurs 'as a result of' a police operation is not defined in the *Coroners Act 2009*. Following the commencement of the 1993 amendments to the *Coroners Act 1980*, New South Wales *State Coroner's Circular No. 24* sought to describe potential scenarios that are likely deaths 'as a result of, or in the course of, a police operation' as referred to in s. 23 of the Coroners Act, as follows: any police operation calculated to apprehend a person(s); a police siege or police shooting; a high speed police motor vehicle pursuit; an operation to contain or restrain persons; an evacuation; a traffic control/enforcement; a road block; execution of a writ/service of process; any other circumstances considered applicable by the State Coroner or a Deputy State Coroner. (*Report by the NSW State Coroner into deaths in custody/police operations for the year 2016*, pp. 3-4).

[42] Coroners *Act 2009*, section 23(2).

[43] NSW Office of the State Coroner, *Report by the NSW State Coroner into death in custody/police operations for the year 2016*, 25th March 2016 (sic), p. 9.

[44] Form P79A summarises the known details of the deceased person, the name of the next of kin, if known, the circumstances of the death or the discovery of the body. It outlines the preliminary views of the police as to whether the circumstances of the death are suspicious.

[45] Judicial Commission of NSW, *Local Court Bench Book*, "Coronial Matters", https://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html, pp. 5-6. Accessed on 9/1/2017.

brief of evidence goes to the ODPP. Critical incident guidelines stipulate that, at the conclusion of the coronial inquest, the SCII will prepare the final CIIR, which includes any comments or recommendations made by the Coroner.[46]

This provision of the NSW Police Force critical incident guidelines means that final investigation reports for critical incidents are not generated until the conclusion of the coronial process.

The Coroner has publicly acknowledged that there are sometimes delays in hearing cases and discussed some of the reasons for those delays –

> The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is at times unavoidable and there are many various reasons for delay.
>
> The view taken by the State Coroner is that deaths in custody/police operations must be fully and properly investigated. This will often involve a large number of witnesses being spoken to and statements being obtained.
>
> It is settled coronial practice in New South Wales that the brief of evidence be as comprehensive as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case.
>
> It has been found that an initially comprehensive investigation will lead to substantial saving of court time in the conduct of the actual inquest.
>
> In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services.
>
> The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.[47]

4.1.1 FINALISATION OF CORONIAL CRITICAL INCIDENT INVESTIGATIONS BY POLICE

Eighteen of the 29 critical incident investigations reviewed included a coronial inquest. The Commission considered whether these matters were finalised or remained open and the reasons. The NSW Police Force records an investigation as 'finalised' on e@gle.i when a matter has proceeded through the court system, or requires no further investigation and nothing further needs to be added to the e@gle.i system. It also usually means that the brief of evidence was placed into the NSW Police Force archive holdings.[48]

Table 1.5 provides an overview of the status of coronial critical incident investigations as at 1 April 2019.

[46] NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 25. A similar requirement is included in the 2012 Guidelines on p. 34-35.
[47] NSW Office of the State Coroner, *Report by the NSW State Coroner into death in custody/police operations for the year 2016*, 25th March 2016 (sic), p. 10.
[48] Correspondence from the NSW Police Force, Professional Standards Command, to Law Enforcement Conduct Commission. Letter received at the Law Enforcement Conduct Commission on 26 July 2018.

Table 1.5 Overview of status of coronial critical incident investigations as at 1 April 2019.

Status of coronial critical incident investigations as at 1 April 2019	
Status of investigation	**Number**
Investigation finalised	4
Inquest dates have been set but not released as at 1 April 2019	7
Coronial proceedings have been suspended	1
Coronial proceedings were finalised prior to 1 April 2019 but critical incident investigation remains open	5
Coroner dispensed with inquest in March 2018. Investigation remains open as at 1 April 2019	1
Total	18

Four of the 18 coronial investigations (strike forces Duras, Kotari, Scouller and Roeland) were finalised.

For seven investigations (strike forces Tabit, Mayberry, Clemton, Fellows, Ladera, Barnier and Chusan) coronial inquest dates have been set but, as at 1 April 2019, no inquest findings have been attached to e@gle.i.[49]

In strike force Rosslyn coronial proceedings were suspended[50] while a related criminal matter is finalised. The hearing or sentence dates were set for 12 and 13 November 2018. As at 1 April 2019 there is no update on e@gle.i that criminal proceedings have been finalised.

The coronial proceedings for five critical incidents have been finalised. However the matters remain open according to NSW Police Force records. Inquest finding dates were 22 November 2017 (Appenine), 20 April 2018 (Pettit), 2 May 2018 (Barnet), 19 June 2018 (Leawill) and 20 July 2018 (Magarra).[51] A CIIR, review officer report or region commander report could not be located. Given that coronial proceedings are completed, it would be expected that these investigations would have been finalised by NSW Police Force. Inquest findings for these five matters were released by the Coroner between eight and 17 months ago. On 16 November 2018 the NSW Police Force attached a final CIIR for strike force Appenine to e@gle.i, some 12 months after the inquest findings were delivered. However, e@gle.i contained no review report or region commander report. The guidelines stipulate that when a critical incident investigation is concluded, the region commander 'should provide a comprehensive report to the Deputy Commissioner, Field Operations'. The documentation should include the CIIR and review officer report.[52] As at 1 April 2019 no CIIR, review report or region commander report is attached to e@gle.i for strike forces Pettit, Barnet, Leawill and Magarra. All five investigations remain open.

[49] Correspondence from Coronial Case Management Unit, State Coroner's Court of NSW, to Law Enforcement Conduct Commission, 24 April 2018. Correspondence from Coronial Case Management Unit, State Coroner's Court of NSW, to Law Enforcement Conduct Commission, 10 December 2018.
[50] The Coroner must suspend an inquest if he or she is advised that a person has been charged with an indictable offence connected with a death. The inquest will be resumed once the charge has been heard.
[51] Correspondence from Coronial Case Management Unit, State Coroner's Court of NSW, to Law Enforcement Conduct Commission, 24 April 2018.
[52] NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 15; NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 17.

As mentioned, NSW Police Force critical incident guidelines provide no guidance of what constitutes a timely completion of a critical incident investigation. While the guidelines do not explain the threshold for 'timely completion', on the basis of the available documentation, the Commission considers the failure to finalise these five investigations is unreasonable.

In strike force Begrinda, the Coroner dispensed with the holding of an inquest pursuant to section 25 of the Coroners Act on 26 March 2018. The following day the NSW Police Force attached a record to e@gle.i which stated – 'projected task is to commence critical incident investigation report.' The critical incident occurred on 3 October 2015. As at 1 April 2019 no CIIR, review report or region commander was attached to e@gle.i and the investigation remains open. There appears to be no reason why this investigation has not been finalised.

For those matters in which inquest findings were available on e@gle.i (strike forces Barnet, Kotari, Duras and Roeland) the Coroner made no adverse comments about police, the critical incident investigation or the timeliness of the investigation. The Coroner did, however, make recommendations in three of the four inquests. The recommendations included organisation wide training of police officers in areas such as mental health, custody, First Aid and the development of a system that would allow Emergency Service Operators to have easy access to Triple Zero call information.

No records on e@gle.i indicate that the Coroner's recommendations have been considered, accepted or implemented by the NSW Police Force as at 1 April 2019. However, the Commission has not considered this to be a deficiency. Premier's Memorandum 2009-12 sets out the process for Ministers and Government agencies to respond to recommendations made by the Coroner. In line with the requirements of the memorandum, formal advice, detailing the NSW Police Force response to any recommendations made by the Coroner, is forwarded to the Attorney General. This process is administered by the Office of the Commissioner and may not, in all circumstances, form part of the investigation record. In its response to the draft report the NSW Police Force confirmed that consideration and response to recommendations from the Coroner do not ordinarily form part of the e@gle.i records for investigations.

4.1.2 SERVING THE BRIEF OF EVIDENCE

The Commission also examined how long it took the NSW Police Force to serve a brief of evidence to the Coroner's Office for the 18 applicable investigations. See Table 1.6.

Table 1.6 Length of time (in months) for the NSW Police Force to serve a brief of evidence to the Coroner's Office

Length of time for the NSW Police Force to serve a brief of evidence to the Coroner's Office for 18 applicable investigations							
1-3 months	3-6 months	6-9 months	9-12 months	15-18 months	18-21 months	21-24 months	Total
1	7	3	3	1	1	2	18

The NSW Police Force served fourteen (14) briefs of evidence to the Coroner's Office within 12 months of the critical incident. The remaining four briefs of evidence were served between 16 to 22 months after the critical incident had occurred.

The nature, circumstances and complexity of a critical incident impact on the length of the subsequent investigation. For instance, in strike force Magarra the NSW Police Force served a brief of evidence to the Coroner's Office 19 months after the critical incident had occurred. This incident resulted in a lengthy critical incident investigation, which included taking a large number of statements from civilian witnesses, medical experts, and expert police statements, i.e. scientific officers, crime scene officers, forensic/ballistics etc., obtaining a large number of medical, personnel and electronic HR records of the deceased, review of extensive CCTV footage etc. Strike force Magarra has more than 800 records attached to e@gle.i. By comparison in strike force Duras the NSW Police Force served a brief of evidence to the Coroner's Office three months after the critical incident had occurred. This investigation, which was finalised, has 172 records attached to e@gle.i.

The time taken to complete a coronial inquest is a matter that is beyond the control of the NSW Police Force. At times the inquest may be quite lengthy, and may take years to complete. This is particularly the case where the matters are complex or involve concurrent criminal processes. However, the fact that the NSW Police Force guidelines require the final critical incident report to incorporate the comments or recommendations of the Coroner means that the investigation can remain open for an extended period after the investigative actions of the NSW Police Force are finalised. When an investigation remains open, it impacts both people associated with the victim to the critical incident, involved officers, and actions that could be taken by the NSW Police Force to address any gaps in policy, procedures, education and training that may have contributed to the critical incident occurring.

It is also concerning that even in matters where the coronial inquest has been completed, or dispensed with, the critical incident investigation may remain open for extended periods, as was evident in six of the matters reviewed.

4.2 NON-CORONIAL MATTERS

Non-coronial matters are incidents which are not subject to the coronial jurisdiction/process because the person did not die in the course of their interaction with police. The role of the NSW Police Force in non-coronial matters is as follows -

> The SCII will prepare an investigation report at the conclusion of the investigation and any court related process. The investigation report should include relevant events and activities leading to the incident and comment on the lawfulness of police action, general care, treatment and supervision of the deceased/seriously injured prior to death serious/injury.[53]

[53] NSW Police Force, *Critical Incident Guidelines*, January 2016, p. 25. A similar requirement is included in the 2012 Guidelines at p. 33.

Table 1.7 Overview of status of non-coronial critical incident investigations as at 1 April 2019.

Status of non-coronial critical incident investigations as at 1 April 2019	
Status of investigation	**Number**
Investigation not finalised because of ongoing criminal proceedings	1
Unable to determine why investigation has not been finalised	2
Investigation finalised	8
Total	11

The review found that one investigation (strike force Dobbin) is not finalised because the NSW Police Force is waiting for the completion of criminal proceedings.

The review was unable to establish why the NSW Police Force has not finalised strike forces McElroy and Deer. Criminal proceedings in strike force McElroy concluded on 30 October 2018; the ODPP informed the NSW Police Force of its decision not to appeal the verdict on 19 November 2018. As at 1 April 2019 no further records have been attached to e@gle.i. Strike force McElroy has been open for almost 40 months. Strike force Deer has been open for more than 53 months and is ongoing at the time of writing. The NSW Police Force provided several reasons for the delay in completing this investigation –

- whilst the criminal matters were proceeding through the court system, the critical incident investigation was suspended,
- a number of expert statements were requested,
- the SCII was seriously injured at work whilst performing operational policing duties and was off work for just under six (6) months, and
- the SCII was performing a dual role in two different commands.

An unsigned CIIR, dated 12 October 2017, was located on e@gle.i. As at 1 April 2019, no signed CIIR, review report or region commander report has been attached to e@gle.i.

According to information provided by the NSW Police Force, eight of the 11 non-coronial investigations (strike forces Edison, Edges, Buteo, Mooloobar, Berith, Hibernia, Padman and Pirralea) were finalised. Seven of the eight investigations (Edison, Edges, Buteo, Mooloobar, Hibernia, Padman and Berith) have a CIIR, review report and region commander report attached to e@gle.i. In strike force Pirralea the NSW Police Force caveated the CIIR and review report. We were only able to access and review the region commander report.

4.3 DELAYED FINALISATION

There are a number of reasons why critical incident investigations in non-coronial matters can take a considerable amount of time before being finalised. For example, if there are concurrent criminal proceedings the NSW Police Force needs to wait for the completion of any court related processes before it can complete its critical incident investigation. At the time of

writing the NSW Police Force had to wait for the completion of criminal proceedings for one non-coronial matter.

Notwithstanding this, in some matters, the NSW Police Force records do not provide reasons explaining why the critical incident investigation remains open. Strike force Deer has been open since October 2014. The NSW Police Force provided us with several reasons for this. However, no new records have been attached to e@gle.i since April 2018. E@gle.i records indicate that the final report into the critical incident was completed on 13 October 2017 and has been forwarded to the review officer. An unsigned CIIR, dated 12 October 2017, has been located on e@gle.i, but not a review officer report or region commander report as at 1 April 2019. It is not clear that the NSW Police Force considered whether reassigning the role to another investigator would be appropriate given the significant time the investigator was unable to perform SCII duties. Similarly, in strike force McElroy, criminal proceedings concluded in late October 2018 yet no new records have been attached to e@gle.i since November 2018.

There are a number of factors that impact on the timeliness of a critical incident investigation, some of which are beyond the control of the NSW Police Force. However, the review identified eight investigations (27%), including coronial and non-coronial matters, where the delay in finalising the critical incident investigation appears unreasonable. It is important that the NSW Police Force addresses unnecessary delays as they may result in adverse effects, not the least of which is the distress endured by the families of the deceased and injured and of the officers involved in these incidents.

5. PART 8A COMPLAINT INVESTIGATIONS

NSW Police Force critical incident guidelines require the SCII to –

> Detail any conduct (Part 8A) matters identified and how they were dealt with. You will need to draw on the evidence within the investigation to support your outcome.

and

> Do not address issues as 'sustained/not sustained'. This report does not replace the corporate standard for a Final Report in a Part 8A complaint investigation. This is a separate and distinctive document located on the Professional Standards site on the Intranet).[54]

In addition, NSW Police Force critical incident guidelines require the review officer to –

> Identify and advise the SCII, PSC and region commander of any matters that may constitute a complaint under part 8A of the Police Act.[55]

Part 8A complaints are investigated separately to the critical incident investigation and can be suspended if its continuation could jeopardise a critical incident investigation.[56]

Four of the 29 critical incident investigations reviewed led to a Part 8A complaint.[57] The review found that all four critical incident investigations complied with the requirement of the guidelines to identify and deal with matters that constitute a complaint under Part 8A of the *Police Act 1900.*

[54] NSW Police Force, *Critical Incident* Guidelines, January 2016, p. 46; NSW Police Force, *Critical Incident Guidelines*, August 2012, P1101, Page 4 of 5.
[55] NSW Police Force, Critical *Incident Guidelines*, January 2016, p. 41; NSW Police Force, *Critical Incident Guidelines*, August 2012, p. 36.
[56] NSW Police Force, Complaint Practice Notice 11/12: Procedure to suspend a Part 8A complaint investigation within the c@ts.i system, 17 August 2018.
[57] Strike forces Duras, Edison, Kotari and Roeland.

6. CONCLUSION

The Commission initiated this project as a follow up to Project Harlequin and to measure, among other things, compliance by the NSW Police Force with their own critical incident guidelines and to establish if the completion of certain critical incident investigations may have been unreasonably delayed by the NSW Police Force.

The lack of records attached to e@gle.i impacted on the Commission's ability to properly assess if NSW Police Force had complied with its own critical incident guidelines. In more than one third of investigations no conflict of interest forms were attached to e@gle.i; this figure jumped to more than two thirds for interim reports.

The Police Integrity Commission's Project Harlequin similarly identified a lack of documentation located on e@gle.i for the 83 critical incident investigations it audited. In that matter, PIC expressed a view which resonates in relation to the matters in the current review –

> The Commission acknowledges that records and documents alone will not guarantee the integrity of critical incident investigations. However, available and well-managed records provide reassurance to the NSW Police Force, and any other external review process, that officers involved in critical incident investigations have recorded decisions they have made and actions they have taken and removes any doubt as to whether those acts occurred.[58]

In addition to the absence of conflict of interest forms, there is also a concern with the adequacy of the identification of potential conflicts and the management of any identified conflicts. In many instances, the way that conflicts of interest were documented did not clearly identify what the conflicts were, nor what treatment strategies would be implemented to avoid any such conflict, actual or perceived, impacting on the conduct of the investigation. It is important that the NSW Police Force addresses this issue, both to ensure the probity and integrity of investigations, and to reassure the public that in these often traumatic incidents which involve death or serious injury in the course of police operations, the NSW Police Force will investigate the circumstances thoroughly and impartially.

The review shows that the length of time taken to finalising coronial inquests and concurrent criminal proceedings does delay the finalisation of NSW Police Force critical incident investigations. While the duration of these proceedings is, to some extent, beyond the control of the NSW Police Force, it is important that the NSW Police Force takes steps to promptly finalise investigations after coronial proceedings come to an end, and to finalise non-coronial critical incident investigations without delay.

Since the commencement of Part 8 of the LECC Act on 1 July 2017, the Commission has had the responsibility for the independent oversight of NSW Police Force critical incident investigations. As part of this oversight function the Commission's CIMT monitors the conduct and progress of each critical incident investigation from the time that the incident is declared by police until the time that the investigation report is completed and the investigation finalised. In the course of monitoring a critical incident investigation the Commission's investigators ensure that requisite records are uploaded to e@gle.i and that concerns that arise in the course of the investigation, including but not limited to delays and conflicts of interest, are addressed at the time they become apparent with a consequent improvement in compliance with the guidelines. Our review suggests that in the absence of this monitoring function, adherence to the critical incident guidelines has been less stringent.

[58] Police Integrity Commission, *Project Harlequin, Audit of the NSW Police Force investigations into 83 critical incidents occurring between 1 January 2009 and 30 June 2012, May 2017*, pp. 228-241.

GLOSSARY

GLOSSARY	DISCRIPTION
CIIR	Critical incident investigation report
CIIT	Critical incident investigation team
CIMT	Critical Incident Monitoring Team
CPN 2018	Coronial Practice Note No 2 of 2018
D&ATU	Drug and Alcohol Testing Unit
e@gle.i	NSW Police Force investigations management system
LAC	Local area command
LECC	Law Enforcement Conduct Commission
LECC Act	*Law Enforcement Conduct Commission Act 2016*
ODPP	Office of the Director of Public Prosecutions
PIC	Police Integrity Commission
PSC	Professional Standards Command of the NSW Police Force
SCII	Senior critical incident investigator

LECC

Law Enforcement
Conduct Commission

Level 3, 111 Elizabeth Street
Sydney NSW 2000
Email: *contactus@lecc.nsw.gov.au*

Postal address
GPO Box 3880
Sydney NSW 2001
Phone: (02) 9321 6700
Toll free: 1800 657 079
Fax: (02) 9321 6799