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

Research & Prevention Publication

May 2017

Project Harlequin: Audit of the NSW Police Force investigations into 83 critical incidents occurring between 1 January 2009 and 30 June 2012

Research and Prevention Publication May 2017

Police Integrity Commission
Level 3, 111 Elizabeth Street, Sydney NSW 2000
www.pic.nsw.gov.au

ISBN 1 74003 185 7

CONTENTS

ABBREVIATIONS

Act	*Police Integrity Commission Act 1996*
BAS	Breath Analysis Operator
CAD	Computer Aided Dispatch
CCTV	Close-circuit television
CIDS	Crime Incident Dispatch System
CIIR	Critical Incident Investigation Report
CIIT	Critical Incident Investigation Team (Unit of the NSWPF)
CMT	Complaints Management Team
COPS	Computerised Operational Policing System (NSW Police Force data system)
CPR	Cardiopulmonary resuscitation
CSSB	Crime Scene Services Branch (Unit of the NSWPF)
DOI	Duty Operations Inspector
EAP	Employee Assistance Program
FBIS	Forensic Ballistics Investigations Section (Unit of the NSWPF)
FSG	Forensic Services Group (Unit of the NSWPF)
GMO	Government Medical Officer
HWP	Highway Patrol (Unit of the NSWPF)
ICRC	International Committee of the Red Cross
IPCC	Independent Police Complaints Commission (UK)
ICV	In-car video
LAC	Local Area Command (NSW Police Force)
LECC	Law Enforcement Conduct Commission
LIDAR	Light Detection and Ranging
NSW	New South Wales
NSWCC	NSW Crime Commission
NSWPF	NSW Police Force
NSWPS	NSW Police Service
OC	Oleoresin capsicum spray
ODPP	Office of the Director of Public Prosecutions
OLAU	Operational Legal Advice Unit (NSW Police Force)
OPI	Office of Police Integrity (Victoria)
OPM	Operational Procedures Manual
OSG	Operations Support Group
PANSW	Police Association of NSW
PDOO	Police Division of the Office of the Ombudsman (NSW)
PIC	Police Integrity Commission (NSW)
POI	Person of interest
PSC	Professional Standards Command (Unit of the NSWPF)
PSM	Professional Standards Manager (NSW Police Force)
QPS	Queensland Police Service
RBT	Random Breath Test
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
RCMP	Royal Canadian Mounted Police

SCAT	Specialist Casualty Access Team (Ambulance Service of NSW)
SCII	Senior Critical Incident Investigator
SDP	Safe Driving Policy (NSW Police Force)
SITREP	Situation report
SOPs	Standard Operating Procedures
VKG	NSW Police Force radio channel

EXECUTIVE SUMMARY

An incident involving a member of the New South Wales Police Force which has resulted in the death of, or serious injury to, a person is called a 'critical incident.' The New South Wales Police Force has issued guidelines for the investigation of critical incidents which state that, as soon as an incident has been declared critical by a region commander, critical incident protocols are to be activated by the New South Wales Police Force.

In 2012 the Commission commenced a project which involved research into the risks associated with critical incident investigations and an audit of New South Wales Police Force investigation files to assess how well the guidelines issued by the New South Wales Police Force managed those risks. The Commission requested the records held by New South Wales Police Force for the investigation of all critical incidents which occurred between 1 January 2009 and 30 June 2012. The New South Wales Police Force provided records for 83 critical incident investigations.

The applicable Critical Incident Guidelines for the sample audited by the Commission were the 2007 Guidelines. Subsequent versions were issued in 2012 and 2016. All versions state that the New South Wales Police Force is committed to investigating critical incidents in an "effective, accountable and transparent manner."

The Commission examined the critical incident investigation records to assess whether or not selected procedural requirements in the guidelines had been complied with. For example, records that indicated if officers involved in critical incidents had been separated at the earliest possible opportunity, if mandatory drug and alcohol testing had been undertaken within the specified timeframes, and whether the critical incident scene had been preserved and relevant exhibits had been collected.

A threshold problem in undertaking the audit was a lack of documentation located on the primary New South Wales Police Force investigations management system, e@gle.i. This had a direct impact on the Commission's ability to assess if the New South Wales Police Force had complied with the procedural requirements that assisted in managing misconduct and other risks associated with critical incident investigations. The records that were available revealed a high rate of compliance with some requirements within the guidelines, such as mandatory drug testing, but a worryingly low rate of compliance with other requirements, such as preservation of the incident scene.

This report presents the results of the Commission's research and audit findings, as well as its recommendations.

KEY FINDINGS

The report is divided into 15 chapters. Chapter 3 documents the research undertaken by the Commission into the risks associated with critical incidents and their investigation. Chapters 5 to 14 present the results of the Commission's audit of the compliance of the New South Wales Police Force with selected procedural requirements in the guidelines.

Chapter 5 examines the process for recognising and declaring a critical incident, as well as the importance of documenting reasons for this decision. One of the Commission's main findings in the chapter is that for 63% of critical incident investigations no

documentation was located concerning the reason why an incident was declared to be a critical incident.

A key requirement for critical incident investigations is ensuring the investigators tasked to undertake the investigation do so with impartiality. One of the mechanisms in the guidelines for achieving this is to ensure that officers undertaking the investigation are independent of the officers involved in the critical incident, and that no conflicts of interest exist. In Chapter 6, the Commission reports that New South Wales Police Force officers investigating critical incidents were from an appropriately senior rank and separate command in most critical incidents reviewed (96%), however, conflicts of interest were considered in only one third of these investigations (33%), despite this being a requirement of the guidelines.

Chapters 7 and 8 present the Commission's assessment as to whether procedures for the management of the early stages of a critical incident investigation had been undertaken. The Commission found that in 84% of critical incident investigations, New South Wales Police Force officers of the appropriate rank and experience attended the scene of the critical incident. The Commission located records that indicated the critical incident scene had been properly preserved in 58% of critical incident investigations. This meant that potentially 42% of incident scenes were at risk of loss of evidence or interference with evidence through either inadvertence or deliberate misconduct.

Chapter 9 includes an examination of the investigative steps taken by New South Wales Police Force to obtain the accounts of people who witnessed all, or some parts, of a critical incident. The Commission found that officers involved in a critical incident were correctly identified by the New South Wales Police Force in 100% of critical incident investigations. However, the Commission found that only half (49%) of these officers were separated. Separation of involved officers reduces the risk that these officers may collude to create a shared (and possibly more favourable) account of what happened, and is one of the key requirements of a critical incident investigation if the risk of misconduct is to be minimised.

Chapter 10 presents the Commission's findings regarding New South Wales Police Force exhibits management. One aspect of a good critical incident investigation is ensuring that all exhibits are collected and stored to maintain their integrity and continuity. In 92% of critical incident investigations, the Commission was unable to identify any documentation that provided information as to the identity of the exhibit officer. In addition, the Commission was unable to locate a Property Seizure/Exhibit Form, recording all the exhibits seized for any of the critical incident investigations.

In Chapter 11, the Commission reports that drug testing was undertaken in 100% of critical incidents which require drug testing, and that this testing was undertaken within the desired 24 hour timeframe in 96% of investigations. With regard to alcohol testing, the Commission found that testing was undertaken in 88% of relevant critical incident investigations, however, in only 14% of these investigations was it apparent that this testing was undertaken within the recommended two-hour timeframe.

The Critical Incident Guidelines impose particular responsibilities upon senior officers of the New South Wales Police Force. When a region commander declares a critical incident, a three-tiered process of supervision of the critical incident investigation is activated. This three-tiered process comprises a senior investigator whose role it is to supervise the critical incident investigation team, an independent review officer who adopts a 'risk management' role in the investigation, and the region commander whose

role it is to oversee the investigation and to give consideration to any systemic issues the incident might raise.

In Chapters 12, 13 and 14, the Commission reviews the compliance of the New South Wales Police Force with the supervisory requirements set out in the guidelines. Amongst other issues, the Commission examines whether review officers conducted their role as 'risk managers' of critical incident investigations according to the guidelines, which require that review officers consider the quality, timeliness and probity of the investigations and any systemic issues they may have identified. Similarly, the Commission assessed whether the region commanders took ultimate responsibility for the management, investigation and review of the critical incident by examining the contents of the region commander reports which are supposed to consider if any broader lessons were identified, or if any improvements to New South Wales Police Force systems, policies, practices and/or training are required.

The Commission located 68 critical incident investigation reports on e@gle.i, and anticipated that a similar number of review officer reports and region commander reports would be located on e@gle.i. However, the Commission's audit located only 27 region commander reports and 56 review officer reports on e@gle.i.

The Commission's analysis of the contents of these 56 review officer reports found that none of the reports considered all investigative components set out in the guidelines. Similarly, the Commission found none of the 27 region commander reports gave consideration to broader lessons to be learnt from the incident, or proposed improvements to police systems, policies, practices and/or training as required by the guidelines.

These findings suggest critical incident investigations were falling short of the supervisory input required by the guidelines, and that senior ranks of the New South Wales Police Force were not giving the expected consideration as to how critical incidents could be prevented in the future.

Prior to publication, the Commission provided the New South Wales Police Force with an opportunity to comment on the findings and recommendations contained within the report. In its response the New South Wales Police Force acknowledged that the Commission's research had identified a significant gap in the record keeping practices associated with critical incident investigations but noted that the fact records were not 'easily identified' on e@gle.i did not mean that investigations were compromised as a result. The Commission accepts this proposition but nevertheless it does not alter the fact that when there is no evidence that a procedural requirement has been complied with it is not possible for the New South Wales Police Force, or any external oversight body to determine if those responsible for investigating a critical incident did so in accordance with the guidelines. In these circumstances it is difficult to have confidence that an investigation has been conducted in an *"effective, accountable and transparent manner*". If it is the case that the circumstances in a particular matter render it inappropriate to follow a particular guideline then it would be good practice for a record to be made explaining the reason for that departure from the guideline.

The Commission acknowledges that record keeping by the New South Wales Police Force may have improved since the critical incident investigations which were audited for the purpose of this report. For example there is now a dedicated Critical Incident Database, which was established by the New South Wales Police Force following the

commencement of the Commission's audit, for registering details of each critical incident (although investigation records will still be attached to e@gle.i).

THE WAY FORWARD

The Commission has proposed 16 recommendations addressing the findings of the audit. There has been no resistance from the New South Wales Police Force to those recommendations. The recommendations are presented in Chapter 15 of this report and, broadly, propose that:

- all New South Wales Police Force records pertaining to critical incident investigations are attached to e@gle.i
- the responsibility for attaching relevant documents to e@gle.i be clearly assigned to nominated officers in the investigation team
- decision-making processes relating to critical incidents are properly documented and attached to e@gle.i
- New South Wales Police Force develop and create templates for use by officers involved in the initial stages of a critical incident and the subsequent investigation and review of those incidents
- regular compliance audits of critical incident investigations take place
- the identification, management and recording of conflicts of interest in critical incident investigations must be documented and located on e@gle.i.

Since the commencement of the Commission's project, legislation has been passed by the New South Wales Parliament, the *Law Enforcement Conduct Commission Act 2016*, which will replace the Police Integrity Commission with the Law Enforcement Conduct Commission ('LECC') later in 2017.

Part 8 of the *Law Enforcement Conduct Commission Act 2016* provides that the LECC may monitor the conduct of a New South Wales Police Force critical incident investigation if the LECC decides that it is in the public interest to do so. Such oversight will enable more timely oversight of individual critical incident investigations and will hopefully provide a new layer of assurance to the community that investigations are being conducted in a manner that is '*effective, accountable and transparent'* as stated in the New South Wales Police Force guidelines. The New South Wales Police Force has undertaken to consider the recommendations contained in this report as part of the process of developing new guidelines and agency agreements to reflect the new oversight role which will be exercised by the LECC.

1. INTRODUCTION

1.1 OVERVIEW

An incident involving a NSW police officer that results in the death of or serious injury to a person is referred to as a 'critical incident'. The NSW Police Force (NSWPF) has guidelines which provide for such an incident to be declared a critical incident and investigated pursuant to certain protocols. The guidelines acknowledge that when police investigate their fellow officers following the death of or serious injury to a person as a result of interaction with police, the impartiality, transparency and accountability of the investigation are of paramount importance (NSWPF 2016a, p. 6).[1]

The Police Integrity Commission (the Commission) initiated Project Harlequin in 2012 to identify the misconduct and other risks associated with critical incident investigations. The Commission then sought to examine the NSWPF processes for investigating critical incidents and to assess how well those processes managed the risks.

Unlike investigation reports published by the Commission, this report does not examine the conduct of individual officers. Hence, this report does not contain any adverse or other findings about any individuals.

1.2 THE ROLE OF THE POLICE INTEGRITY COMMISSION

The Commission is an independent statutory body that reports directly to the NSW Parliament. It was established on 1 July 1996 by the *Police Integrity Commission Act 1996* (the Act). The principal objects of the Act are set out in s 3:

> (a) to establish an independent, accountable body whose principal function is to detect, investigate and prevent police corruption and other serious officer misconduct, and
>
> (b) to provide special mechanisms for the detection, investigation and prevention of serious officer misconduct and other officer misconduct, and
>
> (c) to protect the public interest by preventing and dealing with officer misconduct, and
>
> (d) to provide for the auditing and monitoring of particular aspects of the operations and procedures of the NSW Police Force and the New South Wales Crime Commission.

Section 13 of the Act sets out the principal functions of the Commission, the first of which is 'to prevent officer misconduct'. Other functions of the Commission regarding police activities and education programs are provided in s14 of the Act. The functions which permit the Commission to conduct misconduct prevention projects such as Project Harlequin include the following:

---

1 *NSW Police Force Critical Incident Guidelines*. NSW Police Force, Professional Standards Command, Sydney NSW, January 2016.

14 Other functions regarding police activities and education programs

(a) to undertake inquiries into or audits of any aspect of police activities for the purpose of ascertaining whether there is police misconduct or any circumstances that may be conducive to police misconduct,

(b) in particular, to monitor the quality of the management of investigations conducted within the NSW Police Force and to undertake audits of those investigations,

(c) to make recommendations concerning police corruption education programs, police corruption prevention programs, and similar programs, conducted within the NSW Police Force or by the Ombudsman or the Independent Commission Against Corruption for the NSW Police Force,

(d) to advise police and other authorities on ways in which police misconduct may be eliminated.

Preventing serious officer misconduct is one of the Commission's principal statutory functions. Unlike detecting and investigating officer misconduct, which can only occur *after* misconduct has occurred, preventing misconduct requires determining how best to intervene *before* the misconduct occurs.

Intervention to minimise police misconduct can take many forms. It can involve strengthening systems, policies, procedures, training programs and supervision strategies to reduce the opportunities for misconduct to occur.

1.2.1 POLICE MISCONDUCT

The term 'police misconduct' is defined in s 5(1) of the Act as:

> Misconduct (by way of action or inaction or alleged action or inaction) of a police officer:
>
> (a) whether or not it also involves non-police participants, and
>
> (b) whether or not it occurs while the police officer is officially on duty, and
>
> (c) whether or not it occurred before the commencement of this subsection, and
>
> (d) whether or not it occurred outside the State or outside Australia.

Section 5(2) of the Act provides the following examples of police misconduct:

> Police misconduct can involve (but is not limited to) any of the following:
>
> (a) police corruption,
>
> (b) the commission of a criminal offence by a police officer,
>
> (b1) misconduct in respect of which the Commissioner of Police may take action under Part 9 of the *Police Act 1990*,
>
> (c) corrupt conduct within the meaning of the *Independent Commission Against Corruption Act 1988* involving a police officer,
>
> (d) any other matters about which a complaint can be made under the *Police Act 1990*.

1.3 WHAT IS A CRITICAL INCIDENT?

The current NSWPF guidelines define a critical incident as:

> one involving a member of the NSW Police Force which has resulted in the death of or serious injury to a person:
>
> - arising from the discharge of a firearm by police
> - arising from the use of appointments or the application of physical force by police
> - arising from a police vehicle pursuit or from a collision involving a NSW Police Force vehicle
> - who was in police custody at the time
> - arising from a police operation.
>
> A critical incident may also be any other incident that a region commander considers could attract significant attention, interest or criticism, such that the public interest will be best served by investigating the matter under the *Critical Incident Guidelines* (NSWPF 2016a, p. 7).

For the purposes of Project Harlequin, the Commission considers a critical incident as one in which death or serious injury has occurred following interaction with the NSWPF. A critical incident can occur in a variety of settings, under a variety of circumstances.

1.4 WHY THE INTEREST IN CRITICAL INCIDENTS?

Critical incidents usually attract increased public interest and their investigation is subject to enhanced scrutiny by the media, the affected relatives, the coroner and the broader community. When police investigate their fellow officers following the death of or serious injury to a person as a result of interaction with police, there is often a perception that the investigating officers do not exercise the necessary impartiality in the investigation.

1.4.1 RISKS ASSOCIATED WITH CRITICAL INCIDENTS

The Commission identified a variety of risks related to the management and investigation of critical incidents. Some risks may arise during a police investigation of a critical incident (which may be referred to as 'post-incident risks'). Other types of risks may exist prior to the death or serious injury ('pre-incident risks'). Only post-incident risks were examined in Project Harlequin.

Post-incident risks

Actions that could compromise an investigation may not necessarily be the result of intentional misconduct. For example, failure to preserve the scene of a critical incident which results in a loss of evidence may:

- result from the inexperience of the officers involved, or
- be the result of a delay in identifying and declaring the event to be a 'critical incident', or
- be a deliberate act of misconduct to effect the loss of evidence.

Similarly, failure to separate involved officers thereby allowing them to discuss the incident and develop a shared story of what occurred could:

- result from the inexperience of the officers involved, or
- be the result of a delay in identifying and declaring the event to be a 'critical incident', or
- be a deliberate act of misconduct to provide the officers with the opportunity to collude.

In these examples, without information as to officer intent, it is not always possible to distinguish intentional misconduct from the broader range of officer actions which can adversely affect an investigation. Accordingly Project Harlequin looked beyond misconduct risks and considered risks more broadly that could compromise a NSWPF critical incident investigation. It did not determine whether acts or omissions which compromised particular investigations were due to intentional misconduct or unintentional errors.

When considering the potential risks associated with the investigation of critical incidents it is important to understand and acknowledge the operational framework in which critical incident investigations are undertaken. At the time Project Harlequin commenced and up to the time of writing this report, the framework in which critical incidents were investigated was such that:

- there was no legislation in force that defined a 'critical incident' or governed how investigations were to be undertaken
- the NSWPF had sole responsibility for determining whether an incident was declared to be a critical incident
- the NSWPF had sole responsibility for investigating critical incidents
- there was no mandatory external oversight of NSWPF critical incident investigations.

1.5 PURPOSE OF THE PROJECT

The purpose of the project was subdivided into three research questions:

1. What are the misconduct and other risks associated with a critical incident investigation?
2. What procedures exist in the NSWPF to investigate critical incidents?

3. How well do the NSWPF procedures manage those risks?

The Commission also sought to use the information it collected to identify areas where improvements could be made to the conduct of the critical incident investigations.

1.6 CORPORATE GUIDANCE

The NSWPF has produced guidelines that set out the processes for how critical incidents are to be managed and investigated by NSWPF officers. The guidelines acknowledge the importance of public confidence in critical incident investigations and set out a number of procedural steps to be undertaken by NSWPF officers when completing critical incident investigations. These guidelines have been subject to periodic review and amendment.

At the time the Commission commenced Project Harlequin, the *NSWPF Guidelines for the Management and Investigation of Critical Incidents*, dated 2007, were in operation. These guidelines, referred to in this report as the '2007 Guidelines', remained in operation until they were replaced in August 2012. The 2012 iteration is referred to in this report as the '2012 Guidelines'. On 1 January 2016, the 2012 Guidelines were replaced by a new set of guidelines, referred to in this report as the '2016 Guidelines'.

1.6.1 PRINCIPLES CONTAINED WITHIN THE CRITICAL INCIDENT GUIDELINES

The stated purpose of the guidelines 'is to provide guidance for police officers in relation to the timely and professional investigation and review of critical incidents' (NSWPF 2007a, p. 2).[2] The guidelines also described layers of accountability, and articulated the NSWPF corporate expectations in respect of the principles that are to guide the actions of officers managing and investigating critical incidents.

The requirement for a critical incident investigation to be effective, accountable and transparent was acknowledged in the guidelines. The 2007 Guidelines stated at p.1:

> NSW Police is committed to demonstrating its professionalism by investigating all such incidents in an effective, accountable, and transparent manner. If public credibility is to be maintained, such incidents [sic investigations] are most appropriately conducted independently (NSWPF 2007a, p. 1).[3]
>
> These guidelines are a statement by NSW Police that the community can have full confidence that the facts and circumstances of these incidents will be thoroughly examined and reviewed by NSW Police (NSWPF 2007a, p. 1).[4]
>
> and

2 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 7; NSWPF 2016a, p. 2).

3 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 6; NSWPF 2016a, p. 6).

4 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 6; NSWPF 2016a, p. 6).

> These guidelines impose accountability for the investigation of critical incidents at senior levels of NSW Police. In so doing, the community, members of NSW Police and their families can be assured that all critical incidents are handled professionally, with integrity and that the decisions made and processes used are appropriate and reasonable (NSWPF 2007a, p. 1).[5]

Additional statements that demonstrate an intention by the NSWPF to address community concern that might arise in relation to the management and investigation of critical incidents can be found within the document. For example:

> Managing an incident as a 'critical' one should remove any doubts that might otherwise endure about the integrity of involved officers and provide reassurance that:
>
> - any wrongful conduct on the part of any members of NSW Police is identified and dealt with
> - welfare implications associated with the incident have been considered and addressed
> - consideration is given to improvements in NSW Police policy or procedure to avoid recurrences in the future (NSWPF 2007a, p.1).[6]

1.6.2 GUIDANCE FOR NSWPF OFFICERS INVESTIGATING AND REVEWING A CRITICAL INCIDENT

The 2007 Guidelines indicated that the 'identification of an incident as a "critical incident" activates an independent investigative process to be conducted by a specialist and independent critical incident investigation team, and a review of that investigation by an independent review officer' (NSWPF 2007a, p. 1).[7]

According to the guidelines, a critical incident investigation team (CIIT) is tasked with conducting a full investigation of the incident and is to comprise personnel who do not have a conflict of interest in the investigation. The guidelines indicated that:

> The critical incident investigation team (CIIT) will conduct a full investigation of the incident including relevant events and activities leading to the incident. The team should examine the lawfulness of police action, the extent of police compliance with relevant guidelines, legislation and internal policy and procedures (NSWPF 2007a, p. 20).[8]

In addition to the information provided about the CIIT, the 2007 Guidelines also provided direction as to the actions that certain NSWPF officers in the chain of command were to take when responding to a critical incident. These officers were the region commander, the review officer and the senior critical incident investigator (SCII).

---

5 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 6; NSWPF 2016a, p. 6).

6 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 6; NSWPF 2016a, p.6).

7 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 6; NSWPF 2016a, p. 6).

8 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 11; NSWPF 2016a, pp. 8-9).

According to the 2007 Guidelines, the region commander:

- has ultimate responsibility for declaring an incident as critical. The primary consideration of a Region Commander is whether, based on the information available, the incident warrants being independently investigated and managed as a critical incident
- is accountable for the overall management and investigation of all critical incidents that have occurred within the geographical boundaries of their region
- plays a pivotal role in ensuring that the outcomes of a critical incident investigation are reported to the NSW Police Executive so that matters arising can be dealt with at a senior level (NSWPF 2007a, pp. 7-9).[9]

The 2007 Guidelines indicated that a review officer was to be, at a minimum, of the same rank as the SCII, and to increase independence, the review officer was also to come from a different command to the:

- members of the CIIT
- command where the incident occurred
- involved officers (NSWPF 2007a, p. 26).[10]

The SCII was:

- to come from a different command to the one where the incident occurred
- to lead the CIIT and to ensure that critical incidents are rigorously and thoroughly investigated
- to ensure that the investigation was recorded on e@gle.i
- responsible for ensuring that appropriate action was taken concerning the prosecution of any person for any identified offence arising from the investigation (NSWPF 2007a, p. 20).[11]

1.6.3 INTRODUCTION OF THE NSWPF CRITICAL INCIDENT DATABASE

In the first half of 2012 the Commission consulted with the NSWPF Professional Standards Command (PSC) to determine how, and where, the NSWPF stored information on critical incidents. At that time, there was no single repository of information on critical incidents in NSW.

By August 2012 the NSWPF had introduced the Critical Incident Database, which was supported by the *NSW Police Force Critical Incident Database: Business Rules & User*

9 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, pp. 15-17; NSWPF 2016a, pp. 11-16).

10 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, pp. 35-37; NSWPF 2016a, pp. 25-27).

11 The same messages are conveyed in the 2012 and 2016 Guidelines (NSWPF 2012a, pp. 26-34; NSWPF 2016a, pp. 19-25).

Guide, August 2012. According to the 2016 Guidelines, the critical incident database was to be maintained by PSC, and was to:

> …incorporate information relating to the nature of the incident and any recommendations arising from the investigation.
>
> In relation to the critical incident database, PSC will be responsible for:
>
> - providing overall administrative governance of the database
> - facilitating information regarding investigative and coronial recommendations with corporate implications
> - data input of recommendations made to the NSW Police Force by the NSW Coroner.
>
> As outlined above, regions will contribute to the database and are responsible for:
>
> - data input regarding level 1 and level 2 critical incidents that occur within their geographical region
> - ensuring ongoing regular updates of database information regarding the status of critical incident investigations for their geographical region
> - conducting an analysis of and endorsing critical incident recommendations (NSWPF 2016a, pp. 28-29).

By creating the critical incident database, the NSWPF established a single repository of information on critical incidents in NSW.

1.6.4 CRITICAL INCIDENT GUIDELINES – PUBLIC VERSION

In July 2016, the NSWPF released a public version of the guidelines. According to this version:

> The purpose of this document is to provide the general public with an outline of the key responsibilities of officers who have a role in the police response to a critical incident, and to explain the process that occurs when an incident of this type occurs (NSWPF 2016b, p. 2).

Accordingly, the public version of the guidelines 'do[es] not include full details of all operational responses exercised by officers involved in the investigation of critical incidents' (NSWPF 2016b, p. 2), and:

> To ensure that instructions to investigating police provide contemporary advice regarding the methodology for an effective investigation, the NSW Police Force maintains a separate internal version of the *Critical Incident Guidelines* (NSWPF 2016b, p. 2).

The public release of these guidelines on the NSWPF website followed a 2013 recommendation made by the Commission[12] that the NSWPF critical incident guidelines be made publicly available. This recommendation was also made in two subsequent

12 Police Integrity Commission, Operation Calyx, Police Integrity Commission, Sydney, 2013, p. xix.

reviews commissioned by the NSW Government which considered critical incidents - the McClelland Review (2013)[13] and the Tink Review (2015)[14]. The McClelland Review focussed on the oversight of critical incidents, while the Tink Review considered the oversight of critical incidents as one aspect of a broader review of police oversight in NSW. Further information on these reviews is found below.

1.7 KEY EVENTS SINCE THE COMMENCEMENT OF THE PROJECT

1.7.1 GOVERNMENT REVIEW OF THE INVESTIGATION AND OVERSIGHT OF POLICE CRITICAL INCIDENTS – THE 'MCCLELLAND REVIEW'

On 18 September 2013, the then Premier, Barry O'Farrell MP, announced that the Hon. Robert McClelland had been appointed to undertake the *Government Review of the Investigation and Oversight of Police Critical Incidents* (the McClelland Review). The Terms of Reference of this review were to consider:

1. whether the NSWPF critical incident guidelines provided adequate guidance to ensure critical incident investigations are rigorous, timely and objective
2. whether operational, legal or other barriers existed to the NSW Police Force publicly reporting on the outcomes of critical incident investigations, and how these might be resolved
3. whether improvements could be made to the oversight of critical incidents to guarantee accountability and transparency, including: how and when oversight responsibilities are allocated between different agencies; what gives rise to, and the purpose of, that oversight; and whether there is any unnecessary duplication of roles or responsibilities and, if so, how that might be resolved
4. the need for amendments to relevant legislation, or practices and procedures (such as the Critical Incident Guidelines) to be given further consideration by the Government (McClelland 2013, p. 1).

In relation to these issues, McClelland found that the NSWPF 'is the only body with the skills and expertise and resources to investigate critical incidents where ever they may occur in the State on a 24-hour seven day a week basis' (McClelland 2013, p. ix).

With regard to the critical incident guidelines, McClelland noted:

> …the critical incident guidelines have an inbuilt accountability mechanism whereby the Critical Incident Investigation Team and the Review Officer are required to be appointed from regions other than that where the critical incident occurred (McClelland 2013, p. ix).

13 R. McClelland, Oversight of police critical incidents. Report to the Hon Barry O'Farrell Premier of New South Wales, Sydney, 2013, p. xv.

14 A.Tink, Review of Police Oversight; A report to the New South Wales Government on options for a single civilian oversight model for police, NSW Department of Justice, Sydney, 2015, p. 12.

McClelland further commented that the involvement of the NSWPF Homicide Squad and the Professional Standards Command in the case of death or serious injury resulting from interaction with the police force, as well as the oversight of some investigations by the Ombudsman, 'will ensure the rigorous, timely and objective analysis of police critical incidents' (McClelland 2013, p. x).

With regard to the NSWPF publicly reporting on the outcomes of critical incident investigations, McClelland agreed that information deemed appropriate by the Commissioner of Police contained within the critical incident investigator's report, the review report, or any police response to these or any coronial report, should be made publicly available as soon as reasonably practicable (McClelland 2013, p. 54):

> Even in circumstances where it may have been unavoidable, a death or serious injury resulting from action undertaken on behalf of the State is a very serious matter and it is appropriate that as much information about the circumstances giving rise to the death, as is possible, is communicated to the public. Clearly however there are also broader public interest considerations that must be balanced against the goal of transparency and accountability (McClelland 2013, p. 54).

In undertaking the review, McClelland examined the then current investigation and oversight arrangements of critical incidents in NSW by considering the roles and responsibilities of the following five bodies: the NSWPF; the NSW Ombudsman; the Police Integrity Commission; the WorkCover Authority of NSW; and the NSW State Coroner.

Following a period of consultation with key NSW Government agencies, including this Commission, and consideration of submissions from a variety of entities[15], a report was released on 29 November 2013. The report contained a total of nine recommendations (refer to McClelland 2013, pp. xv–xxi). Below is a summary of seven of these recommendations related to the oversight of critical incidents:

1. that the critical incident guidelines be made publicly available
2. that a NSWPF region commander provide a report to the NSWPF executive as to why interim management action was or was not taken during a critical incident investigation
3. that as much information as possible (taking into account all privacy and operational requirements) concerning the outcome of a critical incident investigation be made publicly available
4. that a committee be established between agencies involved in the investigation and oversight of critical incident investigations, to promote dialogue, and enhance cooperation
5. that legislative amendments to the *Police Act 1990* be made to enable the Ombudsman to conduct oversights of critical incident investigations

[15] The Commissioner of Police, the Acting State Coroner, the Police Association of New South Wales, the NSW Ombudsman, the Police Integrity Commission, the WorkCover Authority of NSW, the Law Society of NSW, the NSW Bar Association, Legal Aid NSW, Aboriginal Legal Service, the Public Interest Advisory Centre, the NSW Council for Civil Liberties, Community Legal Centres NSW, Gay and Lesbian Rights Lobby, Mr David Porter, and Mr David Shoebridge MLC.

6. that amendments are made to the critical incident guidelines to make it a priority for NSWPF critical incident investigators to provide assistance to the State Coroner

7. that organisations involved in either the oversight of critical incident investigations, or in undertaking the critical incident investigation itself, develop a mutually agreed media protocol to avoid any commentary that could prejudge the outcome of a critical incident investigation.

A summary of the report's nine recommendations, and the Commission's views on them, was produced in the Report on the 2014 General Meeting of the Parliamentary Joint Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission.[16] The NSW Government did not release a formal response to the McClelland Review, nor comment publicly on the final recommendations contained within it.

1.7.2 GOVERNMENT REVIEW OF POLICE OVERSIGHT - THE 'TINK REVIEW'

In May 2015, the NSW Government commissioned former NSW Shadow Attorney General, Mr Andrew Tink AM to consider changes to the current police oversight system, including options for a single civilian oversight model. While the focus of the review was on police oversight generally, including any measures to improve efficiency and effectiveness of this oversight, the review also considered options for the oversight of critical incidents.

On 31 August 2015 Tink submitted a report entitled *Review of Police Oversight*, to the NSW Government. In this report Tink stated:

> there is no so-called 'best practice model' from elsewhere which could be wholly adopted, or even adapted, to replace the current system here (Tink 2015, p. 2).

In his review, Tink argued for a review of current police oversight arrangements in NSW by considering changes to the Police Division of the Office of the Ombudsman (PDOO) and the Police Integrity Commission, and recommended:

> …a new model of police oversight for New South Wales, being one which is headed up by a commissioner and one which combines the PIC and the PDOO into a single body (Tink 2015, p. 3).

With regard to critical incident investigations specifically, Tink stated:

> …regardless of whether or not a new single oversight agency is established, there remains a pressing need to provide an oversight body with the statutory power to monitor critical incident investigations in real time. However, the oversight body should not be empowered to direct police investigators in relation to the conduct of any such investigations (Tink 2015, p. 3).

16 Parliament of New South Wales, Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission, Report 8/55 August 2014, 2014 General Meetings, Sydney, 2014, pp. 5-6.

On 26 November 2015, the then Deputy Premier and Minister for Justice and Police, Minister for the Arts, and Minister for Racing, the Hon. Troy Grant, publicly released the *Review of Police Oversight* and the government response to this report.[17]

At that time it was announced that the NSW Government accepted Tink's recommendations for a single civilian oversight body for the NSWPF and the NSWCC, and announced that the NSW Government would establish a new oversight commission to be called the Law Enforcement Conduct Commission (LECC). The Government advised that the LECC would exercise the functions carried out by the Police Integrity Commission, the Police Division of the Ombudsman's Office and the Inspector of the Crime Commission. It also announced that while the NSWPF would retain responsibility for the investigation of critical incidents, the LECC would monitor these investigations as part of the LECC's oversight functions.[18]

Legislation was introduced into NSW Parliament in 2016 to establish the LECC. The legislation passed both houses and commenced, in part, on 14 November 2016. The provisions of the Act providing for LECC officers to undertake real time monitoring of critical incident investigations had not commenced at the time of writing.

1.8 STRUCTURE OF THIS REPORT

This report is divided into 15 chapters, and also includes sections titled Abbreviations, Glossary and Reference list. Ten of these chapters (Chapters 5 to 14) present the results of the Commission's audit of 83 NSWPF investigations into critical incidents which occurred between 1 January 2009 and 30 June 2012. More specifically, Chapters 5 to 14 each provide:

- the Commission's audit findings, in terms of compliance or otherwise with particular requirements of the 2007 Guidelines, supplemented by relevant case studies
- an overview of why the respective requirements are important as well as an outline of the material contained in the chapter
- guidance provided to NSWPF officers in the 2007, 2012 and 2016 Guidelines
- risks to the investigation if the guidelines were not followed
- observations made by the Commission in relation to the audit findings in each chapter.

Following this Introductory chapter, the report includes a 'Methodology' chapter which commences with an outline of each of the information collection strategies used in Project Harlequin, and how these strategies were used to address the project's three research questions. The remainder of the chapter provides a more detailed description of the audit methodology. Chapter 3, the 'Literature Review', provides the Commission's findings with respect to a review of the literature that was undertaken to identify the types

17 http://www.justice.nsw.gov.au/Pages/media-news/media-releases/2015/New-law-enforcement-watchdog-for-NSW.aspx.

18 http://www.justice.nsw.gov.au/Pages/media-news/media-releases/2015/New-law-enforcement-watchdog-for-NSW.aspx.

of misconduct and other risks that may arise when NSWPF conducts an investigation following the death of or serious injury to a person in a critical incident.

The report's results section commences at Chapter 4, which provides some basic descriptive information about the 125 critical incidents that the Commission understood occurred during the time period 1 January 2009 – 30 June 2012. This chapter also describes what is known about 42 critical incidents that were not recorded on the NSWPF investigations management system 'e@gle.i' and describes how these were similar to, or different from, the 83 critical incidents which were located on e@gle.i.

Chapter 5 examines the importance of recognising and declaring a critical incident, as well as the importance of documenting reasons for this decision. It discusses the risks associated with any delay in declaring a critical incident, and presents the Commission's findings on how long it took NSWPF after each incident occurred to declare it a critical incident.

In Chapter 6, the Commission considers the independence and impartiality of critical incident investigations, and how well the NSWPF complied with the guidelines in respect of the appointment of the SCII and CIIT members. Chapter 6 also examines whether conflicts of interest were considered and managed by the NSWPF in respect of the 83 critical incidents in the audit sample. The extent to which critical incident investigations are reviewed by suitably experienced, and independent officers, is also discussed in Chapter 6.

Chapters 7 to 11 present the Commission's findings with regard to the following components of the investigations audited:

- handover of management of the incident scene from the duty officer to the senior critical incident investigator (SCII)
- preservation of the incident scene
- examination of the investigative processes taken to obtain the accounts of people who witnessed all, or some parts, of a critical incident
- appointment of an exhibit officer and the management of specific types of exhibits including vehicles, police records, and NSWPF firearms and other appointments
- mandatory drug and alcohol testing of involved officers.

Chapter 12 focusses on how the review officers conduct their role as 'risk managers' of critical incident investigations and also provides information on the contents of review officer reports.

Chapter 13 presents the Commission's findings of its examination of the contents of investigative reports (critical incident investigation reports, review officer reports, region commander reports) in relation to how well the critical incident investigations had:

- examined the lawfulness of police action
- examined involved officers' compliance with relevant NSWPF guidelines, policies, and procedures
- considered management action for involved officers
- considered the prosecution of involved officers

- considered broader lessons to be learned from the incident and proposed improvements to systems, policies, processes, practices and training.

Chapter 14 focusses on how the region commander's role is undertaken in practice. More specifically, it provides information relating to the monitoring of the critical incident investigation and contents of the region commander report.

Chapter 15 provides an overview of the Commission's findings with regard to NSWPF compliance with its critical incident guidelines. This chapter also provides recommendations to the NSWPF to strengthen its processes and procedures pertaining to critical incident investigations.

A Glossary and a Reference list complete the report.

2. METHODOLOGY

2.1 OVERVIEW

To assess how well the NSWPF was complying with its critical incident guidelines, the Commission undertook an audit of the available documentation of 83 investigations (or strikeforces) into critical incidents which occurred between 1 January 2009 and 30 June 2012. This investigative documentation was stored on the NSWPF investigations management system known as 'e@gle.i'. While the audit was the most resource-intensive component of the Project Harlequin information collection strategies, it was only one of several information collection strategies.

This chapter commences with an outline of each of the information collection strategies used in Project Harlequin. The remainder of the chapter then provides a more detailed description of the audit methodology.

2.2 THREE RESEARCH QUESTIONS AND THEIR INFORMATION COLLECTION STRATEGIES

As mentioned in section 1.5 of this report, the Commission sought to find answers to the following three research questions:

1. What are the misconduct and other risks associated with a critical incident investigation?

2. What procedures exist in the NSWPF to investigate critical incidents?

3. How well do the NSWPF procedures manage those risks?

Table 2.1 outlines the individual information collection strategies used for each of these three research questions.

Table 2.1: Strategies and information sources used to answer three research questions

Research question	Strategy and information sources used to answer the question
1. What are the misconduct and other risks associated with a critical incident investigation?	The Commission: • approached and held separate discussions with eight subject matter experts with specific knowledge in policing, critical incidents and related fields, from across Australia as a first step in this process. These experts comprised: o three academic researchers: one each from Flinders University, Deakin University and Griffith University o representatives from two police oversight agencies o a senior police officer from interstate o a senior non-judicial officer from a coroner's office and o a representative from a Federal research unit. Each of these experts was external to the Commission. • reviewed oversight agency reports and coronial documents on this topic • examined investigation and complaint files from the information holdings of both the Commission and the NSWPF.
2. What procedures exist in the NSWPF to investigate critical incidents?	The Commission examined available NSWPF corporate guidance[19] for officers investigating critical incidents and identified aspects of the recommended procedures that would assist NSWPF officers to manage the risks associated with identifying and investigating critical incidents.
3. How well do the NSWPF procedures manage those risks?	The Commission conducted an audit of the documentation recorded on the NSWPF investigations management system, e@gle.i, pertaining to the investigation of 83 of the 125 critical incidents that occurred between 1 January 2009 and 30 June 2012. This audit examined compliance with the selected procedures recommended in the 2007 Guidelines to assess how well the risks were being managed.

19 At the time the Commission commenced Project Harlequin, the NSWPF Guidelines for the management and investigation of critical incidents, dated 2007 were in operation. These guidelines, subsequently referred to in this report as the '2007 Guidelines', remained in operation until they were replaced in August 2012. The 2012 Guidelines were subsequently replaced by a new set of guidelines on 1 January 2016 (referred to in this report as the '2016 Guidelines').

2.3 THE AUDIT METHODOLOGY

The purpose of the audit was to examine the extent to which 83 critical incident investigations (or strikeforces) complied with the processes outlined in the 2007 Guidelines that were in operation at the time these incidents occurred.

According to the 2007 Guidelines, it was a requirement that investigative information relating to NSWPF critical incident investigations be made available e@gle.i. The guidelines stated:

> all critical incident investigations must be recorded appropriately on e@gle.i (NSWPF 2007a, p. 30).

The Commission notes that while some investigative actions may have been undertaken in critical incident investigations and evidence of this was not recorded on e@gle.i, the Commission's findings are based only on the investigative documentation that could be located on e@gle.i.

It was not the Commission's intention to re-investigate these critical incidents. Rather, the purpose of the audit was to examine, using the available documentation, the compliance by the NSWPF with the suggested procedures for critical incident investigations which would help to manage misconduct and other risks.

The Commission's audit involved a number of steps which were undertaken over significant, and sometimes overlapping, periods of time. These steps and the timeframes within which they were undertaken are outlined in Table 2.2 and discussed further in the text that follows.

2.3.1 DETERMINING THE NATURE AND NUMBER OF CRITICAL INCIDENTS

As a starting point for Project Harlequin, the Commission wished to understand the number and nature of critical incidents that had occurred in NSW over a period of several years. The Commission sought this information as the basis from which it could obtain a sample of critical incidents for inclusion in its audit.

Table 2.2: Overview of the audit process

Timeframe	Steps in the audit process
May 2012 - July 2013	Preliminary work
May - September 2012	• consulting with the NSWPF to understand the number and nature of critical incidents that had occurred during the period 1 January 2009 to 30 June 2012
May 2012 - July 2013	• consulting with the NSWPF to locate where the documents pertaining to the investigation of individual critical incidents were stored
February - April 2013	• identifying, from the 2007 Guidelines, key critical incident investigative actions to be audited
August - September 2012	Drawing a sample of critical incidents to be audited
September 2012 - June 2016	Information collection and analysis of investigative documentation for compliance with 2007 Guidelines
September - November 2012	• obtaining e@gle.i access for the 83 strikeforces within the project's audit sample
March - July 2013	• providing the NSWPF with the opportunity to update the accuracy and completeness of the investigative documents located on e@gle.i for the 83 strikeforces
July 2013 - October 2014 December 2015 - June 2016[20]	• accessing and examining the available investigative records located on e@gle.i pertaining to the 83 strikeforces for compliance with the 2007 Guidelines
November 2013 - June 2014	• obtaining additional information concerning location and rank of senior critical incident investigator (SCII), location of critical incident investigation team (CIIT) members, location and rank of review officers for the 83 strikeforces
December 2015 - June 2016	• assessing the available investigative documentation located on e@gle.i for compliance with the 2007 Guidelines for the 83 strikeforces

20 Due to staffing changes the Commission undertook this component of the audit twice.

The Commission was aware that obtaining records of critical incidents that had occurred during a particular timeframe was not straightforward. In March 2012, prior to the Commission commencing Project Harlequin, the NSWPF had advised the Commission that it did not maintain a centralised database of critical incidents[21], and that data on critical incidents was stored across NSWPF local area commands.[22] It further advised the Commission that the NSWPF duty operations inspector (DOI) at VKG[23] kept 'rough numbers' of critical incidents that were called in to VKG.[24]

In late May 2012, the Commission contacted the NSWPF Professional Standards Command (PSC) for assistance in providing records of critical incidents. More specifically, the Commission asked the NSWPF PSC how, and from what sources, the following information would be collected, if a schedule of critical incidents occurring over a 12 month period were to be compiled by the NSWPF:

- date of incident
- time of incident
- location of incident (including whether the incident occurred on police premises or in a police vehicle)
- type of incident (e.g. shooting, motor vehicle accident, etc.)
- injuries sustained by members of public and/or police officers
- outcome of the critical incident investigation.

In response, the NSWPF advised the Commission that critical incident files are usually held at the region office where the incident occurred, an exception being where the investigation of some deaths or serious injury matters are managed by [the] Homicide [Squad].[25] Hence to provide information to the Commission for this project PSC officers manually compiled the information provided to them by the individual region commands.

In September 2012, the NSWPF PSC provided the Commission with an excel spreadsheet listing 112 critical incidents it advised had occurred between 1 January 2009 and 30 June 2012.[26] This list was compiled using information obtained by PSC from each of the six region commands of the NSWPF. The spreadsheet made provision for recording the following information for each of the critical incidents: year (of incident); region (where incident occurred); strikeforce name or event number (where known)[27];

---

21 In August 2012 'overall corporate administrative responsibility for declared critical incidents involving NSW Police Force personnel' was given to the NSWPF Professional Standards Command (NSWPF 2012b, p. 5). At that time, the NSWPF established a new database for critical incidents and assigned the responsibility for administering the database to the Professional Standards Command. In August 2012 the NSWPF prepared and made available on the NSWPF intranet its NSW Police Force Critical Incident Database: Business Rules and User Guide. As its title suggests, the stated aim of this document was to 'provide business rules and a brief user guide' for the NSWPF Critical Incident Database (NSWPF 2012b, p. 5). These business rules were still in force at the time of the drafting of this report.

22 Email from the NSWPF Professional Standards Command to the Commission dated 30 March 2012.

23 Police radio channel.

24 Correspondence from the NSWPF Professional Standards Command dated 30 March 2012.

25 Email from the NSWPF Professional Standards Command to the Commission dated 28 May 2012.

26 Correspondence from the NSWPF Professional Standards Command dated 6 September 2012.

27 No identifying strikeforce name or event number was provided for 23 of the 112 critical incidents listed on this spreadsheet. Eighteen of these critical incidents without an identifying strikeforce name or event number occurred in the South West Metropolitan Region and five occurred in the Northern Region.

type of incident (e.g., police pursuit, police operation, police firearm); status of the investigation and a very brief summary (of the incident).[28]

Further checking identified that the figure of 112 critical incidents included both some duplicates and some omissions.[29] Based on information provided by the NSWPF, the Commission's best estimate of the number of events declared to be critical incidents that occurred between 1 January 2009 and 30 June 2012 is 125. Given the absence of a central database for critical incidents, however, it was not possible for either the NSWPF or the Commission to confirm that information concerning each individual critical incident had been identified for the period 1 January 2009 – 30 June 2012.

2.3.2 LOCATING THE DOCUMENTS PERTAINING TO THE INVESTIGATION OF INDIVIDUAL CRITICAL INCIDENTS

Consulting with the NSWPF

In late May 2012, the Commission also sought advice from the NSWPF PSC concerning where critical incident investigation files (including investigation reports) were stored following the completion of critical incident investigations. The NSWPF advised the Commission that 'e@gle.i' was used to store and manage documents relating to a critical incident investigation.[30]

This advice was consistent with the 2007 Guidelines, which required that investigation documentation pertaining to critical incidents be recorded on e@gle.i, stating that a specific task of the SCII was to:

> ensure that the investigation is recorded on e@gle.i (NSWPF 2007a, p. 20).

Purpose of e@gle.i

With regard to e@gle.i, the NSWPF advised the Commission that:

- e@gle.i is an IT investigations management system that was introduced in 2000 and is designed for large protracted investigations where there is a large amount of documentation
- e@gle.i is a tool to store and manage the documents related to an investigation – it is not the investigation itself

---

28 In most cases these brief summaries did not include the name of the person who had been killed or seriously injured as a result of the critical incident. Of the 112 critical incidents listed on this spreadsheet, only 29 included the name of the person who had been killed or seriously injured. The remaining 83 summaries did not include the name of the person who had been killed or seriously injured as a result of the critical incident. This lack of information about some of the critical incidents made it difficult to cross-check records for possible duplicates.

29 This list of 112 incidents included a list of 75 strikeforces. The Commission was able to identify that the list included two duplicates and 15 omissions.

30 Advice provided by the NSWPF Professional Standards Command at a meeting with the Commission on 11 March 2013.

- officers do not receive access to e@gle.i unless they are involved in a specific investigation, therefore training is not offered to all NSWPF officers[31]
- just because a document or action is not recorded on e@gle.i does not mean that the document does not exist or that the action has not occurred, it could mean simply that the officer has not uploaded it to e@gle.i.[32]

While the 2007 Guidelines specified that all critical incident investigations must be recorded appropriately on e@gle.i, the Commission was advised that this, in fact, was not always NSWPF practice. More specifically, the NSWPF advised the Commission that, at that time there was no easy way of identifying which of the investigations stored on the e@gle.i system pertained to investigations of critical incidents, as not all critical incidents were recorded or managed on e@gle.i. The NSWPF further informed the Commission that the investigator decided whether or not the incident was managed on e@gle.i.[33]

2.3.3 DRAWING A SAMPLE OF CRITICAL INCIDENT INVESTIGATIONS TO BE AUDITED

The NSWPF identified that 83 of the 125 strikeforces were recorded on e@gle.i

Of the estimated 125 events that were declared to be critical incidents between 1 January 2009 and 30 June 2012, the NSWPF was able to locate records of the investigation on e@gle.i for 83 (two-thirds) of these critical incidents. The remaining 42 (one-third) incidents were either not managed on e@gle.i or the NSWPF was unable to locate files for them on e@gle.i.[34]

The 83 investigations of critical incidents (or strikeforces) that were located on e@gle.i are the subject of the Commission's audit. The Commission recognises that the 83 critical incident investigations that were located on e@gle.i are likely to differ in a number of (unknown) ways from the 42 critical incidents that were not located on e@gle.i.

Sampling considerations

The Commission considered whether it should audit the e@gle.i records pertaining to all 83 available critical incident investigations, or whether it should choose a smaller representative sample to audit. It decided to audit the documentation pertaining to all 83 available investigations because the diversity in the nature of the critical incidents, as well as the potential diversity in their investigation, would make it difficult to select a smaller representative sample that would capture this diversity.

---

31 Information on the NSWPF intranet about access and training in relation to e@gle.i in late 2015 provided that: 'By default all sworn officers have e@gle.i access, non-sworn usually need to have authority before they can access. If assigned to an investigation you will be able to access it in e@gle.i from any computer terminal with access to the NSW Police network. An Online help facility has been developed. By selecting the e@gle.i Help icon on the relevant screen of the system you can access the help manual. In addition Training Manuals and Investigator Reference Guides will be distributed in the near future. A practice environment is on the way together with the creation of a "Help Desk" facility'. (Downloaded from the e@gle.i FAQs page on the NSWPF intranet on 28/10/2015).

32 Advice provided by the NSWPF Professional Standards Command at a meeting with the Commission on 11 March2013.

33 Advice provided by the NSWPF Professional Standards Command in an email dated 28 May 2012.

34 Advice provided by the NSWPF Professional Standards Command in emails dated 10 July 2012, 21 August 2012and 18 July 2013.

Critical incidents differ in many ways, including in terms of:

- whether the incident results in the death of or serious injury to a person(s)
- whether the person(s) injured is a member of the community or a police officer
- the type of police action or inaction that led to the critical incident (e.g., whether there was a police pursuit, the discharge of a firearm, an incident in police custody)
- whether the incident occurred in a highly populated area or in an isolated area
- the number of police officers involved
- the number of police and civilian witnesses
- the time of day the incident occurred
- the length of time between the incident occurring and when it is declared to be a critical incident.

Such factors can affect the nature of the investigation to be undertaken as well as the ease and speed with which investigative actions are undertaken. Investigations of critical incidents can differ in terms of:

- whether the investigation is conducted by officers from a specialist command (such as the Homicide Squad) or whether it is investigated by officers from a local area command
- the experience of the SCII in investigating critical incidents, his/her familiarity with the NSWPF guidelines and with the SCII role
- the length of time it takes to establish a CIIT and the time it takes that team to arrive at the scene of the critical incident
- the experience of the review officer, his/her familiarity with the NSWPF guidelines and understanding of the review officer role
- the region commander's familiarity with the NSWPF guidelines, and his/her understanding of his/her role in relation to the management, investigation and review of critical incidents.

2.3.4 ACCESSING AND EXAMINING THE NSWPF INVESTIGATION RECORDS ON E@GLE.I FOR THE 83 STRIKEFORCES

In September 2012, the Commission sought approval from the NSWPF to access the e@gle.i records for each of the 83 strikeforces within the audit sample. After consultation, the NSWPF granted the Commission access to the relevant e@gle.i records in November 2012.

An examination of the records located on e@gle.i for each strikeforce to identify specific documentation was a component of the audit that Commission officers undertook twice. This step was first undertaken in the period July 2013 – October 2014. Due to staff changes at the Commission, this component was again undertaken by Commission officers in the period December 2015 – June 2016. This provided the Commission with

an opportunity to further examine the documentation, as well as providing the NSWPF with additional time to update and complete the records of its investigation.

The Commission observed that individual critical incident investigation files located on e@gle.i varied in length, containing anywhere from ten to almost 2000 documents. The records located on e@gle.i were generally investigative documentation that provided information as to whether an action had been taken or not.

Documents examined

To establish whether the investigative processes outlined in the 2007 Guidelines had been documented on e@gle.i, Commission officers commenced reviewing, where available, the following documents:

- the critical incident investigator report (CIIR)
- the review officer report
- the region commander report.

If the information sought was not recorded in any of these documents, the Commission reviewed a number of additional documents[35] located on e@gle.i, most notably:

- statements, including: duty officer statements, senior critical incident investigator statements, first officer(s) at the incident scene statements, statements of involved officers, crime scene guard statements and witness statements
- logs and running sheets, including: crime scene logs, critical incident operation logs, duty officer logs, VKG logs, investigation chronology and running sheets
- reports, including: forensic evidence reports – for example ballistics and gunshot residue testing, SITREPS[36] and COPS[37] reports relating to critical incidents
- other documents, including: notebook entries of involved officers, duty operations inspector 'critical incident notification forms', interview transcripts, alcohol and drug testing records of involved officers, exhibits handling records, crime scene photos, notations regarding access to CCTV footage, ambulance and medical records and coronial inquest records (where applicable).

Opportunity to update records

In commencing its audit of the documentation pertaining to the 83 strikeforces, the Commission observed that certain information relating to some of the individual critical incident investigations appeared to be either incorrect (e.g. investigation status), or that

35 The Commission reviewed a large number of documents that related to critical incident investigations and established that these documents were those most likely to contain the information sought.

36 Situation reports.

37 Computerised Operational Policing System.

certain documentation such as CIIRs, review officer reports and region commander reports could not be located on e@gle.i.

The Commission provided the NSWPF with an opportunity to update its records prior to the Commission commencing its audit. To this end, in March 2013, the Commission requested that NSWPF ensure all relevant information was uploaded to e@gle.i and that the investigation status of each strikeforce was checked for accuracy. This process concluded in July 2013. While the outcome was a more accurate and detailed data set for the Commission to work with, it did highlight some inconsistencies in the way that e@gle.i was used by officers in the field, and that not all information was uploaded in a timely or systematic way.

As mentioned previously, an examination of the records located on e@gle.i for each strikeforce was a component of the audit that Commission officers undertook twice. This also provided the NSWPF with additional time to complete the investigations, and upload all relevant records to e@gle.i. Overall, the NSWPF had between four and seven-and-a-half years to complete critical incident investigations within the project audit sample, and to attach documentation to e@gle.i.

Obtaining additional information

In November 2013, the Commission sought advice on how it could obtain the names of review officers and the SCIIs for the critical incidents being audited. The NSWPF PSC advised the Commission that 'there is no easy way to identify the SCII or review officer for the critical incident investigations'.[38] A similar request was made by the Commission in late June 2014. In July 2014 the NSWPF PSC provided information obtained from the regions on:

- the name and rank of the senior critical incident investigator (for 34 strikeforces)
- the names of the critical incident investigation team members (for 27 strikeforces)
- the critical incident investigation team location (for 36 strikeforces)
- the review officer's name (for 35 strikeforces)
- the review officer's location (for 31 strikeforces).

2.3.5 PROCEDURAL REQUIREMENTS AUDITED

NSWPF critical incident procedural requirements assessed for compliance were drawn from the 2007 Guidelines. These procedural requirements were considered for each of the 83 critical incidents within the audit sample. Documentation located on e@gle.i for each strikeforce was checked for compliance against the following requirements:

- whether the critical incident was identified in an appropriate and timely manner

38 Correspondence from the NSWPF Professional Standards Command dated 25 November 2013.

- whether a reason for declaring, or not declaring, an incident to be a critical incident was documented
- whether the investigating officers were of a suitable rank, and were from an independent command
- whether conflicts of interest had been identified and managed appropriately
- whether the critical incident scene had been preserved
- whether a duty officer running sheet/log was created, and if so whether it was provided to the SCII
- if involved officers and other witnesses were separated
- if exhibits were collected appropriately
- whether the mandatory drug and alcohol testing of involved officers was completed, and if so, whether this testing was undertaken in a timely way
- whether a thorough and impartial review of the critical incident investigation was undertaken
- whether the investigation examined the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation and internal policy and procedures
- whether the investigation considered improvements to NSWPF policies and procedures to avoid future recurrences
- whether there was evidence that the region commander took overall responsibility for the management, investigation and review of critical incidents in the region commander report.

3. LITERATURE REVIEW

3.1 OVERVIEW

The Commission undertook a review of oversight agency reports and publicly available coronial documents to identify the misconduct and other risks associated with police forces investigating deaths or serious injuries sustained following an interaction with police. In NSW these incidents are referred to as critical incidents. The Commission also sought the views of academic and other subject matter specialists with expertise in policing, critical incidents and related fields.[39]

A misconduct risk, as previously outlined in this report, may be regarded as any opportunity for an officer involved in, or associated with, a critical incident investigation to make a decision, to act or fail to act in a way that the integrity of the investigation may be undermined or weakened.

3.2 INFORMATION SOURCES

While there is a considerable body of academic literature relating to critical incidents and critical incident investigations, very few publications provided original insights into the misconduct and other risks associated with critical incident investigations. By contrast, the Commission identified a range of non-academic publications, from Australia and overseas, that describe:

- occasions where police systems and compliance failures, together with the actions and/or inactions of individual officers, have undermined or weakened the integrity of critical incident investigations or police investigations into deaths in custody

- standards and best practice guidelines for the conduct and management of police investigations into deaths in custody.

A brief description of the publications consulted for this chapter is provided below.[40] Where relevant, commentary has also been included as to the limitations of this material in identifying the misconduct and other risks associated with critical incident investigations. Following this is an examination of what can be learnt from these publications about these risks, and their applicability to Project Harlequin.

---

39 Further information on the individuals consulted can be found in Chapter 2, Table 2.1: Strategies and information sources used to answer three research questions of this report at page 16.

40 The Commission has adopted the terminology used in original source documents when referring to 'police' and/or officers' and/or 'police officers'.

3.2.1 ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY REPORTS[41]

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was established in October 1987:

> in response to a growing public concern that deaths in custody of Aboriginal people were too common and public explanations were too evasive to discount the possibility that foul play was a factor in many of them (Johnston 1991, section 1.1.2).

Under its terms of reference, the RCIADIC was charged with examining these deaths and:

> any subsequent action taken in respect of each of those deaths including … the conduct of coronial, police and other inquiries and any other things that were not done but ought to have been done (Johnston 1991, section 1.1.4).

Along with the RCIADIC *National Report*[42], three additional separate RCIADIC reports were reviewed for the purposes of this chapter. These were:

- RCIADIC *Regional Report of Inquiry in Queensland*[43] (RCIADIC Queensland Regional Inquiry report)
- RCIADIC *Regional Report of Inquiry into Individual Deaths in Custody in Western Australia, Volume 2*[44] (RCIADIC Western Australia Regional Inquiry report)
- RCIADIC *Regional Report of Inquiry in New South Wales, Victoria and Tasmania*[45] (RCIADIC NSW, Victoria and Tasmania Regional Inquiry report).

The relevance of the RCIADIC reports to the identification of misconduct and other risks associated with critical incident investigations may be questioned for the following two reasons:

1. having been published in 1991, the reports are dated and therefore of questionable relevance to understanding contemporary issues associated with critical incidents
2. the scope of the RCIADIC does not appear to relate directly to the scope of this project, given that the RCIADIC examined deaths that occurred in different forms of state custody, including but not limited to police custody.

---

41 The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) reports accessed for the purposes of this chapter were viewed online at http://www.austlii.edu.au/au/other/IndigLRes/rciadic. The electronic version of the reports available at this website do not contain page numbers. Section or chapter numbers have therefore been used as a point of reference in the footnotes that follow.

42 E. Johnston, Royal Commission into Aboriginal Deaths in Custody, National Report, 1991.

43 L.F. Wyvill, Royal Commission into Aboriginal Deaths in Custody, Regional Report of Inquiry in Queensland, 1991.

44 D.J. O'Dea, Council for Aboriginal Reconciliation, Royal Commission into Aboriginal Deaths in Custody, Regional Report of Inquiry into Individual Deaths in Custody in Western Australia, Commissioner, 1991.

45 J.H. Wootten Royal Commission into Aboriginal Deaths in Custody Regional Report of Inquiry in New South Wales, Victoria and Tasmania, 1991.

With regard to the issue of timeliness, while more than twenty five years have elapsed since the RCIADIC reports were published, they continue to influence the way in which Aboriginal and other deaths in custody are investigated across all jurisdictions in Australia. These reports have proven to be seminal.[46] Based alone on the number of years that have passed since publication, it would seem unreasonable to exclude the RCIADIC reports from this chapter's examination of misconduct and other risks associated with critical incident investigations.

With regard to the relevance to Project Harlequin, the following points may be made:

- in relation to a number of deficiencies with police investigations, the reports made clear the cases upon which they were based were cases in which the deaths had occurred in police custody. This is demonstrated in the information and discussion presented in this chapter
- at the commencement of the RCIADIC National Report, a schedule is included which contains the names of the persons whose deaths fell within the jurisdiction of the Royal Commission, and indicates their last place of custody. This schedule shows that approximately 65% of the deaths examined in the RCIADIC Regional Inquiry reports reviewed for this chapter occurred in police custody (Johnston 1991, preface). The corollary of this is, that where both the RCIADIC National Report and RCIADIC Regional Inquiry reports have identified patterns and trends relating to deficiencies with all police investigations into deaths in custody and propose standards that should apply them, these may be regarded as being directly relevant to the scope of this project
- both deaths in non-police custody and death or serious injury following an interaction with police have in common that extreme physical harm is experienced by persons following an interaction with employees of public institutions. Regardless of whether the physical harm experienced takes the form of serious injury or death or the employees of the state are custodial or police officers, the very fact that an interaction with representatives of the state has preceded such an occurrence has specific implications as to how they should be investigated.

The Commission made the following observations of the RCIADIC reports, which may have as much application to the investigation of critical incidents as they do to the investigation of deaths in non-police custody:

- investigations should be regarded as matters of public interest, given that in all cases an interaction of some type which preceded the death or serious injury has occurred with employees of institutions belonging to the public

46 Speaking at the Asia Pacific Coroners Society Conference in November 2011, the regional Royal Commissioner for NSW, Victoria and Tasmania the Hon. JH Wootten QC, described the post-death inquiries conducted by the Royal Commission as 'possibly the most intensive examination of coronial work ever made' (Wootten 2011, p. 4). In her inquest findings into the Death of Tyler Cassidy Victorian State Coroner, Judge Jennifer Coate, observed that many of the RCIADIC's recommendations 'have been at the heart of coronial reform across the nation over the past two decades' (Coate 2011, p. 108). Finally, the principles for how deaths in custody should be investigated in Queensland set out in the Queensland Coroner's Guidelines, were informed by the RCIADIC National Report (Queensland Courts 2014, p. 11).

- a natural suspicion can arise amongst the family of the deceased or injured party, and possibly the broader community, that misconduct caused or contributed to the injury or death, particularly if the incident occurred in circumstances which were physically isolated and where the only other witnesses were other custodial or police officers
- investigations should as a matter of course examine the systems and processes pertaining to the interaction that preceded the death and determine whether or not they contributed in some way to the death or serious injury, or failed to perform to an optimum level.

3.2.2 EXPERT PANEL CONVENED BY VICTORIAN OFFICE OF POLICE INTEGRITY (OPI)

An expert panel convened by OPI during its *Review of the investigative process following a death associated with police contact*[47] concluded that an optimal and accountable framework for an investigation where a death has occurred following an interaction with police officers should be underpinned by the following ten principles: accountability; expertise and professionalism; proportionality; inclusion of the affected next of kin or loved one; impartiality; independence; integrity; promptness/timeliness; rigour and systemic perspective (OPI 2011, p. 29). The report goes on to state:

> While these principles are established as standards for investigations into deaths caused by the State, they do not prescribe a specific form (or model) of investigation necessary for the State to fulfil its obligation to investigate a death (OPI 2011, p. 29).

3.2.3 REPORTS ON INQUIRIES INTO DEATHS AND SERIOUS INJURIES SUSTAINED FOLLOWING AN INTERACTION WITH POLICE OFFICERS

Ten official inquiry reports were identified for consideration within this chapter. These reports related to eight incidents where death or serious injuries occurred to an individual following an interaction with police. These reports provided information as to the types of misconduct and other risks that can undermine, or contribute to undermining, the effectiveness or ethical integrity of a police investigation into a critical incident. A brief overview of the deaths and serious injuries to which these reports related is provided below. Some of the findings of these reports, and links to possible risks associated with critical incident investigations, are discussed later in this chapter.

Death of Roni Levi, NSW, June 1997

On 28 June 1997 Mr. Roni Levi (Levi) was shot dead on Bondi Beach, Sydney by two NSW Police Force (NSWPF) officers. Levi, who had been displaying symptoms of a mental illness, was in possession of a knife at the time. An investigation by the Police Integrity Commission (the Commission) between 1999 and 2000 examined, amongst other things, the NSWPF investigation of the shooting death and allegations of drug use by the two officers who had fired the shots. A public report on the investigation was issued by the Commission in June 2001.[48]

---

47 Office of Police Integrity, Review of the investigative process following a death associated with police contact, Office of Police Integrity, Victoria, 2011.

48 Police Integrity Commission, Operation Saigon, Police Integrity Commission, Sydney, 2001.

Death of Frank Paul, Canada, December 1998

On 6 December 1998 Mr. Frank Paul (Paul) was found dead on a street in Vancouver, Canada. The cause of death was hypothermia caused by exposure. Paul was found to be heavily intoxicated when he died. The day before his death, Paul had been picked up twice by police officers for being intoxicated in a public place. On the second occasion he was released by police on the mistaken belief that he was not intoxicated. In March 2007 an inquiry was conducted into, amongst other things, the circumstances of this death. A report on the inquiry was published in February 2009.[49]

Serious injuries sustained by Allan Hathaway, NSW, February 2003

In February 2003 in Wagga Wagga NSW, after being chased by police officers, Mr. Allan Hathaway (Hathaway) sustained a number of very serious physical injuries to his face and head as a result of baton blows from a NSWPF officer. In August 2004 the Commission commenced an investigation into allegations of excessive force in that and other incidents by some NSWPF officers attached to the Southern Region of the NSWPF. The Commission held public hearings for the purposes of this investigation in February and March 2005. A public report on the investigation was issued by the Commission in December 2005.[50]

Death of Cameron Doomadgee (Mulrunji) Queensland, November 2004

Mr. Cameron Doomadgee (Mulrunji) was arrested by Queensland Police Service (QPS) on 19 November 2004 on Palm Island, Queensland. While in police custody Mulrunji sustained serious internal injuries from which he later died. Between March 2005 and 16 August 2006, the Queensland coroner held an inquest into his death. Inquest findings were delivered on 27 September 2006.[51]

Death of Jean Charles de Menezes, United Kingdom, July 2005

On 22 July 2005 Mr. Jean Charles de Menezes (de Menezes) was shot and killed by London Metropolitan Police officers as he boarded a train at Stockwell Underground station in London. These police officers believed de Menezes, a Brazilian national who had been under surveillance from the time he left his residence that morning, to be a suicide bomber. The United Kingdom's Independent Police Complaints Commission subsequently investigated this shooting and complaints made about the London Metropolitan Police Service's handling of public statements following the shooting.[52]

---

49 W. H. Davies, Alone and Cold, the Davies Commission Inquiry into the Death of Frank Paul, Interim Report, Vancouver, 2009.

50 Police Integrity Commission, Operation Whistler, Police Integrity Commission, Sydney, 2005.

51 C. Clements, Finding of Inquest, Inquest into the death of Mulrunji, Office of the State Coroner, Queensland, 2006.

52 Independent Police Complaints Commission, Stockwell One, Investigation into the shooting of Jean Charles de Menezes, at Stockwell underground station on 22 July 2005, Independent Police Complaints Commission, London, 2007 & Independent Police Complaints Commission, Stockwell Two, An investigation into complaints about the Metropolitan Police Service's handling of public statements following the shooting of Jean Charles de Menezes on 22 July 2005, London, 2007.

Death of Robert Dziekanski, Canada, October 2007

On 14 October 2007 the Royal Canadian Mounted Police (RCMP) used a taser to subdue Mr. Robert Dziekanski (Dziekanski), a 40-year-old Polish national in the process of immigrating to Canada, following reports that he was intoxicated and throwing suitcases and chairs in the airport international reception lounge. Dziekanski died within minutes of being subdued and handcuffed. An independent inquiry into the death and use of taser by constables, sheriffs, and authorised persons in British Columbia commenced in 2008. A report on the inquiry was issued in May 2010.[53]

Death of Adam Salter, NSW, November 2009

On 18 November 2009 Mr. Adam Salter (Salter) was shot and killed by an officer of the NSWPF in the home he shared with his father in the Sydney suburb of Lakemba. Salter had experienced episodes of mental illness for about 18 months, but in the two days preceding his death, Salter's mental health had deteriorated. On the morning of 18 November, Salter's father found his son in a seriously injured state, having cut and stabbed himself with a knife in the kitchen of the family's home. He called triple 0 and ambulance and police attended, following which Salter was shot by a NSWPF officer. A coronial inquest into the death was conducted in 2011.[54] A public report on the investigation was issued by the Commission in June 2013.[55]

Death of Roberto Laudisio-Curti, March 2012, NSW

On 18 March 2012 Mr. Roberto Laudisio-Curti (Laudisio-Curti), a 21-year-old Brazilian national died on a Sydney street shortly after being pursued by up to 15 police officers who used physical force, multiple tasers, OC spray, handcuffs and a baton to restrain him. A coronial inquest into the death was conducted in 2012.[56] The NSWPF critical incident investigation was monitored by the NSW Ombudsman, who produced a public report in February 2013.[57]

3.3 LESSONS FROM THE LITERATURE ON MISCODUCT AND OTHER RISKS RELATED TO CRITICAL INCIDENT INVESTIGATIONS

The following section draws together key information from the publications described above. It examines the following two questions:

1. In what ways can the integrity, effectiveness and credibility of a critical incident investigation be undermined or damaged?

53 T.R Braidwood, Why? The Robert Dziekanski Tragedy, Braidwood Commission on the Death of Robert Dziekanski, Vancouver, 2010.

54 S. Mitchell, Inquest into the death of Adam Quddus Salter, State Coroner's Court of New South Wales, Sydney, 2011.

55 Police Integrity Commission, Operation Calyx, Police Integrity Commission, Sydney, 2013.

56 M. Jerram, Inquest into the death of Roberto Laudisio-Curti, State Coroner's Court of New South Wales, Sydney, 2012.

57 New South Wales Ombudsman, Ombudsman monitoring of the police investigation into the death of Roberto Laudisio-Curti A Special Report to Parliament under s.161 of the Police Act 1990, New South Wales Ombudsman, Sydney, 2013.

2. How should a critical incident be investigated so as to manage or minimise misconduct and other risks?

This section also describes some of the misconduct and other risks that can occur in circumstances where critical incident investigations do not follow police protocols for critical incidents.

3.3.1 PRINCIPLES UNDERPINNING CRITICAL INCIDENT INVESTIGATIONS

Sources consulted by the Commission for this chapter advocated the requirement for investigations into deaths or serious injury following interaction with police to abide by such principles as transparency, independence and accountability to ensure public confidence in the investigative process.

Furthermore, unlike other types of deaths (such as homicides) investigations into deaths following interaction with police were thought to require that consideration be given as to how and why the death occurred while the deceased was in the care of the state. The state, observed the Queensland State Coroner's Guidelines, bears a responsibility to protect and care for people it incarcerates who are 'vulnerable and deprived of the ability to care for themselves' (Queensland Courts 2014, p. 11).

Similar views were expressed by the RCIADIC National Report which concluded that since police and prison staff perform their duties on behalf of the community they should be held accountable for the proper performance of those duties by the community. A death in custody, it noted, is a public matter (Johnston 1991, chapter 4). The RCIADIC NSW, Victoria and Tasmania Regional Inquiry report concluded that investigations into deaths in custody must be accompanied by an:

> … appreciation of the need to satisfy the concerns of relatives and of the public about what happened in circumstances from which people other than custodial officers are usually completely cut off (Wootten 1991, part four, chapter 10).

Similarly, the International Committee of the Red Cross *Guidelines for Investigating Deaths*[58] (ICRC Guidelines) observed that society as a whole has a vested interest in the effective and ethical investigation of deaths following contact with police, as effective and ethical investigations help to protect the interests of the deceased, the next of kin and the detaining authorities (ICRC 2013, p. 9).

The impact of a serious injury or death following interaction with police officers on the family of the deceased, and the potential for it to lead to suspicion about the actions of the officers involved (both before and after the death), was highlighted by a number publications.

The RCIADIC National Report observed that deaths in custody, as well as being distressing for families and friends 'engender suspicion and doubt in their minds' (Johnston 1991, sec. 1.2.4). The RCIADIC Queensland Regional Inquiry report indicated that 'only if the investigation is thorough and meticulous will it serve to allay any suspicion

58 International Committee of the Red Cross, Guidelines for Investigating Deaths in Custody, International Committee of the Red Cross, Geneva, 2013.

or doubt in the minds of next-of-kin and the public of foul play or maltreatment by the custodians of the deceased' (Wyvill 1991, section 3.1.1).

The expert panel convened by OPI during its Review of the investigative process following a death associated with police contact[59] identified the involvement of the affected next of kin as part of an optimal investigation (OPI 2011, p. 29). The report stated:

> Central to enhancing public confidence is increasing transparency of the investigative process. OPI requests that stakeholders make accessible to the public information regarding their protocols and services in the event of a death associated with police contact and that agencies collaborate to ensure this information is consistent across agencies (OPI 2011, p. 64).

Similarly, the ICRC Guidelines advised that the next of kin should receive legal assistance, have access to the case file, and take part in the proceedings, they should also be permitted to have a medical or other qualified representative in attendance at the autopsy (ICRC 2013, p. 13).

Public transparency, according to a number of publications, is the key to conducting publicly accountable investigations into deaths following an interaction with police officers. The European Court of Human Rights indicated that procedures and the decision making of police departments and other public agencies relating to deaths following police contact should be open and transparent (Commissioner for Human Rights 2009, p. 3). The ICRC Guidelines indicated that the conclusions of investigations should be made public (ICRC 2013, p. 13).

3.3.2 EXAMINATION OF SYSTEMIC OR ORGANISATIONAL ISSUES

The RCIADIC Queensland Regional Inquiry report observed there was a perception by QPS[60] that investigations should be limited to determining whether there were suspicious circumstances associated with the death, and that QPS officers did not consider their role to involve identifying systemic problems that could assist in preventing future similar deaths (Wyvill 1991, sec 3.1.3). The RCIADIC NSW, Victoria and Tasmania Regional Inquiry report concluded that investigations into deaths in custody should examine both whether organisational policies or practices contributed to the death or allowed the risk of injury as well as the lessons that can be learnt from the death so that similar deaths may be prevented in the future (Wootten 1991, part four, chapter 10).

More recent publications have similarly emphasised the importance of investigations maintaining a broad scope. The OPI concluded a systemic perspective was needed in investigations into deaths in custody (OPI 2011, p. 12) and that any conduct, policy, procedural or training issues identified are to be used for learning and prevention (OPI 2011, p. 74). Similarly, the ICRC Guidelines indicated that one of the objectives that can be realised through a death in custody investigation is preventing the recurrence of deaths in custody in that the investigation may reveal a pattern or practice likely to result in further deaths in custody, which should enable the detention authorities to adopt the preventive measures necessary (ICRC 2013, pp. 9 and 25).

---

59 Office of Police Integrity, Review of the investigative process following a death associated with police contact, Office of Police Integrity, Victoria, 2011.

60 Queensland Police Service

3.3.3 REQUIREMENT TO COMPLY WITH POLICE CORPORATE GUIDANCE

The question of how police officers understand the role of corporate policies relating to the investigation of deaths in custody was considered in the RCIADIC National Report and Regional Inquiry reports, though this is not a prevalent theme in other publications reviewed for this chapter.

The RCIADIC Queensland Regional Inquiry report found that police conducting investigations into deaths in custody generally did not undertake an examination of the extent to which officers had complied with various forms of corporate policy and procedure. The report commented on the way in which investigating officers applied corporate policy and procedure, noting the practice of police officers was to treat forms of corporate policy as 'guidelines only and to be followed at the individual officer's discretion or judgement' (Wyvill 1991, sec. 3.1.3).

The RCIADIC National Report observed similar views had been espoused by the NSWPF in supporting the actions of one particular officer, with the report stating that the officer's views were 'shared by Police Headquarters and in the end the rationalisation that the Police Instructions were only guides anyway was used' (Johnston 1991, sec. 29.5.23).

The perception of police corporate policy and procedure as a form of non-mandatory guidance was noted by the RCIADIC NSW, Victoria and Tasmania Regional Inquiry report as an example of officers not being held accountable:

> The New South Wales Police Instructions contained many clear (and some unclear) directions about how police shall carry out their duties, including the care of prisoners, when the deaths which I investigated occurred. One might think that the enforcement of these Instructions would be one way in which police might be made accountable, particularly as the *Police Rules* made by the Governor under the authority of the *Police Regulation Act* 1899 provide for the issuing of the Instructions, and lay down that each member of the Force 'shall strictly comply' with the Instructions. However on a number of occasions representatives of police before this Commission strongly maintained that the Instructions are only guidelines that do not have to be strictly complied with… (Wootten 1991, part three, chapter six).

3.3.4 EXPERIENCE AND EXPERTISE OF OFFICERS CONDUCTING CRITICAL INCIDENT INVESTIGATIONS

To varying degrees, most sources consulted for this chapter emphasised that police officers assigned to investigate critical incidents or deaths in custody must be both highly experienced and skilled. For example, an expert panel convened by OPI nominated expertise and professionalism as amongst the key criteria for an effective investigation into a death following interaction with police (OPI 2011, p. 12).

Similarly, the Davies Commission into the death of Paul observed that the investigation of police related deaths can be complex, requiring special training and skills. While acknowledging that using 'currently serving, experienced homicide investigators would promote competency' (Davies 2009, p. 220), the report highlighted that 'other jurisdictions have found other ways to address this concern; for example, through specialized training programs and the employment of former or retired police officers for some purposes' (Davies 2009, p. 220).

The RCIADIC National Report and RCIADIC Queensland Regional Inquiry report both highlighted the importance of investigations being conducted by officers who are highly qualified investigators (Johnston 1991, sec 4.7.4, recommendation 34; Wyvill 1991, sec 3.1.1), while the RCIADIC Western Australia Regional Inquiry report expressed concern where junior or inexperienced police officers were appointed to investigate deaths in custody and/or sudden deaths (O'Dea 1991, sec 6.1.2, subsection 3).

The RCIADIC NSW, Victoria and Tasmania Regional Inquiry report examined the types of personal qualities needed by officers conducting death in custody investigations. The report quoted a recommendation from the NSW coroner that officers appointed to conduct investigations into deaths in custody should have 'a demonstrated commitment to independence of mind and objectivity to ensure the proper oversighting of other police investigations' (Wootten 1991, part four, chapter 10).

Following the inquest into the death of Levi, NSW Coroner D. W Hand recommended that investigations into police shootings be monitored by police of at least rank of Assistant Commissioner or Chief Superintendent, and that an officer of the rank of Assistant Commissioner or above attend the scene of any shooting resulting in death (Hand 1998, pp. 1-2).

3.3.5 DELAYS IN DECLARING A CRITICAL INCIDENT

As soon as an incident has been declared to be a 'critical incident', NSWPF protocols specific for critical incident investigations can be activated (NSWPF 2007a, p, 1). Significant risks to an investigation of a critical incident may arise when a delay occurs in determining that these protocols should be applied. An example of such risks includes the potential loss of an 'independent' investigation by a specially appointed team of investigators that is selected by the region commander.

The Commission's Operation Whistler report revealed that a critical incident was not declared until sometime during the afternoon of 6 February 2003, while the injuries were sustained by Hathaway at around 11.15am (Police Integrity Commission 2005b, p. 39). The Commission concluded that by the time a critical incident had been declared 'a number of events had taken place that made a thorough, vigorous, and independent investigation of what had occurred within the bedroom at the Property impossible' (Police Integrity Commission 2005b, p. 39).

In its report on the inquiry into the shooting death of de Menezes, the United Kingdom's Independent Police Complaints Commission (IPCC) observed that a delay in the notification of the incident resulted in consequences to the quality of the investigation that was undertaken. The IPCC report indicated that the surveillance log was handed back to staff to make amendments, and that alterations were made by police to the log which changed its meaning (IPCC 2007a, p. 87). The IPCC observed that had it been involved at the commencement of the investigation into the incident, the surveillance log would not have been released for amendments to be made (IPCC 2007a, p. 87).

3.3.6 CONFLICTS OF INTEREST

A personal association between police officers assigned to undertake a critical incident investigation and officers who are persons of interest to that same investigation, represents a conflict of interest. While only one such case was identified in the

Commission's review of published material, the consequences can be seen as damaging to the integrity of the investigation.

The report by the Queensland coroner into the death of Mulrunji observed that some of the QPS officers involved in the investigation into the death personally knew the officer who had arrested Mulrunji (and in whose custody the fatal injuries were sustained). The coroner found that the integrity of the investigation into Mulrunji's death was compromised because of this. In order to strengthen the practices of the QPS regarding how conflicts of interest are managed, the coroner recommended that the QPS amend its *Operational Procedures Manual* (OPM) 'to make explicit the need to consider, when selecting officers for involvement in an investigation of a death in custody, the impartiality and the appearance of impartiality in the conduct of the investigation' (Clements 2006, p. 31). The coroner further recommended the OPM be amended 'to explicitly require officers involved in an investigation into a death in custody to disclose any relationship with an officer involved in, or a witness to, that death' (Clements 2006, p. 31).

The coroner found that the investigation's appearance of impartiality had been undermined when the police officer involved in the incident causing Mulrunji's death met the investigators at the airport and drove them to the scene of Mulrunji's arrest (Clements 2006, p. 31). Similarly, the coroner concluded that it was 'a serious error of judgement for the investigating team, including officers from ethical standards, to be sharing a meal at the home' (Clements 2006, p. 10) of the officer under investigation. As a result, the coroner recommended that:

> The OPM be amended to more clearly state the need for officers involved in an investigation to consider the impartiality and the perception of impartiality in the conduct of the investigation at all times (Clements 2006, p. 31).

Another conflict of interest identified by the Commission in the material reviewed for this chapter related to circumstances where officers assigned to conduct a death in custody investigation are drawn from the station or local command structure where the death occurred. The RCIADIC NSW, Victoria and Tasmania Regional Inquiry report noted a number of instances where this occurred (Wootten 1991, part four, chapter 10). The RCIADIC Queensland Regional Inquiry report indicated that investigators should be experienced and independent of the police force whose officers were responsible for the custody of the deceased in order to overcome the 'inherent difficulty' associated with police investigating their fellow officers (Wyvill 1991, sec 3.1.1). Further, the report noted that investigators should be located in an independent unit reporting and accountable to the coroner (Wyvill 1991, sec 3.1.1).

In its Operation Saigon report, the Commission raised concerns about investigators being drawn from the location where the death occurred, noting that the officers investigating the shooting of Levi came from the same police station as the two officers who discharged their weapons (Police Integrity Commission 2011, p. 80). The report concluded that while there was no evidence of impropriety on the part of the investigators, there was a 'clear systemic failure by the Police Service to comply with the then procedures with the real risk of important investigations being carried out by officers who might be perceived as not being at arm's length from [the two NSWPF officers who had fired the fatal shots] (Police Integrity Commission 2011, p. 80).

Similarly, at the inquest into the 2004 death of Mulrunji, the coroner found the involvement of officers from Townsville and Palm Island in the investigation of Mulrunji's death was 'inappropriate and undermined the integrity of the investigation' (Clements

2006, p. 31). Palm Island, the location of Mulrunji's death, formed part of the QPS Townsville District Command. The coroner concluded that 'in all deaths in custody, officers investigating the death should be selected from a region other than that in which the death occurred. The OPM [Operational Procedures Manual] should be amended to require this' (Clements 2006, p. 31).

3.3.7 SEPARATION OF POLICE WITNESSES AND INVOLVED OFFICERS

The RCIADIC NSW, Victoria and Tasmania Regional Inquiry report found that, in circumstances where police witnesses had been interviewed in connection with deaths in custody, measures had 'rarely been taken to prevent prior discussion and agreement between them, and what they say has not been tested or probed' (Wootten 1991, part four, chapter 10).

The RCIADIC Queensland Regional Inquiry report made similar observations, noting that in some of the investigations it examined, officers prepared statements in collaboration with one another resulting in almost identical statements being prepared (Wyvill 1991, sec 3.1.3). In terms of consequences, the report concluded that this practice can lead to:

> … the fabrication of evidence or raises the suspicion of fabrication, thereby diminishing the evidentiary value of the statements and the general integrity of the investigation. Furthermore, the collaboration of witnesses can lead to the observations of one witness being overlooked if not shared by others. Conversely, a witness may adopt certain occurrences because they were observed by other witnesses. Such practices conflict with the basic rules of evidence-gathering and have a damaging effect on the success and independence of an investigation (Wyvill 1991, sec. 3.1.3).

Reports from more recent inquiries have also described instances where officers were not separated following a death or serious injury arising from a police operation. The Commission's Operation Whistler report regarding the serious injuries sustained by Hathaway during his arrest in 2003 found no attempt had been made 'to ensure the officers did not discuss the incident with each other or that they made independent notes and statements' (Police Integrity Commission 2005b, p. 52). Three officers acknowledged 'that they had discussions with the officer who had made the arrest seeking to find out what had happened within the bedroom' (Police Integrity Commission 2005b, p. 52) where Hathaway had sustained the injuries.

The IPCC report on its inquiry into the 2005 police shooting death of de Menezes observed the officers involved in the police operation were allowed to return to their base, confer and write up their notes together and that while this was accepted practice, it made those accounts less credible (IPCC 2007a, p. 166). In contrast, members of the public who witnessed the shooting were required to make statements soon after witnessing the shooting without being able confer with other witnesses and provide a joint account (IPCC 2007a, p. 166).

The Braidwood Commission of Inquiry into the 2007 death of Dziekanski rejected the evidence of a number of RCMP officers about the events preceding their use of a taser on Dziekanski at Vancouver Airport. The report concluded some of the claims made by the police officers 'were not innocent inaccuracies but deliberate misrepresentations made for the purpose of justifying their actions' (Braidwood 2010, p. 266). The report concluded there was an opportunity for officers to discuss the incident before being required to give their versions of events. Braidwood found that:

> While the evidence does not justify a conclusion that they colluded to fabricate a story, I am satisfied that their discussions resulted in them giving surprisingly similar accounts of the incident that tended to misrepresent what had happened, and tended to portray Mr. Dziekanski's actions in an unfairly negative light and their own actions in an unfairly positive light (Braidwood 2010, p. 13).

There appeared to be a consensus amongst the sources consulted for this chapter that police officers, along with all other witnesses, should be separated as a matter of course following a death or serious injury in the interests of preserving the integrity of the investigation. The RCIADIC National Report indicated that:

> … all witnesses should be separately and formally interviewed. It is desirable that interviews with custodians who were on duty during the time of last detention of the person who died should be tape recorded and that transcripts of all interviews be made (Johnston 1991, sec. 4.2.16).

The coronial inquest into the death of Levi recommended that all police eyewitnesses should be interviewed as soon as possible after the incident; and separated and directed not to discuss the incident with others (Hand 1998, p. 2). In addition, the Davies Commission report into the death of Paul identified the separation of witnesses as one of the early steps that must implemented in the aftermath of a death resulting from police actions (Davies 2009, p. 220). Finally, the RCIADIC Queensland Regional Inquiry report concluded that:

> … all witnesses should be interviewed promptly and separately by investigators. Statements should be prepared on the basis of such interviews with witnesses and signed as soon as possible to avoid any suspicion of collusion, collaboration or fabrication (Wyvill 1991, sec 3.1.1).

3.3.8 PRESERVATION AND MANAGEMENT OF THE INCIDENT SCENE

An issue raised in the publications consulted for this chapter was the failure by police to preserve and manage the incident scene, or to do so to an adequate standard, and the impact this can have on the quality of the investigation that is completed.

The RCIADIC Queensland Regional Inquiry report noted that one of the deficiencies in the police investigations into deaths in custody was that in some cases photographs of the scene were not taken and in others they were taken after the scene had been disturbed (Wyvill 1991, section 3.1.3). Similarly, the RCIADIC Western Australian Regional Inquiry report noted that in the police investigations reviewed by that inquiry, there had been a failure to take adequate photographs of the scene of death and body of deceased in situ, and a failure to adequately preserve the scene of death or collect and retain relevant exhibits (O'Dea 1991, section 6.1.2).

The RCIADIC National Report indicated that investigations 'should be structured to provide a thorough evidentiary base for consideration by the coroner on inquest' (Johnston 1991, section 4.2.16). Similarly, the RCIADIC Queensland Regional Inquiry report provided specific guidance on scene preservation and management. The report indicated that the deceased should be carefully observed and injuries and marks noted by the investigator; the scene should be left undisturbed until photographs can be taken; photographs should be of good quality and of sufficient number to provide a clear view of all relevant features of the death scene (Wyvill 1991, section 3.1.1).

The Commission's Operation Saigon report observed that following the shooting death of Levi in 1997, no orderly or structured control was taken of the scene of the shooting immediately after it occurred and no one appeared to be in charge (Police Integrity Commission 2001, pp. 78-79).

The Commission's Operation Whistler report made similar criticism of the NSWPF in that the officer in charge of the investigation gave evidence to the Commission that he took no action to preserve the scene, though he agreed it would have been good police practice to have done so (Police Integrity Commission 2005b, pp. 41-42). This officer also did not appoint a guard or record who was going in and out of the house in which the incident scene was located, and agreed that 'he failed to take this step claiming, again, that he did not realise the "seriousness of the situation at the time"' (Police Integrity Commission 2005b, p. 43). In that matter professional cleaners appointed by the duty officer had commenced cleaning the incident scene before the police photographers arrived to take photos. It was also alleged that a knife found at the scene by the cleaners had been planted by the police to incriminate Hathaway. The Commission concluded:

> Because the proper steps were not taken in accordance with the guidelines to preserve and secure the scene, there were a number of officers who, during the course of the day, were in a position to plant the knife. This was acknowledged by Inspector Murphy as quoted above. The evidence falls short of satisfying the Commission as to the identity of the particular officer. That said, in all the circumstances, it is concerning that those involved in the prosecution of Hathaway considered it appropriate to persist with the charge involving the knife' (Police Integrity Commission 2005b, p. 91).

The more recently published ICRC Guidelines stipulated that in order to protect evidence, the death scene should be preserved and that the relevant investigating authorities must attend as promptly as possible (ICRC 2013, p. 13).

3.3.9 STANDARDS OF RIGOUR AND IMPARTIALITY

A common criticism found in the publications reviewed for this chapter was the failure by police officers to undertake an effective, transparent and thorough investigation of deaths or serious injuries following interactions with police. The RCIADIC Western Australia Regional Inquiry report observed that in the cases it reviewed, the versions of events provided by officers of interest to the inquiries tended not to be subjected to close scrutiny by investigating officers (O'Dea 1991, section 6.1.2, subsection 2). Similarly, the RCIADIC Regional Inquiry report for NSW, Victoria and Tasmania observed that where police investigate police the 'need is not seen for the same scrutiny of evidence as in other cases' (Wootten 1991, part four, chapter 10).

Two RCIADIC Regional Inquiry reports noted that, with regard to some police investigations into deaths in custody, officers had not submitted statements until the investigations were well advanced. The RCIADIC Queensland Regional Inquiry report noted that in many cases officers were not required to submit statements until the investigation file, together with the investigator's report on the death, had been forwarded to their stations (Wyvill 1991, section 3.1.3). The RCIADIC NSW, Victoria and Tasmania Regional Inquiry report similarly noted that in most of the cases it examined, police officers were allowed to write their own statements up to a week or a fortnight before the coronial inquest into the death (Wootten 1991, part four, chapter 10).

Police investigations into deaths in custody came under criticism in the RCIADIC Queensland Regional Inquiry report and the RCIADIC Western Australia Regional Inquiry report for a failure to take statements from, or interview all witnesses present during the arrest and detention in custody of the deceased (Wyvill 1991, section 3.1.3; O'Dea 1991, section 6.1.2, subsection 2). The RCIADIC Queensland Regional Inquiry report explained the consequences of such a failure, noting that 'the investigation is incomplete and open to accusations of shoddiness and cover-up and superior officers are denied the opportunity of reviewing the investigation' (Wyvill 1991, section 3.1.3).

The Davies Commission of Inquiry into the death of Paul found, amongst other things, that:

- the forensic identification officer attending was not provided with adequate instructions and did not carry out investigative steps which are standard to a potentially culpable homicide;
- the investigating officer did not locate, or interview several relevant witnesses;
- the investigating officer did not seek to interview police officers, Corrections employees, and Jail staff in circumstances where interviews were required; and
- the investigating officer did not identify or reconcile inconsistencies in the evidence or attempt to do so (Davies 2009, pp. 10-11).

The Commission's Operation Calyx report concluded that the leading investigator omitted significant parts of the accounts of the four civilian witnesses and 'the cumulative effect of these omissions was to obscure the conflict in the evidence as to the material fact on which [the investigator] based his conclusion' (Police Integrity Commission 2013, p. 220). The Commission's Operation Calyx report also concluded that the senior investigator 'did not conduct the critical incident investigation into the death of Salter and did not prepare his report, with rigour and impartiality' (Police Integrity Commission 2013, p. 228).

The Commission's Operation Whistler report found that a 'number of involved officers had not applied standard practice in relation to note-taking and the preparation of statements' (Police Integrity Commission 2005b, p. XVIII) and noted additional deficiencies, including 'collaboration amongst officers in the preparation of notebook entries and court statements' (Police Integrity Commission 2005b, p. XIX) occurred.

Discussion and comment regarding the standards of rigour that should be applied to critical incident investigations, particularly deaths in custody, is found in many of the publications consulted for this chapter. The ICRC Guidelines indicated that investigations should 'determine whether the death was natural or accidental, or a case of suicide or homicide' and that investigations 'should proceed on the basis that the death may be a homicide and that suicide should never be presumed' (ICRC 2013, p. 13). The Queensland Coroner's Guidelines stated that 'all investigations must commence from the premise that they are potential homicide cases' (Queensland Courts 2014, p. 6).

The RCIADIC reports emphasised the importance of treating deaths in custody as potential homicides. The RCIADIC National Report concluded that 'investigations should be approached on the basis that the death may be a homicide. Suicide should never be

presumed' (Johnston 1991, section 4.7.4, recommendation 35) while the RCIADIC Queensland Regional Inquiry report concluded that a death in custody investigation should 'proceed on the assumption that the death has occurred in suspicious circumstances and be conducted with the same degree of thoroughness as a homicide investigation' (Wyvill 1991, section 3.1.1). The report cautions against drawing premature conclusions about the cause of death noting that such an approach 'will avoid the investigation being directed towards substantiating such a conclusion and becoming no more than an administrative process of gathering the minimum information necessary for the coroner' (Wyvill 1991, section 3.1.1).

The RCIADIC NSW, Victoria and Tasmania Regional Inquiry report concluded that investigations should seek to eliminate the possibility that 'wrong doing, ill-treatment, or official or unofficial policies or practices contributed to the death or allowed the risk of injury' (Wootten 1991, part four, chapter 10). The report also expressed support for a decision by the then NSW Government, that all deaths in custody would be approached as potential homicides (Wootten 1991, part four, chapter 10).

The Davies Commission of Inquiry emphasised the need for a quick investigative response for the purpose of 'identifying and questioning suspects, sealing off the incident scene, separating suspects and witnesses, conducting a thorough forensic investigation, and preserving evidence' (Davies 2009, p. 220). Finally, the Opinion of the Commissioner for Human Rights indicated that an investigation should be carried out 'promptly and in an expeditious manner in order to maintain confidence in the rule of law' (Commissioner for Human Rights 2009, p. 3).

On the subject of witness statements, the ICRC Guidelines indicated that all key witnesses, including eyewitnesses and suspects, should be identified and interviewed, and that 'testimonies must be carefully recorded and analysed by the investigating authorities. Failure to interview and seek evidence from key witnesses may be sufficient reason to consider the investigation seriously inadequate' (ICRC 2013, p. 13).

In its report, the OPI noted that as soon as practicable an investigator should 'audio and visually record a "free narrative" account of what happened by police involved in any incident involving a death associated with police contact as soon as possible after the incident has occurred' (OPI 2011, p. 52). In addition, the OPI suggested that an investigator undertake an audio-visually recorded walkthrough with the police officers involved (OPI 2011, p. 63).

The RCIADIC Queensland Regional Inquiry report indicated that in an ideal investigation:

> All witnesses should be interviewed promptly and separately by investigators. Statements should be prepared on the basis of interviews and signed as soon as possible to avoid any suspicion of collusion, collaboration or fabrication. The witnesses interviewed should include all persons involved in the arrest, detention or supervision of the deceased, and should include all prisoners detained in custody in the vicinity of, or who had relevant contact with, the deceased (Wyvill 1991, section 3.1.1).

3.3.10 ALCOHOL AND OTHER DRUG TESTING OF OFFICERS INVOLVED IN CRITICAL INCIDENTS

The coronial inquest into the death of Levi recommended that legislation be introduced to provide for officers involved in critical incidents to be the subject of mandatory alcohol

and drug testing so that officers may be able to answer allegations that they may have been affected by alcohol or drugs at the time of the incident (Hand 1998, pp. 2-3).

The Commission's Operation Saigon report observed that neither of the officers who had fired shots at Levi were drug and alcohol tested following the shooting, and observed that the NSWPF was, at that time, in the process of introducing a drug and alcohol testing program for NSWPF officers involved in critical incidents (Police Integrity Commission 2001, p 58). The Commission observed the Levi case was:

> … a powerful example of the necessity for an effective system of drug and alcohol testing of police officers involved in a critical incident such as this. If the test is negative, it will serve to clear the air where suggestions of drug or alcohol intoxication have been made. If the test is positive, it should provide an objective foundation to assess impairment of the officer at the time of the incident. Effective testing serves the interests of the officers in question, the Police Service and, most importantly, the community (Police Integrity Commission 2001, p. 68).

3.3.11 LACK OF CLARITY AS TO ROLES TO BE PERFORMED BY OFFICERS INVOLVED IN RESPONSE TO CRITICAL INCIDENTS

In its Operation Whistler report relating to the serious injuries sustained by Hathaway in 2003, the Commission observed there was some overlap of responsibility with regard to the roles performed by NSWPF officers under the critical incident guidelines (then in force) and that this had the potential to cause uncertainty (Police Integrity Commission 2005b, p. 136). For example, although the NSWPF critical incident guidelines (then in force) stated that the first officer at the scene was required to make certain decisions, including advising the duty operation inspector, VKG Sydney[61] that a critical incident had occurred, these same guidelines also stated that the duty officer was to assume command of the scene until relieved by the local area commander or senior investigator (Police Integrity Commission 2005b, p. 136).

The Commission's Operation Whistler report concluded that the NSWPF critical incident guidelines 'need to be unambiguous as to whose responsibility it is to call the critical incident so that the decision is made as early as possible and the appropriate actions taken, for example, the preservation of the scene' (Police Integrity Commission 2005b, p. 136).

The RCIADIC NSW, Victoria and Tasmania Regional Inquiry report referred to one police investigation into a death in which officers had adopted a narrow interpretation of their roles and responsibilities to the detriment of the quality and integrity of the investigation. Of the police officers involved in the investigation, the report stated:

> … the detective said that his only function was to take photographs; the inspector said that his task was purely administrative and not investigative; and the Internal Investigation Branch representative said that his function was to 'oversight', which turned out to mean that he had just accepted what he was told by the officer in charge (Wootten 1991, part four, chapter 10).

Finally, the Commission's Operation Saigon report found that there was a significant failure on the part of the NSWPF Internal Affairs officers to pass on information to the

61 NSWPF Radio Channel

Shooting Investigation Team, and that as a result, investigative opportunities were lost and the 'circumstances served to kindle legitimate concerns that a proper investigation of the shooting had not been undertaken' (Police Integrity Commission 2001, p. 61).

3.3.12 FAILURE OF POLICE INTERNAL REVIEW AND QUALITY CONTROL PROCESSES

The Commission's Operation Saigon report noted that, following the shooting death of Levi in 1997, the weekend call out officer from NSWPF Internal Affairs did not know what his functions as review officer were under NSWPF procedures and took no steps to find out (Police Integrity Commission 2001, p. 79). More recently, the Commission's Operation Calyx report concerning the police investigation into the death of Salter in 2009, noted that under the NSWPF critical incident guidelines (then in force):

> the identification of an incident as a "critical incident" triggered an independent investigation "*and a review of that investigation by an independent review officer*" (NSW Police Integrity Commission 2013, p. 229).

The Commission's report noted:

> The role of the review officer was stated under the Guidelines as being "*to ensure that a high quality comprehensive investigation is conducted and to ensure that the investigation process has integrity and can withstand independent scrutiny*" (NSW Police Integrity Commission 2013, p. 229).

An inspector from the NSWPF Professional Standards Command was appointed to perform the role of the review officer. The Commission indicated in its Operation Calyx report that this review officer did not comply with these obligations. More specifically, the review officer:

- limited the scope of his investigation
- did not detect or report on deficiencies identified in the investigation or the accompanying report
- did not recognise the conflict in evidence on what was regarded as the critical factual issue
- uncritically accepted the evidence of the police officers and disregarded the evidence of the civilian witnesses on the critical factual issue (NSW Police Integrity Commission 2013, p. 243).

3.4 HOW WERE THE LESSONS FROM THE LITERATURE REVIEW APPLIED TO THE AUDIT

As stated earlier, the Commission undertook an audit of NSWPF critical incident investigation documentation that could be located on the e@gle.i information management system. The audit sought to examine the compliance of 83 critical incident investigations with particular requirements in the 2007 Guidelines which, if followed, would significantly contribute to the prevention or minimisation of the misconduct and other risks identified in this Chapter. The requirements which the Commission audited were:

- the timely declaration of a critical incident by the region commander and the recording of reasons why/why not such a declaration was made (this ensures that the consequential procedures for critical incident investigations are activated at an early stage)
- the appointment of investigators of a suitable rank from a command other than the command where the incident occurred or where the involved officers were from (to avoid inferior investigations and conflicts of interest likely to affect the impartiality of the investigating officers)
- the taking control of the scene by a duty officer at the earliest opportunity and commencement of a running sheet for handover to the critical incident investigator (to ensure a written record is available of the earliest police actions and continuity is assured)
- the preservation of the incident scene (to avoid destruction of evidence, planting of evidence or tampering)
- the separation of involved officers (to remove the opportunity for collusion or fabrication of evidence)
- the correct handling of exhibits (to prevent the opportunity for loss of evidence or tampering)
- the administration of drug and alcohol testing of involved officers (to remove any doubts about the whether or not the judgement of the involved officers was impaired by drugs or alcohol)
- the undertaking of a thorough and impartial review of the investigation (to ensure that senior officers are also involved and take responsibility for the investigation outcome)
- the consideration of the lawfulness of police actions and consideration of improvements to policies and procedures (to prevent a recurrence of what occurred).

The outcomes of the audit of the NSWPF compliance with the above requirements are set out in Chapters 5 to 14 following.

4. NUMBER AND NATURE OF CRITICAL INCIDENTS JANUARY 2009 – JUNE 2012

4.1 OVERVIEW

As described in Chapter 2, based on the information provided by the NSWPF, 125 is the Commission's best estimate of the number of events that were declared to be 'critical incidents' between 1 January 2009 and 30 June 2012. The NSWPF advised that records for the investigation of 83 of these incidents were able to be located on the NSWPF investigations management system known as 'e@gle.i' and the investigations of the remaining 42 critical incidents were either not managed on e@gle.i or not able to be located on e@gle.i.

Prior to outlining the results of the Commission's audit of the investigation of the 83 critical incidents (presented in Chapters 5 to 14), this chapter provides some basic descriptive information about the 125 critical incidents that the Commission understood occurred during this time period. It also describes what is known about how the 42 critical incidents that were not located on e@gle.i were similar to or different from the 83 critical incidents that were located on e@gle.i. The individual case studies outlined in Chapters 5 to 14 complement the descriptive statistics in this chapter. Taken together they provide a better understanding of the variations and complexity of the circumstances of the critical incidents that occurred in NSW between the beginning of 2009 and mid-2012.

More specifically, this chapter provides an outline of the characteristics of the 125 critical incidents – as well as a comparison of the incidents that were located on e@gle.i with those that were not located on e@gle.i - in terms of:

- the numbers that occurred each calendar year
- the critical incident type (e.g. 'police pursuit', 'police custody')
- the investigation status (e.g. 'current' or 'finalised')
- the NSWPF geographical region in which the critical incident occurred.

The Commission was able to access additional information for the 83 strikeforces that were located on e@gle.i. Hence for the 83 strikeforces some additional descriptive information is provided concerning:

- whether the critical incident pertained to: a death, a serious injury, or neither a death nor a serious injury
- factors that pertained to the victim(s) of the critical incidents, specifically whether a victim was known to:
    - be affected by drugs
    - be affected by alcohol
    - be a member of a visible minority group
    - identify as either Aboriginal or Torres Strait Islander

- be suffering from mental health issues
- be aged less than 25 years.

Summary of findings

- Although it is contrary to the guidelines, according to the NSWPF, not all critical incident investigations are recorded or managed on e@gle.i.
- For the time period 1 January 2009 to 30 June 2012 the Commission identified 125 critical incidents:
  - for 83 of the 125 critical incidents records were located on e@gle.i
  - for 42 of the 125 critical incidents no records were located on e@gle.i.
- The majority of the investigations of critical incidents that had occurred between January 2009 and June 2012 (88%) had been finalised by March 2016.
- More than half of the critical incidents occurred in the three metropolitan regions (58%). More events were declared to be critical incidents in the South West Metropolitan Region than in either of the other two metropolitan regions.
- The investigations of critical incidents that were not located on e@gle.i were more likely to:
  - have occurred in the South West Metropolitan Region than in other regions
  - have occurred in 2010 than in the other years examined
  - have been categorised as 'police pursuits' than other types of incidents.
- While almost two-thirds of the critical incidents resulted in a death (65%), the proportion of critical incidents that resulted in a death was much higher in the 15 critical incidents that occurred in the first half of 2012 (80%). It is not possible to determine whether this increase in the percentage of deaths reflected a change in the nature of the events that occurred during this period or whether there was a change in the way the NSWPF categorised events such that fewer events resulting in injury were being classified as critical incidents.
- 54 of 83 critical incidents located on e@gle.i had resulted in a death.

4.2 CHARACTERISTICS OF THE 125 CRITICAL INCIDENTS

The tables below provide information on the characteristics of the 125 critical incidents understood to have occurred between 1 January 2009 and 30 June 2012, as well as provide a broad comparison of the critical incidents that were located on e@gle.i with those that were not located on e@gle.i.

4.2.1 NUMBER OF CRITICAL INCIDENTS PER YEAR

The number of events declared to be critical incidents varied amongst the years examined. If the 125 critical incidents had occurred at a uniform rate across the three-and-a-half year period, one would have expected approximately 18 critical incidents in each six month period (or approximately 36 critical incidents each calendar year). From Table 4.1 one can see that the total number of critical incidents in 2010 is higher (45 in 2010) and the total number in 2011 is a little lower (30 in 2011) than what would have been expected had they been occurring at a uniform rate.

Table 4.1: Calendar year critical incidents occurred

Calendar Year	Number of critical incident investigations located on e@gle.i	Number of critical incidents not located on e@gle.i[62]	Total critical incidents	
			Number	%
2009	23	9	32	26%
2010	25	20[63]	45	36%
2011	20	10[64]	30	24%
2012 (up to 30 June 2012)	15	3[65]	18	14%
Total	**83**	**42**	**125**	**100%**
%	**66%**	**34%**	**100%**	

62 Ten of the 42 critical incidents listed as not able to be located on e@gle.i had a strikeforce name.

63 Three incidents in 2010 not recorded on e@gle.i were originally investigated as critical incidents but were later de-escalated by the NSWPF.

64 Two incidents in 2011 not recorded on e@gle.i were originally investigated as a critical incident but were later de-escalated by the NSWPF.

65 One incident in 2012 not recorded on e@gle.i was originally investigated as a critical incident but was later de-escalated by the NSWPF.

4.2.2 CRITICAL INCIDENT TYPE

The incident types recorded in Table 4.2 are those provided to the Commission by the NSWPF. From the information in Table 4.2, approximately two-thirds of the critical incidents were classified by the NSWPF as 'police operation' or 'police pursuit'.[66]

Table 4.2: Incident type

Incident type using categories provided by NSWPF[67]	Number of critical incident investigations located on e@gle.i	Number of critical incidents not located on e@gle.i	Total critical incidents	
			Number	%
Police Operation	29	16[68]	45	36%
Police Pursuit	21	14[69]	35	28%
Police Firearm	19	7	26	21%
Police Custody	5	2[70]	7	6%
Motor Vehicle Accident	5	1	6	5%
Taser	4	1	5	4%
Nil	0	1[71]	1	1%
Total	**83**	**42**	**125**	**101%**[72]
%	**66%**	**34%**	**100%**	

These categories do not provide a clear description of the nature of the incident. In particular it is not clear what types of incidents the NSWPF included within the 'police operation' category. Tink (2015, pp. 152, 167) had observed that neither the NSWPF 2012 Guidelines nor the *Coroners Act 2009* (NSW) define the term 'police operation'. Tink did, however, refer to a circular issued by the NSW State Coroner that 'sought to

66 Correspondence from the NSWPF, dated 19 September 2012.

67 The NSWPF subsequently moved to a 13-category classification system: 'Homicide of police officer'; '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'; 'Attempted homicide of a police officer including serious injuries'; 'Death or serious injury to a person in police custody'; 'Death or serious injury to a person arising from a NSW Police Force operation'; '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'; 'Discharge of a firearm by police in high risk operational circumstances'; 'Suicide or attempted suicide by a NSW Police officer or member of the public resulting from the discharge of a police firearm (subject to Homicide Squad response)' (NSWPF 2012a, p. 14; NSWPF 2016a, p. 52).

68 Three incidents classified as 'Police Operation' that were not located on e@gle.i were initially investigated as critical incidents but were later de-escalated by the NSWPF.

69 One incident with the incident type 'Police Pursuit' that was not located on e@gle.i was initially investigated as a critical incident but was later de-escalated by the NSWPF.

70 One incident with the incident type 'Police Custody' that was not located on e@gle.i was initially investigated as a critical incident but was later de-escalated by the NSWPF.

71 One incident not located on e@gle.i was initially investigated as a critical incident but was later de-escalated by the NSWPF after the alleged victim was found unharmed. The incident type was classified as 'Nil'.

72 Total adds to 101% due to rounding.

describe potential scenarios involving deaths likely to have been caused "as a result of, or in the course of, a police operation" ' as:

- any police operation calculated to apprehend a person(s)
- a police siege or a 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 circumstance considered applicable by the State Coroner or a Deputy State Coroner (Tink 2015, p. 168).

Tink recommended that statutory definitions of 'critical incident' and 'police operation' should be developed in consultation with the State Coroner and the Police Commissioner (Tink 2015, p. 12).

It is not clear whether the categories listed in Table 4.2 are intended to be mutually exclusive or whether, for example, a 'motor vehicle accident' can occur within a 'police operation' or whether a 'police firearm' can be used within a 'police operation'. The Commission observed that the 'incident type' of a number of critical incidents was categorised differently across different sets of critical incident data provided by the NSWPF. For example, one strikeforce which concerned a critical incident involving a foot pursuit by police, had been categorised both as a 'police pursuit' and as a 'police operation' in different sets of data provided by the NSWPF.[73]

4.2.3 INVESTIGATION STATUS

The Commission reviewed the electronic files of critical incident investigations in early March 2016 to determine the status of these investigations.

It can be seen from Table 4.3 that the majority of the investigations of the critical incidents that had occurred between January 2009 and June 2012 (88%) had been finalised[74] by March 2016.

[73] For this reason the statistics regarding the incident type for critical incidents have been taken only from one source to provide consistent results.

[74] The Commission assigned this status if e@gle.i records mentioned that the investigation status was either 'finalised' or 'investigation complete'.

Table 4.3: Investigation status of critical incidents

Investigation status using categories provided by NSWPF	Number of critical incident investigations located on e@gle.i	Number of critical incidents not located on e@gle.i	Total number of critical incidents	
			Number	%
Provisional[75]	1	0	1	1%
Suspended[76]	1	0	1	1%
Current[77]	6[78]	7[79]	13	10%
Finalised[80]	56	35[81]	91	73%
Investigation Complete[82]	19	0	19	15%
Total	**83**	**42**	**125**	**100%**
%	**66%**	**34%**	**100%**	

4.2.4 LOCATION OF CRITICAL INCIDENT

From Table 4.4 it can be seen that more than half of the critical incidents occurred in the three metropolitan regions (58%). More events were declared to be critical incidents in the South West Metropolitan Region than in either of the other two metropolitan regions.

Of the three rural regions, more events (23) were declared to be critical incidents in the Northern Region than in either of the other two rural regions (15 events each).

75 An investigation is created with status 'Provisional' (NSWPF 2015, p. 17). As is noted below, the investigation status is changed to 'current' once Terms of Reference have been created and formally accepted.

76 An investigation status is set to 'Suspended' when activity on the investigation has stopped temporarily, but there is every intention of resuming activity when circumstances permit or additional information is provided (NSWPF 2015, pp. 17-18).

77 An investigation automatically changes to 'Current' when the Terms of Reference have been created and formally accepted (NSWPF 2012a, p. 17).

78 The NSWPF did not provide information explaining the 'Current' investigation status of six of these critical incident strikeforces located on e@gle.i. However, three critical incident strikeforces recorded as 'Current' on e@gle.i were awaiting the outcome of criminal proceedings, whilst another critical incident strikeforce was awaiting the report of the Professional Standards Command review officer prior to being finalised.

79 One incident with a 'Current' investigation status but not located on e@gle.i, was initially investigated as a critical incident but was later de-escalated by the NSWPF.

80 An investigation status is set to 'Finalised' when all court (or other) proceedings relating to the investigation have finished (NSWPF 2015, p. 18).

81 Five incidents with a 'Finalised' investigation status but not located on e@gle.i were originally investigated as critical incidents but were later de-escalated by the NSWPF.

82 An investigation status is set to 'Investigation Complete' when the investigative activity on it has finished. Note that information may still be added to the investigation to support any proceedings resulting from the investigation. This is the brief preparation status generally when all persons of interest (POIs) have been identified and actioned (NSWPF 2015, p. 17).

Table 4.4: NSWPF region in which critical incident occurred

NSWPF region in which incident occurred	Number of critical incident investigations located on e@gle.i	Number of critical incidents not located on e@gle.i	Total number of critical incidents	
			Number	%
North West Metropolitan	14	5[83]	19	15%
Central Metropolitan	18	5[84]	23	18%
South West Metropolitan	11	19	30	24%
(Metropolitan regions subtotal)	**(43)**	**(29)**	**(72)**	**(58%)[85]**
Northern	15	8[86]	23	18%
Southern	12	3	15	12%
Western	13	2[87]	15	12%
(Rural regions subtotal)	**(40)**	**(13)**	**(53)**	**(42%)**
Total	**83**	**42**	**125**	**100%**
%	**66%**	**34%**	**100%**	

4.3 COMPARISON OF THE CRITICAL INCIDENT INVESTIGATIONS LOCATED ON E@GLE.I WITH THOSE NOT LOCATED ON E@GLE.I

As described in Chapter 2, the NSWPF advised the Commission that it used an investigations management system known as 'e@gle.i' to store, plan and manage documents related to an investigation.[88] Also, while the 2007 Guidelines specified that all critical incident investigations must be recorded appropriately on e@gle.i, the Commission was advised that this, in fact, was not (always) NSWPF practice.

Two-thirds (83) of the 125 critical incident investigations were able to be located on e@gle.i, while the remaining one-third were not able to be located. The de-escalation of six of these events might be the reason that records of six investigations were not placed on e@gle.i. The Commission, when querying why 42 of the 125 critical incident investigations were not managed or able to be located on e@gle.i, was advised by the NSWPF that the decision as to whether or not to manage the investigation on e@gle.i was made by the investigator:

83 Two incidents from the North West Metro Region not located on e@gle.i were originally investigated as a critical incident but were later de-escalated by the NSWPF.
84 Two incidents from the Central Metropolitan Region not located on e@gle.i were originally investigated as a critical incident but were later de-escalated by the NSWPF.
85 Total adds to 58% due to rounding.
86 One incident from the Northern Region not located on e@gle.i was originally investigated as a critical incident but was later de-escalated by the NSWPF.
87 One incident from the Western Region not located on e@gle.i was originally investigated as a critical incident but was later de-escalated by the NSWPF.
88 Advice provided by NSWPF Professional Standards Command officer at a meeting with a Commission officer on 11 March 2013.

> Not all critical incidents are recorded / managed on e@gle.i. Based on need – e@gle.i is designed for large protracted investigations where there is a large amount of documentation / statements other products etc. – decision is made by investigator on how to manage.[89]

Tables 4.1 to 4.4 indicate how, in some key respects, the 83 critical incidents located on e@gle.i differed from the 42 critical incidents that were not able to be located on this system. The data within these tables indicates that a higher proportion of the investigations of the following types of critical incidents were not able to be located on e@gle.i:

- critical incidents that occurred in South West Metropolitan Region (63% of the 30 critical incidents that occurred in the South West Metropolitan Region were not able to be located on e@gle.i compared to 34% of the 125 critical incidents)
- critical incidents that occurred in 2010 (44% of 45 critical incidents that occurred in 2010 were not able to be located on e@gle.i compared to 34% of the total of 125 critical incidents)
- critical incidents categorised as 'police pursuits' (40% of 35 critical incidents that were classified as police pursuits were not able to be located on e@gle.i compared to 34% of the total of 125 critical incidents).

4.4 SOME CHARACTERISTICS OF THE 83 CRITICAL INCIDENTS LOCATED ON E@GLE.I

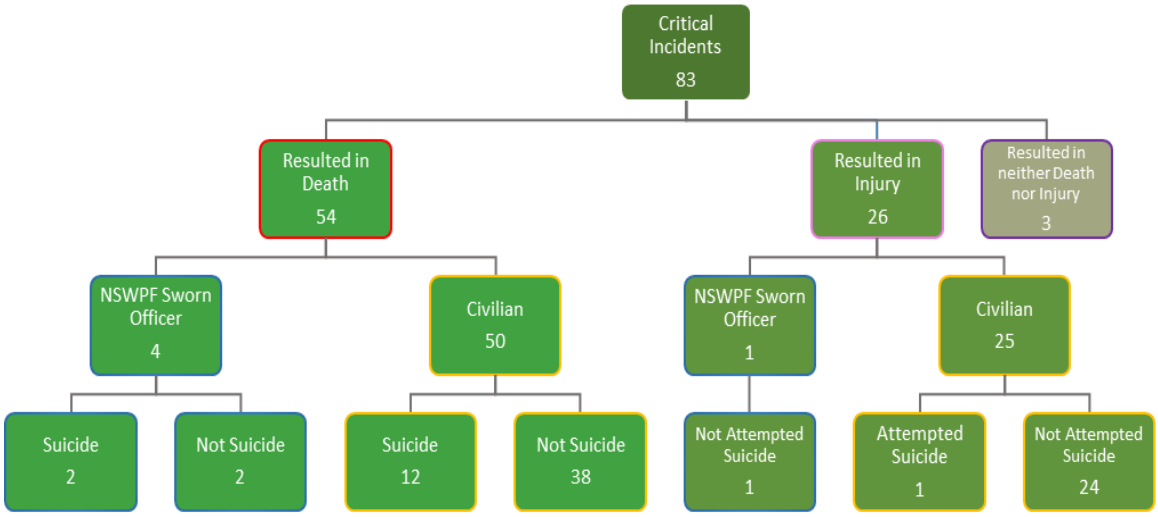
4.4.1 DEATHS OR INJURIES INCURRED

As can be seen from Figure 4.1, of the 83 investigations examined during the audit process:

- 54 critical incidents resulted in a death (65%)[90], 26 resulted in injury (31%)[91], and three resulted in neither death nor injury (4%)[92]
- four incidents involved the death of a sworn officer and 50 incidents involved the death of a civilian
- 14 incidents concerned a suicide (two sworn officers and 12 civilians) and one concerned an attempted suicide.

89 Correspondence received from NSWPF Professional Standards Command dated 28th May 2012.
90 One of these critical incidents resulted in both a death and an injury.
91 In one incident the injury occurred prior to NSWPF intervention where an intoxicated male had been found unconscious and suffering hyperthermia and was conveyed in a police vehicle to hospital with life threatening injuries.
92 The three critical incidents that resulted in neither death nor injury involved the discharge of a firearm.

Figure 4.1: Numbers of the 83 critical incidents that resulted in deaths or injuries to NSW Police Force officers and to civilians



While almost two-thirds of the critical incidents resulted in a death (65%), the proportion of critical incidents that resulted in a death was much higher in the 15 critical incidents that occurred in the first half of 2012 (80%) (see Table 4.5.). It is not possible to determine whether this increase in the percentage of deaths reflects a change in the nature of the events that occurred during this period or whether there was a change in the way the NSWPF categorised events such that fewer events resulting in injury were being classified as critical incidents.

Table 4.5: Number of critical incidents located on e@gle.i resulting in death or injury by year incident occurred

Death or injury incurred	Calendar year incident occurred				Number of critical incidents located on e@gle.i
	2009	2010	2011	2012 (up to 30 June 2012)	
Death	16	15	11	12	**54**
Injury	8	8	7	3	**26**
Discharge of firearm – neither death nor injury	0	1	2	0	**3**
Number of critical incidents located on e@gle.i	**24**	**24**	**20**	**15**	**83**

4.4.2 INVESTIGATION STATUS

Table 4.6 provides information of the investigation status of critical incidents by the year the incident occurred. While it is clear that some investigations remain open for lengthy periods awaiting the outcome of a coroner's inquest or the outcome of criminal proceedings, the Commission contacted the NSWPF on a number of occasions from early March 2013 to the middle of July 2013 to determine the reasons why the investigations of some of the incidents that occurred in earlier years remained 'current' at the time that the Commission was examining these files. As critical incidents prior to 2012 were administered at a region command level, the NSWPF sent correspondence to each region commander, on behalf of the Commission, to check the status of 'current' critical incident investigations. The final responses from respective region commands were received by the Commission in mid-July 2013. The reasons provided as to why, at that time, the critical incident investigation status of some matters was still categorised as 'current' were as follows:

- matters are still before the coroner
- matters remain before the criminal courts
- critical incident investigation reports have not been completed yet
- review officer reports have not been completed yet
- neither the critical incident investigation report nor the review officer report had been completed
- awaiting coroner's decision on whether to hold an inquest.

As at March 2016 eight of the strikeforces had yet to be finalised.

Table 4.6: Investigation status of critical incidents, as at 3 March 2016, located on e@gle.i by year incident occurred

Investigation status using categories provided by NSWPF	Calendar year incident occurred				Number of critical incidents located on e@gle.i
	2009	2010	2011	2012 (up to 30 June 2012)	
Provisional	0	0	0	1	**1**
Suspended	1[93]	0	0	0	**1**
Current	4[94]	1[95]	0	1	**6**
Finalised	17	17	14	8	**56**
Investigation Complete	2	6	6	5	**19**

93 The NSWPF did not provide information explaining the 'Suspended' investigation status of this 2009 critical incident.

94 The NSWPF did not provide information explaining the 'Current' investigation status of these four 2009 critical incident strikeforces.

95 The NSWPF did not provide information explaining the 'Current' investigation status of this 2010 critical incident strikeforce.

Investigation status using categories provided by NSWPF	Calendar year incident occurred				Number of critical incidents located on e@gle.i
	2009	2010	2011	2012 (up to 30 June 2012)	
Number of critical incidents located on e@gle.i	24	24	20	15	83

4.4.3 VICTIM RISK FACTORS

For each of the 83 critical incidents that were located on e@gle.i, available information was examined to determine whether any of the following victim risk factors had been identified:

- affected by drugs
- affected by alcohol
- a member of a visible minority group (e.g. Sudanese)
- identifies as either Aboriginal or Torres Strait Islander
- suffering from mental health issues
- a young person[96].

From Table 4.7, it can be seen that none of these factors was identified in over one-third of the critical incidents (37%). On the other hand, approximately one-quarter or more of the critical incidents involved victims who were young, affected by drugs, affected by alcohol or suffering from mental health issues.

It was also common for combinations of these victim factors to occur within the one incident. The most common combinations were:

- victim was aged less than 25 and was affected by alcohol and other drugs (five critical incidents)
- victim was affected by alcohol and other drugs and was suffering from mental health issues (four critical incidents)
- victim was affected by alcohol and other drugs (four critical incidents)
- victim was aged less than 25 years old and identified as either an Aboriginal or Torres Strait Islander (three critical incidents)

96 Taken by the Commission to be someone less than 25 years old at time of incident.

- victim was affected by drugs and was suffering from mental health issues (three critical incidents) victim was aged less than 25 and was affected by drugs (three critical incidents).[97]

Table 4.7: Victim risk factors associated with the critical incidents

Victim risk factors	Number of 83 critical incidents located on e@gle.i	Percentage of 83 critical incidents located on e@gle.i
None (of the factors below) identified	31	37%
Drug use	26	31%
Young person	24	29%
Alcohol	20	24%
Mental health	20	24%
Aboriginal/Torres Strait	6	7%
Visible minority group	3	4%
Homeless	1	1%

97 Other combinations of victim factors identified in these 83 critical incidents were: affected by drugs and alcohol and identified as Aboriginal or Torres Strait Islanders (identified in two critical incidents); affected by alcohol and a member of a visible minority group (one critical incident); young person affected by drugs and suffering from mental health issues (one critical incident); affected by alcohol and suffering from mental health issues (one critical incident); young person and a member of a visible minority group (one critical incident); young person suffering from mental health issues (one critical incident); young person affected by alcohol and suffering from mental health issues (one critical incident); young person affected by alcohol (one critical incident); homeless, affected by alcohol and other drugs and suffering from mental health issues (one critical incident); and member of visible minority group and suffering from mental health issues (one critical incident).

5. APPROPRIATE AND TIMELY DECLARATION OF CRITICAL INCIDENT

5.1 OVERVIEW

The NSWPF has recognised the importance of distinguishing the investigation of critical incidents from the investigation of officer conduct in other types of circumstances. This recognition is apparent from the fact that the NSWPF has developed specific guidelines to inform police officers in relation to the timely and professional investigation and review of critical incidents (NSWPF 2007a, p. 2). More specifically, as stated in the 2007 Guidelines:

> NSW Police is committed to demonstrating its professionalism by investigating all such incidents in an effective, accountable, and transparent manner. If public credibility is to be maintained, such incidents are most appropriately conducted independently. Accordingly, the identification of an incident as a 'critical incident' activates an independent investigative process to be conducted by a specialist and independent critical incident investigation team, and a review of that investigation by an independent review officer (NSWPF 2007a, p. 1).

The NSWPF describes the 'most significant implication of an incident being declared a critical incident is that the incident is subject to independent investigation and review' (NSWPF 2007a, p. 29).

As soon as an incident has been declared 'critical', critical incident protocols are activated by the NSWPF. Time is of the essence as any delays can impact on the subsequent investigation.

This chapter focuses on the importance of recognising and declaring an incident to be 'critical', when it is appropriate to do so. A significant risk to the investigation of a critical incident would occur if the event were not declared to be a 'critical incident'. Where an event is not identified and declared to be a 'critical incident' then the guidelines to activate an independent investigative process and independent review do not come into play.

This chapter also considers the risks associated with any delay in declaring the event to be a critical incident.

After first providing a context by describing who decides whether or not an event is a critical incident and the criteria for an event to be declared a critical incident, this chapter focuses on the analysis of available documentation located on e@gle.i concerning:

- the decision to declare or not to declare an incident to be 'critical'
- how long after an incident occurred the decision was made to declare it a critical incident.

Summary of findings

Documentation of reasons for incidents declared to be a critical incident

- For 52 (63%) of 83 strikeforces[98] no documentation was located concerning the reason why an incident was declared to be a critical incident.
- For 31 (37%) of 83 strikeforces where some documentation was located as to the reason an incident was declared to be a critical incident:
    - the reason was usually a statement of the category which best described the event (for example, 'death arising from a police operation – police at scene' or 'death or serious injury to a person in police custody')
    - no documentation was located concerning the reason an injury was considered to be serious
    - similarly no documentation was located about the source and basis of considering an injury to be serious (such as advice of ambulance officers or medical practitioners)
    - there was little consistency in where the decision-making processes were documented with different strikeforces recording this information in seven different document types.

Documentation of reasons for incidents not declared to be a critical incident

- The Commission located 117 COPS reports for the period 1 July 2011 to 30 June 2012 which included both the term 'critical' and 'incident'. The Commission identified that 18 of these reports concerned circumstances that potentially could have pertained to a critical incident where there was also some reference that the NSWPF did not consider them to be a critical incident.
- While some of these incidents may have been considered not to be critical incidents either because of the limited involvement of NSWPF officers leading up to the incident or because of the nature of the injury, the reason was, at times, unclear from the available documentation. In some cases the documentation of the decision-making process was limited to statements such as 'This matter has not been declared as a critical incident' or 'After consultation with the region commander it was determined that this incident was not a critical incident'.
- Some of the events that were considered not to be a critical incident, raise the question of what constitutes a 'serious injury':

  Example 1

  A man self-harmed at a police station and lost consciousness. The treating doctor assessed the man and due to the man's limited brain function he was placed into a paralysed state, intubated and flown to hospital. The region commander, after having received advice from the treating doctor about any long term injuries made the decision not to declare this incident as 'critical'.

98 The term 'strikeforce' is used within this report to refer to the NSWPF investigation of an individual critical incident.

Example 2

A man tried to avoid being stopped for a random breath test and was pursued by police. The man's vehicle collided with a tree. The man sustained a broken left femur, broken pelvis, broken hip, broken ribs, hands and fingers and suffered from a contusion to the chest. The COPS report stated that an inspector from the region where the incident occurred attended the scene 'which was not declared a critical incident'.

Such examples suggest that when in doubt concerning the seriousness of the injury, the NSWPF does not always initiate the critical incident protocols.

- The Commission's review of these 18 COPS event summaries revealed that there was limited, if any, information in relation to:
    - details of the reason why these event were considered not to be critical incidents
    - who established the seriousness of the injuries
    - who determined that the injuries did not constitute a 'serious injury'
    - where, in addition to the COPS report, the decision-making processes in relation to the incident are recorded
    - time and date the decision was made that the incident did not constitute a critical incident.

Timeliness of the decision

- For 30 (36%) of the 83 strikeforces the Commission was not able to locate any information or records on e@gle.i as to the time or date the region commander declared the incident to be critical.
- For the 52 strikeforces where information was available:
    - half of the incidents were declared as critical within an hour of the event occurring with the remaining incidents being declared within five hours of the event occurring
    - there was little consistency in where information concerning the date and time were documented with different strikeforces recording this information in 15 different document types.
- For one strikeforce the Commission was able to locate information on e@gle.i concerning the day, but not the time, the region commander declared the incident to be critical.

Timely establishment of a critical incident investigation team (CIIT)

- 59 (71%) of the 83 strikeforces included information as to the date and time when the CIIT was formed.
- For 61 (73%) of the 83 strikeforces there was insufficient information to calculate the time it took between the incident being declared critical and the formation of the CIIT.
- 22 (27%) of the 83 strikeforces included information on both when the critical incident was declared and when the CIIT was formed.

5.2 WHAT INFORMATION DID THE COMMISSION CONSIDER?

The 2007 Guidelines specified that the region commander should, where appropriate, declare a critical incident and ensure that a record is made of the decision to call or not call an incident critical, together with the reason for that decision (NSWPF 2007a, p. 10).[99]

In an attempt to locate documentation of the decision to declare an incident to be 'critical' and the time when the event was declared to be 'critical' the Commission commenced by reviewing, where available, the critical incident investigator report (CIIR), the review officer report and the region commander report for the 83 strikeforces located on e@gle.i. If information about the decision was not recorded in any of these reports, the Commission reviewed a number of additional documents[100] located on e@gle.i, most notably:

- duty officer statements
- senior critical incident investigator statements
- first officer at the scene statements
- statements of officers involved in the critical incident
- crime scene guard statements
- crime scene logs
- critical incident operation logs
- duty officer logs
- VKG incident logs
- NSW police radio log books
- investigation chronology
- running sheets
- notebook entries of involved officers
- duty operation inspector critical incident notification form
- situation reports.

In an attempt to locate documentation of reasons where a decision was made that an event was not a critical incident, the Commission needed to look beyond the e@gle.i system. In an attempt to identify events that the NSWPF had considered as potential critical incidents but decided that they were not to be declared 'critical incidents' the Commission undertook a search on the NSWPF COPS database[101] for the terms 'critical'

---

99 The same requirements are recorded in the 2012 Guidelines (NSWPF 2012a, p. 15) and the 2016 Guidelines (NSWPF 2016a, pp. 11-12).

100 The Commission reviewed a large number of documents that related to critical incident investigations and established that these documents were the ones most likely to contain the sought information.

101 The NSWPF stores operational and intelligence information on an electronic data system called Computerised Operational Policing System ('COPS'). COPS is the main repository for any information on persons, organisations, locations, objects, events and vehicles that come to the attention of NSW police officers during the performance of their duties. Officers of all ranks and positions use COPS to record and enquire on the details of any entities as part of their policing duties.

and 'incident'. This search was conducted for all records that contained these terms for the financial year 1 July 2011 to 30 June 2012. The Commission identified 117 COPS reports that included both of the words 'critical' and 'incident'. Of these 117 COPS reports the Commission identified 18 reports that mentioned 'critical incident' and some reference that the NSWPF did not consider these events to fit the criteria of critical incidents.

5.3 WHO MAKES THE DECISION?

The 2007 Guidelines stated that the region commander 'has ultimate responsibility for declaring an incident as critical' (NSWPF 2007a, p. 7)[102] and must ensure that a critical incident investigation team (CIIT) is formed (NSWPF 2007a, p. 8).[103]

5.4 WHAT ARE THE CRITERIA FOR AN EVENT TO BE DECLARED A 'CRITICAL INCIDENT'?

Critical incidents are incidents which, by their nature or circumstances, require an 'independent investigation and review' (NSWPF 2007a, p. 4).[104] The 2007 Guidelines provided examples of incidents that might constitute critical incidents, such as:

> - Homicide of a police officer (including attempted homicide with serious injuries)
> - Death or injury resulting from the discharge of a firearm by a police officer
> - Suicide or attempted suicide of a police officer from the discharge of a police firearm
> - Suicide or attempted suicide of a member of the public from the discharge of a police firearm
> - Discharge of a police firearm in high risk operational circumstances (no injury)
> - Death or serious injury from use of police appointments (not firearm) or as a result of the application of physical force by a police officer
> - Death or serious injury to a person in police custody
> - Death or serious injury to a person arising from a police operation
> - Death or serious injury arising from police vehicle pursuit or from a motor vehicle collision involving a police vehicle (non-pursuit)
>
> and any other event that could attract significant attention, interest or criticism from the community, and the circumstances are such that the public

102 The same requirement is included in the 2012 Guidelines (NSWPF 2012a, p. 15) and the 2016 Guidelines (NSWPF 2016a, p. 11).

103 The same requirement is included in the 2012 Guidelines (NSWPF 2012a, p. 15) and the 2016 Guidelines (NSWPF 2016a, p. 12).

104 Similar requirements are recorded in the 2012 Guidelines (NSWPF 2012a, p. 6) and 2016 Guidelines (NSWPF 2016a, p. 6).

> interest is best served through an investigation independent of the officers involved (NSWPF 2007a, p. 4).

The 2012 Guidelines classified a critical incident as:

> an incident involving a member of the NSWPF which resulted in the death of or serious injury to a person:
>
> - arising from the discharge of a firearm by the member
> - arising from the use of appointments or application of physical force by the member
> - arising from a police vehicle pursuit or from a collision involving a NSWPF vehicle
> - in police custody
> - arising from a NSWPF operation
>
> or any other event, as deemed by the region commander, that could attract significant attention, interest or criticism from the community, and the circumstances are such that the public interest is best served through an investigation independent of the officers involved (NSWPF 2012a, p. 9).

This definition of what constitutes a critical incident remains substantially unchanged in the 2016 Guidelines (NSWPF 2016a, p. 7).

In addition, the 2012 Guidelines and the 2016 Guidelines differentiate between 'Level 1 critical incidents' and 'Level 2 critical incidents' according to the degree of seriousness, with level 1 critical incidents being the more serious ones. These guidelines further provide a mandatory requirement that the SCII will be an officer from the Homicide Squad, State Crime Command and the investigation will be independently monitored and reviewed by an officer from the Professional Standards Command (PSC). For level 2 critical incidents there is a 'mandatory requirement that the investigation will be conducted and led by a critical incident investigation team (CIIT) independent to the incident' (NSWPF 2012a, pp. 10-11; NSWPF 2016a, pp. 7-8).

5.4.1 DETERMINING WHETHER AN INJURY IS 'SERIOUS'

One of the issues identified during the Commission's audit of 83 strikeforces relates to the categorisation of injuries that persons have received while in the custody of police or as a result of, or in the course of, police operations. While the classification of incidents where a death occurs would seem relatively clear, far more discretion is allowed in making a decision as to whether an injury is 'serious'.

The 2007 Guidelines stated that a critical incident is declared when a person receives 'serious injuries' as a result of contact with police (NSWPF 2007a, p. 4). The following examples were provided as a 'guide' to the types of injuries which of their nature are likely to be 'serious':

- life threatening injuries
- an injury that would normally require emergency admission to a hospital and significant medical treatment

- an injury likely to result in permanent impairment or long term rehabilitation
- an injury that would constitute grievous bodily harm (NSWPF 2007a, p. 5).[105]

While these examples assist in understanding some of the types of injuries that should be classified as 'serious injuries' they should not be regarded as a definitive list. For example, just as people may differ in their understanding of what is meant by 'serious injury' people may also differ in their understanding of what is meant by 'significant medical treatment'.

There are a number of difficulties associated with determining whether or not an injury is 'serious':

- some injuries, especially internal ones, may not be detected at the time of the incident
- the consequences of an injury may not become apparent until later
- the officer assessing the injury may not be qualified to do so and may incorrectly categorise the seriousness of the injury
- there is also the risk that an injury could potentially be deliberately miscategorised as less serious to avoid the matter being declared a critical incident.

The 2007 Guidelines stated that in the event that there is no definitive outcome in the initial phases of managing the incident, the injury is to be classified as 'serious' and the appropriate critical incident protocols initiated. In the event that injuries are classified as not serious at a later stage, the NSWPF can reassess whether or not to proceed as a critical incident investigation (NSWPF 2007a, p. 7).[106]

The following example illustrates the risk that the seriousness of an injury may not become apparent until sometime after the incident has occurred. This can cause a delay in declaring a critical incident with the consequence that critical incident protocols are not implemented immediately.

105 The same guidance as to the types of injuries which of their nature are likely to be serious is included in the 2012 Guidelines (NSWPF 2012a, p. 9) and 2016 Guidelines (NSWPF 2016a, p. 9) except that the example 'An injury that would constitute grievous bodily harm' has been omitted from both the 2012 and the 2016 Guidelines.

106 This requirement remains substantially unchanged in the 2012 Guidelines (NSWPF 2012a, pp. 9-10) and the 2016 Guidelines, (NSWPF 2016a, p. 9).

In late 2010 police arrested a man as a result of a covert police drug operation at a regional location in NSW. Due to some confusion as to the location of the offender, two police officers, rather than the whole team, tried to arrest two men. While one of the men complied with police direction, the other man walked away from police and eventually stumbled and fell backwards. One police officer struggled with the man and during the struggle came into contact with the man's shoulder and the middle of his chest. The officer stated that he struggled 'violently' with the man attempting to remove the man's hands from his pants. Two more police officers arrived at the scene and tried to arrest the man. All three police officers struggled with the man and eventually subdued him with the use of OC spray. The man was handcuffed and treated for the effects of the OC spray.

The man was taken to the police station and entered into custody. The custody manager contacted the Ambulance Service and arranged for them to attend the police station and treat the man. Upon examination of the man the Ambulance officers decided that he needed to be taken to the nearest hospital.

Medical examination of the man at the hospital revealed that he was suffering from 11 broken ribs, three fractured vertebrae and a fractured nose. It was only when a thorough examination of the man was completed at the hospital, 24 hours after his arrest, that the seriousness of the man's injuries became apparent. It was at this point that the critical incident was declared.

5.5 WHAT IS THE RISK IF THE EVENT IS NOT APPROPRIATELY DECLARED TO BE A 'CRITICAL INCIDENT' IN A TIMELY MANNER?

Where an event is not recognised and identified to be a 'critical incident' then the guidelines to activate an independent investigative process and review do not come into play. That is to say, if an event is not declared as 'critical', critical incident protocols are not implemented, resulting in:

- a potential loss of an 'independent' investigation by a specially appointed team of investigators that is selected by the region commander
- no review of the investigation by an independent officer
- officers involved in the incident are not immediately separated
- the region commander has no direct involvement with or responsibility in regard to the investigation
- officers involved in the incident are not considered for drug and alcohol testing in accordance with s211A of the *Police Act* and the NSW Police Drug and Alcohol policy.

In instances where there is a delay by the region commander in declaring an incident as 'critical' there are a number of risks that can impact on the ensuing critical incident investigation. These risks include:

- a delay in the preservation of the incident scene

- involved officers not separated immediately after the incident may result in possible discussion among involved officers as to the events that have led to the critical incident
- delay in notifying the on duty state/deputy state coroner
- possible unsupervised access to involved officers by other officers or members of other organisations.

In addition, a delay in declaring an incident as critical also results in a delay in the establishment of a CIIT. Such a delay may result in a loss of evidence as a consequence of:

- potential cross-contamination of evidence by witnesses and directly involved police officers, including possible collusion of involved officers in relation to the circumstances that led to the critical incident.
- a delay in conducting alcohol and drug testing with relevant directly involved officers.

5.6 DOCUMENTATION OF THE DECISION

5.6.1 WHAT DO THE GUIDELINES SAY?

The 2007 Guidelines stated that the region commander should 'ensure that a record is made of the decision to call or not call an incident 'critical' together with the reason for that decision' (NSWPF 2007a, p. 10), however, the guidelines did not specify where that information needed to be documented.[107] The 2007 Guidelines further stipulated that the decision-making process should include the source and basis for the classification, i.e. ambulance officers and/or medical practitioners (NSWPF 2007a, p. 5).[108]

The 2007 Guidelines also mentioned that the decision to classify, or not classify an injury as serious, needed to be considered and documented by those responsible for managing the incident in which the injury was occasioned (NSWPF 2007a, p. 5). The same requirement was included in the 2012 Guidelines (NSWPF 2012a, p. 9). The 2016 Guidelines simply state that 'the decision to classify an injury as 'serious' needs to be documented at the time of the incident' (NSWPF 2016a, p. 9).

In terms of where the decision to classify or not classify an injury as 'serious' needs to be documented and by whom, the NSWPF advised the Commission:

> All information regarding the nature of an injury is supplied by officers at the scene (usually a duty officer) to the Regional Professional Standards Manager (PSM) who then briefs the relevant Region Commander. The Region Commander then makes the determination as to whether the matter will be investigated as a critical incident or whether a standard investigation will be conducted. Regardless of the decision, details of the incident are

107 The 2012 Guidelines and the 2016 Guidelines include the same requirement (NSWPF 2012a, p. 15; NSWPF 2016a, p.12).

108 The 2012 Guidelines and the 2016 Guidelines include the same requirement (NSWPF 2012a, p. 9; NSWPF 2016a, p.9).

recorded in a COPS event and usually in a SITREP.[109] Region Commanders and Regional PSMs may also make their own personal notes.[110]

5.6.2 WHAT DID THE COMMISSION FIND?

Documentation of reasons for events declared to be a critical incident

Documentation located on e@gle.i for 31 of the 83 strikeforces included information as to the reason why an incident was declared critical by a region commander. Some of the reasons listed by region commanders to declare an incident critical were:

- death arising from police operation – police at scene
- serious injury from the discharge of a firearm by a NSW Police officer
- death or serious injury to a person in police custody
- death or serious injury to a person arising from a police operation
- serious injury from the use of police appointments (not firearm)
- death of person X was deemed a critical incident due to the fact that police had engaged in a conversation and negotiations with the deceased prior to death
- apparent suicide of police officer with his police issue firearm
- due to the circumstances surrounding the collision the matter was classified as serious injury resulting from a police pursuit as per NSWPF guidelines for the Management and Investigation of Critical Incidents.

There was little consistency in where the decision-making processes were recorded. The Commission located information about region commanders' reasons for declaring an event to be a 'critical incident' in eight types of documentation.[111] In addition, the Commission's audit of these 31 strikeforces did not find any evidence that the region commander complied with the guidelines to include the source and basis of classifying an injury as 'serious'.

For 52 strikeforces the Commission was unable to locate any information as to the reason why a region commander declared an incident as 'critical'. More specifically:

- for 38 strikeforces, the Commission was unable to locate any information as to the reason why a region commander declared the incident as 'critical' even though the Commission located CIIRs for all 38 strikeforces and/or review officer reports and/or region commander reports
- for 13 strikeforces the Commission was unable to locate CIIRs, review officer reports or region commander reports. In these circumstances the

109 A SITREP, or situation report, is an internal NSWPF document that provides an overview of an event and any proposed further action by the NSWPF.

110 Email from NSWPF to PIC, dated 13/11/2012.

111 This information was recorded in the following range of documents: CIIRs (21 strikeforces), region commander report (four strikeforces), SCII statements (one strikeforce), review officer report (one strikeforce), situation report (one strikeforce), e@gle.i summary for strikeforce matter (one strikeforce), critical incident log (one strikeforce), CMR (Central Metropolitan Region) Critical Incident Criteria & Response Checklist (one strikeforce).

Commission examined, where available, SCII statements, critical incident logs, situation reports, duty officer statements/running sheets etc. to be confident that there was no available recorded reason by a region commander to declare incidents as critical. The Commission was unable to locate any recorded reason in any of these documents

- for one strikeforce the Commission located a CIIR that indicated that this incident was not a critical incident as defined in the policy at the time. The Commission was unable to locate any documented reason why this matter was declared a critical incident in the first instance.

Documentation of reasons for events declared NOT to be a critical incident

As mentioned earlier in this chapter the Commission also undertook a search on the NSWPF COPS database for the terms 'critical' and 'incident' for the time period 1 July 2011 to 30 June 2012.[112] Of 117 COPS reports that included the terms 'critical' and 'incident', there were 18 reports that mentioned 'critical incident' and some reference that the NSWPF did not consider them to fit the criteria of a critical incident. The Commission examined the available documentation to establish why these incidents were not considered to be 'critical'. A synopsis of each of the 18 incidents is provided below:

Incident 1: In one incident police conducted surveillance upon premises in metropolitan Sydney. A man tried to evade police and climbed out of the window and fell 7on the ground below. At some time it was established that the injuries to the man did not fall under the critical incident criteria.

Incident 2: Police accompanied a woman to her premises as she wanted to remove some property and was in fear of her partner. When police attended the premises the woman's partner threatened self-harm and was found in the kitchen with brown liquid foam around his mouth. The man was transported to hospital and medical staff indicated that the incident was not life threatening. Due to the brief contact police had with the man before he self-harmed, police commenced critical incident protocols. After the condition of the man improved the incident was no longer considered to be a critical incident.

Incident 3: Police engaged in a vehicle pursuit which resulted in the car colliding with a power pole. One of the passengers in the car that collided as a result of the police pursuit sustained a dislocated right foot and a broken tibia. The COPS report stated that 'this matter has not been declared as a critical incident'. No further information was provided concerning the basis for that decision.

Incident 4: Police attended the house of a woman to organise an appointment that day with her at the police station. When the woman did not turn up at the police station police conducted a number of inquiries. Sometime later that day a relative of the woman attended the police station and reported the woman missing. Police went back to the woman's house and found her with a gunshot wound to her head. The woman was conveyed to hospital where she subsequently died. The COPS report stated that a briefing was given to the 'Western Region' and an assessment was made whether that

[112] Because it was not possible to search for the term 'critical incident', the Commission undertook a search of the two words, 'critical' and 'incident'. This resulted in many 'false positives' of event reports which did not relate to critical incidents.

incident fitted the criteria of a critical incident. It was determined that the matter did not meet the criteria of a critical incident.

Incident 5: A man sustained a broken sternum as a result of a police pursuit. The 'region' where the incident occurred was contacted and it was decided that the incident 'was not classed as a critical incident'.

Incident 6: A man self-harmed at a police station and lost consciousness. The treating doctor assessed the man and due to the man's limited brain function he was placed into a paralysed state and intubated and flown to hospital. The region commander, after having received advice from the treating doctor about any long-term injuries, made the decision not to declare this incident as 'critical'.

Incident 7: A police pursuit resulted in the driver of a car being pursued colliding with an electric light pole. Initially it was thought that no one involved in the crash had received serious injuries and based on that information the region commander did not declare a critical incident. However, the condition of one of the passengers of the vehicle deteriorated and the person underwent spinal surgery. Based on that information the region commander 'escalated' the information. There is no information included in the COPS report if this incident was declared 'critical'.[113]

Incident 8: Police were called to a location by a man who threatened self-harm. Police located the man on top of a tower and commenced negotiations with the man. The man eventually fell a couple of metres and received some injuries to his face. Ambulance officers immediately treated the man before he was conveyed to hospital. Police contacted the region commander and appraised him of the situation. The region commander 'deemed the situation not to be a critical incident'.

Incident 9: One COPS report briefly stated that there had been a serious motor vehicle accident on the Pacific Highway and stated: 'not critical incident'. No further information was included in this report.

Incident 10: In one incident a man was pursued by police when his motorcycle impacted with several trees, causing the man to be ejected. As a result of this collision the man suffered a broken leg and fracture to his neck. After consultation with the region commander it was determined that this incident was not a critical incident.

Incident 11: A man threatened two women with a gun in their house. When police were called the man shot himself and was dead when located by police. The region commander was advised of this incident and declared it to not be a critical incident.

Incident 12: A man tried to avoid being stopped for a random breath test and was pursued by police. The man's vehicle collided with a tree. The man sustained a broken left femur, broken pelvis, broken hip, broken ribs, hands and fingers and suffered from a contusion to his chest. The COPS report stated that an inspector from the region where the incident occurred attended the scene 'which was not declared a critical incident'.

---

113 The Commission tried to match this incident with data obtained from the NSWPF in relation to all critical incident investigations in the time period audited by the Commission to ascertain if this incident progressed to a 'critical incident' investigation. This incident did not match with any of the records obtained from the NSWPF pertaining to critical incident investigations.

Incident 13: Several police officers tried to arrest a man who had minutes earlier stabbed a person. The man was given a burst of OC spray from police and a short time later stabbed himself in the leg. The region commander, informed of this incident, declined to declare a critical incident.

Incident 14: Police followed two motorcycle riders who were observed to drive erratically. One of the motorcycle riders collided with a truck and as a result injured his finger. The report noted that the motorcycle rider was at no time aware that he was being followed by police and therefore this incident was not deemed a pursuit nor a critical incident.

Incident 15: Police saw a man in a vehicle speed away from police. A short time later police located the vehicle on its roof. The driver sustained an injury to his left arm. The duty officer informed the region commander of the incident. Due to the fact that police had not gotten close enough to the vehicle to engage in a pursuit, the region commander determined that this was not a critical incident.

Incident 16: Two officers pursued a woman, suspected to be in possession of an illicit drug, by foot. During the foot pursuit the woman fell and injured her forehead. The woman was conveyed to hospital. A short time after the incident it was established that the injuries were not serious enough to warrant a critical incident.

Incident 17: One COPS report provided limited details in relation to a collision between two vehicles. It did not appear that there was any direct police involvement. After the collision one of the drivers was unconscious. The COPS report only stated 'Matter not declared a Critical Incident'.

Incident 18: One COPS report provided limited information in relation to a woman who had received facial injuries after falling over and hitting her face while being under the influence of alcohol. The report only stated 'At this time no critical incident'.

The Commission's review of these 18 COPS reports revealed that there was limited information included in these reports in relation to:

- who made the decision that these incidents were not 'critical'
- the reasons these incidents were not 'critical'
- who determined that the injuries did not constitute a 'serious injury'
- where the decision-making processes in relation to this incident are recorded, apart from the COPS report
- time and date when the decisions were made that these incidents did not constitute critical incidents.

Who decided these incidents were not critical incidents?

In relation to who made the decision that these incidents were not 'critical', the Commission's audit of these 18 reports revealed that:

- in eight reports there was no information in terms of who within NSWPF reached the decision that these incidents did not fit the criteria of a critical incident
- in seven reports, there was information that the region commander concluded that these incidents did not fit the criteria of a critical incident
- in two reports there was a generic comment that 'the region' reached the decision that these incidents did not fit the criteria of a critical incident
- in one report there was mention that an inspector reached the decision that this incident did not fit the criteria of a critical incident.

Why were these incidents not declared to be critical incidents?

In relation to the reasons these incidents were not declared 'critical', the Commission's audit of these 18 COPS reports identified five reports that included reasons why these incidents were not declared 'critical incidents':

- two reports referred to the nature of the injuries
- one report referred to the brevity of police contact
- one report referred to officers not having gotten close enough to the vehicle to engage in a pursuit
- one report referred to the injured motorcycle rider not being aware of the police pursuit.

In the remaining 13 reports, the Commission was unable to identify any explanation for the decision that the incident not be declared a 'critical incident'.

Another issue that emerged during the Commission's review of these 18 COPS reports that were not declared critical incidents is the issue of what constitutes a 'serious injury'. The three sets of guidelines define a serious injury as one that is either life threatening; would normally require emergency admission to hospital requiring significant medical treatment; or would result in permanent impairment or long term rehabilitation. The Commission's review of these 18 COPS reports identified reports that made reference to some injuries which, without further information, could appear to be serious, including:

- the person suffered a punctured lung
- the person was placed into a paralysed state and intubated due to limited brain function and activity
- the person suffered a broken left femur, broken pelvis, broken hip, broken ribs, hand and fingers and suffering from a contusion to his chest
- the person underwent spinal surgery to fuse a fractured vertebrae and also sustained a broken pelvis.

5.7 TIMELINESS OF THE DECISION

5.7.1 WHAT DO THE GUIDELINES SAY?

None of the three sets of guidelines provides any specific timeframes as to when a critical incident should be declared. The 2007 Guidelines simply stated that it is the responsibility of the region commander to declare an incident as critical, but they did not elaborate as to the timeframes within which this decision needs to be made. Similarly the 2012 Guidelines and the 2016 Guidelines do not provide any further guidance in relation to what constitutes the timely identification of a critical incident.

5.7.2 WHAT DID THE COMMISSION FIND?

Documentation for 52 of the 83 strikeforces included information as to the date and time when the critical incident was declared by the region commander.

For one additional strikeforce information was located on e@gle.i concerning the day, but not the time, the region commander declared it to be a 'critical incident'.

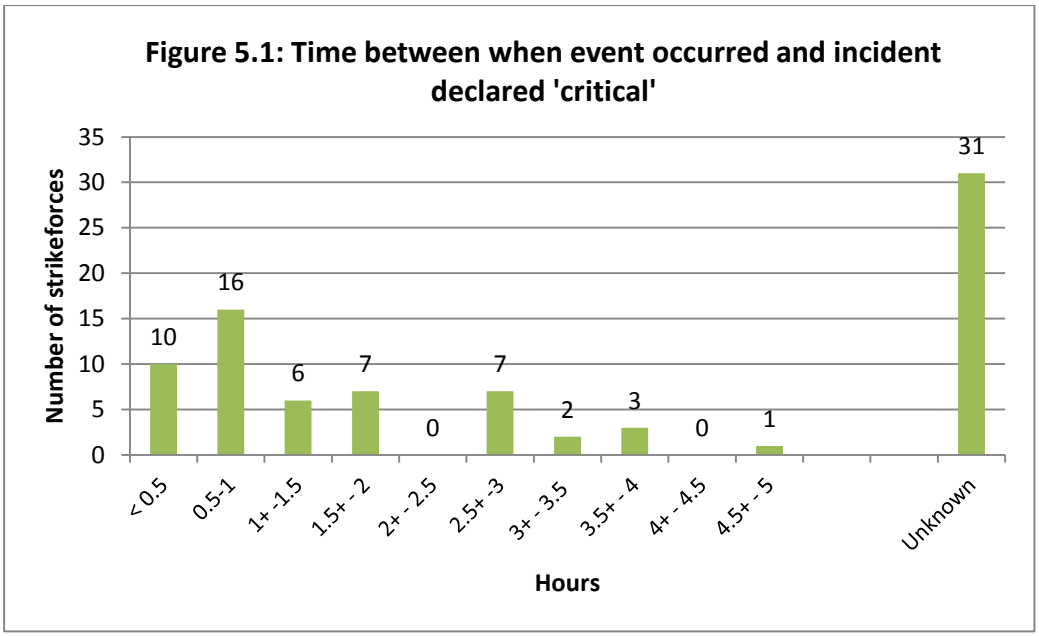
There was little consistency in where this information was recorded, with the Commission locating these details in 15 types of documentation.[114]

For 30 strikeforces, the Commission was unable to locate any information on e@gle.i as to the time or the date the region commander declared it to be critical.

As can be seen in Figure 5.1, for the 52 strikeforces where the information was available, half of the incidents were declared as 'critical' within an hour of the event occurring while the remainder of the 52 strikeforces were declared as 'critical' within five hours of the event occurring.

However, most notable is that there was insufficient information on e@gle.i to calculate the time between when the event occurred and the incident was declared 'critical' for 31 (37%) of the strikeforces.

[114] This information was recorded in the following range of documents: CIIRs (for 21 strikeforces); SCII statements (for 11 strikeforces); duty officer statements (for eight strikeforces, including the one strikeforce that included the date but not the time, the region commander declared the 'critical incident'); crime scene logs (for two strike forces); a situation report (one strikeforce); a duty office running sheet (one strikeforce); a 'CIIT supervisor statement' (one strikeforce); region commander report (one strikeforce); review officer report (one strikeforce); a 'Major Incident Log' created by a duty officer (one strikeforce); critical incident running sheet (one strikeforce); 'CMR Critical Incident Criteria and Response Checklist' (one strikeforce); incident log (one strikeforce); 'VKG Duty Operations Inspector log entry' (one strikeforce); Computer Aided Dispatch (CAD) report printout' (one strikeforce). CAD is a NSWPF resource deployment and incident management system. CAD manages and supports deployment of police resources in response to incidents generated by the community and other NSW response agencies (NSWPF Intranet, accessed on 18/2/2016).



The following example illustrates some of the risks to a critical incident investigation where a delay occurred in declaring the critical incident and the critical incident guidelines were not immediately applied.

In the early hours of a morning in 2009 officers from a metropolitan command were called to an armed robbery at a hotel. Police confronted the armed robber and shortly afterwards shots were exchanged between the robber and police. One police officer received a gunshot wound to his arm whilst the robber was hit a number of times by police gunshots. Neither the police officer nor the robber received life-threatening injuries. The robber was subsequently arrested by police and conveyed to hospital for treatment.

There was a three-hour delay in declaring this incident critical as the local area commander, who was on the scene shortly after the incident had occurred and after assessing the situation, mistakenly informed the region commander that the matter was not a critical incident. The CIIR noted that it was obvious from the outset that this incident met the criteria for a critical incident in two categories:

1. Police officer discharge firearm in execution of duty
2. Offender occasioning serious bodily harm during a police operation.

The CIIR noted that the delay in categorising this matter as a critical incident created problems for the CIIT including:

- critical incident protocols were not implemented and involved officers were not immediately separated by the duty officer and did not make independent notebook entries
- delay in Healthy Lifestyle[115] attending
- the Police Association of NSW gained unsupervised access to involved officers.

The CIIT, as a result of these events, had difficulty in gaining cooperation from the involved officers. The CIIR stated that when members of the CIIT arrived at the local area command of the involved officers, the involved officers were freely moving around the station and had discussed the incident with non-involved officers and had also spoken to a member

115 'Healthy Lifestyles' was the name of a former NSWPF unit that co-ordinated alcohol and other drug testing.

of the Police Association. As a result, involved officers refused to provide statements to members of the CIIT and only made statements where a standard objection was typed at the beginning. The SCII was critical of the behaviour of the involved officers, calling it 'unconscionable' and mentioned that they 'turned their backs on their oath of office which they swore on joining the New South Wales Police Force'.

The SCII recommended that access to involved officers should be controlled and supervised during critical incidents.

The review officer report supported the criticisms made in the CIIR and, in addition, commented on the lack of documentation and transparency in the region commander's decision-making process in relation to this incident. The review officer also recommended that clear guidelines should be established between the NSWPF and the Police Association of NSW in the response to critical incidents. These guidelines should establish protocols on how and when NSWPF representatives should interact with police involved in critical incidents. The guidelines should also clearly set out the legal obligations of police officers in such situations so that there is no confusion in the advice given.

An example of a strikeforce that clearly recorded the time and date when a critical incident was declared by the region commander is described below.

In late 2010, a man was driving his car when it collided with a fully marked police car driven by a police officer. At the time of the collision the police officer was on urgent duty with emergency warning devices, lights and sirens activated. The man died as a result of the vehicle collision.

The critical incident occurred at 3 pm. The matter was declared a critical incident by the region commander at 4 pm. At 4.04 pm the region's professional standards manager contacted the superintendent of a neighbouring local area command for the purpose of activating a CIIT. At 4.20 pm the superintendent contacted the SCII informing him that he would be in charge of the CIIT. The CIIT travelled to the police station where the officer involved in the critical incident had been kept separate from any officer involved in the investigation of this incident. The CIIT arrived at 8 pm. The delay in attendance by the CIIT was caused by the distance the CIIT had to travel to reach the police station.

The CIIR included all details in terms of the times and actions taken by the NSWPF as a result of declaring the critical incident.

5.8 TIMELY ESTABLISHMENT OF A CRITICAL INCIDENT INVESTIGATION TEAM

5.8.1 WHAT DID THE GUIDELINES SAY?

Critical incidents are investigated by a CIIT. The 2007 Guidelines stated that one of the major implications of an incident being classified as a critical one was 'the timely formation of a critical incident investigation team (led by a commissioned officer) to conduct the investigation' (NSWPF 2007a, p. 2). When the Commission sought information as to *what are the time limits on the formation of a CIIT?* the NSWPF advised that the CIIT should be formed:

> as soon as practicable. Although the CIIT may not be able to attend immediately, action is taken to secure the scene and initiate mandatory testing. There is constant contact with the SCII while that officer is en route'.[116]

The region commander is responsible for forming the CIIT and 'will select the CIIT members according to an established protocol' (NSWPF 2007a, pp. 8, 20, 29). On receiving notification of a critical incident, the nominated SCII 'must immediately marshal a CIIT, identifying and addressing any conflicts of interest' (NSWPF 2007a, p. 20). The same responsibilities are reiterated in the 2012 and the 2016 Guidelines (NSWPF 2012a, pp. 15, 26, 27; NSWPF 2016a, pp. 12, 20).

5.8.2 WHAT DID THE COMMISSION FIND?

It is understandable that the logistics of forming a CIIT, and accordingly, the timeframe in which the CIIT can be formed, will differ with both the location and the nature of the critical incident. Noting that there is no specific time requirement by which a CIIT should be formed, only that it should be formed 'as soon as practicable', the question of compliance with the guidelines is not relevant. Rather, the Commission reviewed the documentation located on e@gle.i to see what it could learn about how long it takes in practice to 'marshal a CIIT'.

Documentation for 59 of the 83 strikeforces included information as to the date and time when the CIIT was formed.[117] For a further five strikeforces information was located on e@gle.i about the date but not the time when the CIIT was formed.

On the other hand, for 19 strikeforces, the Commission was unable to locate information on e@gle.i on either the date or time when the CIIT was formed.

Time between an incident being declared 'critical' and formation of CIIT

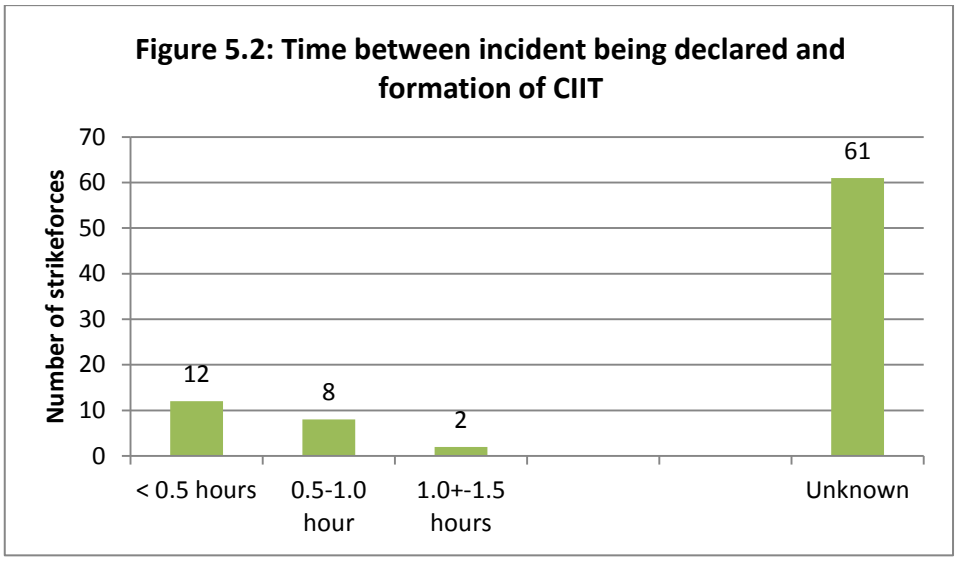
The Commission's audit identified 22 strikeforces that included information on both when the region commander declared an incident critical and when the CIIT was formed. As can be seen in Figure 5.2, for all 22 of these strikeforces the CIIT was formed within one and a half hours of the critical incident being declared.

However, most notable is that there was insufficient information located on e@gle.i to calculate the time taken to form the CIIT for 61 (73%) of the strikeforces.

---

116 Email received from NSWPF Professional Standards Command, 13 November 2012.

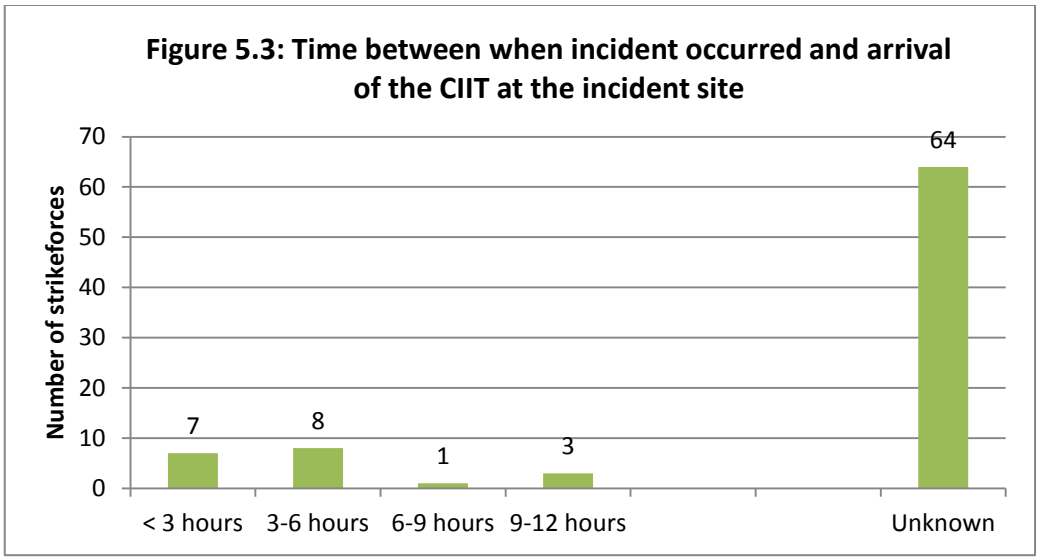
117 This information was recorded in the following range of documents: CIIRs (for 27 strikeforces); SCII statements (for 14 strikeforces); duty officer statements (for six strikeforces); review officer reports (for six strikeforces); statements provided by the members of the CIIT (for three strikeforces); log document created by the SCII (for one strikeforce), CAD details for (one strikeforce); 'summary of action [for a particular day]' created by a member of the CIIT (for one strikeforce).



Time between when a critical incident occurred and when members of CIIT arrived at incident site

The Commission's audit identified 19 strikeforces that included information on both the time when the critical incident occurred and the time when members of the CIIT arrived at the site of the incident. As can be seen in Figure 5.3, for all 19 of these strikeforces members of the CIIT arrived at the site within 12 hours of the incident. In half of these 19 strikeforces, the CIIT arrived at the incident site less than three-and-a-half hours after the incident occurred.

Once again most notable is that there was insufficient information located on e@gle.i to calculate the time taken for the CIIT to reach the site of the critical incident for 64 (77%) of the strikeforces.



5.9 OBSERVATIONS

One of the major risks in relation to critical incident investigations can occur when police officers do not recognise an incident as critical. In these circumstances critical incident protocols are not implemented. To mitigate this risk NSWPF critical incident guidelines include two requirements:

1. in instances where officers attending the scene of an incident are uncertain as to the extent of injuries received by a person, they are required to treat the incident as 'critical' until informed otherwise
2. region commanders must document their decision-making processes as to why they declared or did not declare an incident 'critical'.

The Commission conducted some additional research on the COPS database to attempt to identify instances that have been considered as potential critical incidents but where the NSWPF decided that they were not critical incidents. The purpose of doing this was to better understand why some incidents are not declared critical and how these decisions are documented. The results showed that there was limited information as to the decision-making processes and insufficient information to determine why some incidents were not classified as critical incidents. The Commission is unable to assess how many potential critical incidents have not been classified as critical incidents.

All three sets of guidelines specify that it is the responsibility of the region commander to declare an incident as 'critical' and to document their decision-making processes. However, the guidelines do not provide information or guidance where this decision and the reasons for the decision are to be recorded. The Commission's review of 83 strikeforces identified 52 strikeforces that included information as to the date and time when the region commander declared an incident as 'critical'. This information was recorded in 15 different types of documents. As mentioned previously, it is vital that an incident is declared 'critical' as soon as possible to ensure that NSWPF critical incident guidelines are being implemented. As such NSWPF decision-making processes in relation to critical incidents need to be clear, transparent and well documented.

6. INDEPENDENCE AND IMPARTIALITY OF THE INVESTIGATION

6.1 OVERVIEW

The 2007, 2012 and 2016 Guidelines make clear that one of the primary reasons for declaring a critical incident is to ensure the independence and impartiality of a critical incident investigation in circumstances where the actions of officers in the execution of their duty may have resulted in death of or serious injury to a person.

The 2007 Guidelines noted, 'the public interest arises from the element of doubt that the ensuing investigation, involving as it will the actions of a fellow officer, may not be conducted with absolute impartiality' (NSWPF 2007a, p. 1).

This chapter describes what the Commission learnt from an audit of documents located on e@gle.i regarding the strategies used by the NSWPF to ensure the impartiality and independence of the 83 strikeforces under review. More specifically it provides information relating to the level of compliance by the NSWPF with the following requirements:

- the appointment of an appropriately independent and commissioned officer[118] as senior critical incident investigator (SCII)
- the selection of an appropriately independent critical incident investigation team (CIIT)
- the consideration, identification and management of any conflicts of interest between the SCII and CIIT members with any officers, victims or suspects directly involved in the incident.

A related topic, the independent review of the critical incident investigation by a suitably experienced and independent review officer of senior rank, is discussed in Chapter 12.

Summary of findings

Choice of senior critical incident investigator

Of the 83 strikeforces reviewed, 80 (96%) complied with the requirement to choose a SCII from a local area command different to that of the involved officers and the incident location. Almost two-thirds of the SCIIs (63%) were commissioned officers with a rank of or above that of inspector.

Composition of critical incident investigation team

Of the 83 strikeforces reviewed, 73 (88%) complied with the requirement to choose CIIT members from a local area command different to that of the involved officers and the incident location.

[118] A 'commissioned officer' means a police officer of or above the rank of inspector.

Identification and management of conflicts of interest

Of the 83 strikeforces audited, 27 (33%) documented some consideration of the issue of conflicts of interest in at least one of the three critical incident report types (that is the critical incident investigation report, the review officer report or the region commander report).

6.2 WHY IS INDEPENDENCE AND IMPARTIALITY IMPORTANT IN CRITICAL INCIDENT INVESTIGATIONS?

The 2007 Guidelines outlined the importance of conducting critical incident investigations with independence and impartiality in the opening statement as follows:

> NSW Police is committed to demonstrating its professionalism by investigating all such incidents in an effective, accountable, and transparent manner. If public credibility is to be maintained, such incidents are most appropriately conducted independently. Accordingly, the identification of an incident as a 'critical incident' activates an independent investigative process to be conducted by a specialist and independent critical incident investigation team, and a review of that investigation by an independent review officer (NSWPF 2007a, p. 1).

This statement is reiterated in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 6; NSWPF 2016a, p. 6).

In the case of critical incidents where a member of the public or a police officer has died or sustained a serious injury as a result of police action, the public needs to be assured that:

- the investigation is conducted with absolute impartiality (NSWPF 2007a, p. 1)
- the facts and circumstances of these incidents will be thoroughly examined and reviewed by the NSWPF (NSWPF 2012a, p. 6)
- any wrongful conduct on the part of any members of the NSWPF is identified and dealt with (NSWPF 2007a, p. 1)
- consideration is given to improvements in NSWPF policy or procedure to avoid recurrences in the future (NSWPF 2007a, p. 1).

A failure to safeguard the independence and impartiality of a critical incident investigation may result in the following possible consequences:

- improper interference in the critical incident investigation by a SCII, CIIT member or review officer from the same local area command (LAC) as the incident and/or involved officers, or with an undisclosed conflict of interest, leaving the investigation open to one or more of the following:
    - failure to thoroughly examine and review the facts and circumstances of the incident

- failure to identify, prosecute and/or undertake management action for any wrongful conduct on the part of the involved officers
- failure to identify and consider any improvements to NSWPF policy or procedure

- involved officers may be vulnerable to criticisms that the investigation into their conduct was biased and lacking integrity
- the public may perceive the critical incident investigation, its findings and recommendations, to be tainted
- loss of public confidence in the ability of the NSWPF to independently conduct critical incident investigations.

6.3 WHAT INFORMATION DID THE COMMISSION CONSIDER?

The Commission considered information located on e@gle.i, in critical incident investigation reports (CIIRs) and through direct correspondence with the NSWPF in its assessment of whether the 83 critical incident investigations appropriately and adequately employed the strategies concerning impartiality and independence outlined in the 2007 Guidelines. This information was more specifically used to determine the following:

- the identification of the SCII, their LAC and whether this coincided with either the LAC where the incident occurred or the LAC where the involved officers were from
- the identification of the SCII and whether they were commissioned officers
- the identification of CIIT members, their LACs and whether this coincided with either the LAC where the incident occurred or the LAC where the involved officers were from
- whether the CIIR, review officer report and region commander report provided evidence that a critical incident investigation considered the issue of the identification and management of conflicts of interest.[119]

6.4 CHOICE OF SENIOR CRITICAL INCIDENT INVESTIGATOR

6.4.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that to avoid conflicts of interest during the critical incident investigation members of the CIIT must be drawn from:

- a different command to the one in which the incident occurred, and

[119] As the 2007 Guidelines provided no guidance as to where the identification and management of conflicts of interest should be recorded the Commission decided that the CIIR, review officer report and region commander report were the documents most likely to contain the information being sought.

- a different command to that of the involved officers (NSWPF 2007a, p. 29).

As the officer in charge of the CIIT the above criteria also applied to the SCII who must be, 'a commissioned officer…with demonstrated experience in investigating homicides, suspicious deaths and/or complex matters' (NSWPF 2007a, p. 29).[120] The 2012 and 2016 Guidelines reiterate these criteria for the selection of the CIIT and therefore the SCII as well (NSWPF 2012a, p. 16; NSWPF 2016a, p. 12).[121]

However, both the 2012 and 2016 Guidelines also provide an exception to the application of the criteria in the selection of the SCII and CIIT. The 2012 Guidelines noted:

> It is recognised that in remote locations, the investigation of the incident may be best served through the appointment of an independent experienced investigator from the same LAC as that of the directly involved officers or where the incident occurred. This decision must be made by the region commander and may be based on considerations such as the preservation of physical evidence, the welfare of the officers directly involved and the timeliness of the investigation itself. The region commander must be satisfied that there is no conflict of interest before such an appointment is made (NSWPF 2012a, p. 16).

The 2016 Guidelines restate the above advice, where in the case of a remote location, a SCII and CIIT may need to be drawn locally from the LAC of the involved officers or where the incident occurred (NSWPF 2016a, p. 13).

6.4.2 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement for the SCII to be a commissioned officer and chosen from a command different to that of the involved officers and the location of the incident, to be applicable in all 83 strikeforces.

As can be seen in Table 6.1 below, 96% of the 83 strikeforces complied with the requirement to choose a SCII from a local area command different to that of the involved officers and the incident location. Almost two-thirds of the SCIIs (63%) were commissioned officers with a rank of or above that of inspector.

120 Although the 2007 Guidelines did not directly stipulate that the above criteria applied to the selection of the SCII, as the officer in charge of the CIIT it is reasonable to assume that the same criteria would be required in choosing a SCII to lead the CIIT.

121 The 2012 and 2016 Guidelines do not require the SCII to be a 'commissioned' officer, however, they do state that the CIIT should be led by a 'suitably experienced' investigator (NSWPF 2012a, p. 15; NSWPF 2016a, p.12).

Table 6.1: Summary of compliance with requirements for selection of SCII

Requirements for selection of SCII	%	Number				
	% of strikeforces on e@gle.i that that complied[122]	Total strikeforces reviewed[123]	Evidence strikeforces complied	Evidence strikeforces did not comply	Unable to assess available information	Strikeforces where Investigative action not applicable
SCII chosen from different local area command to where incident occurred	**99%**	83	82	1	0	0
SCII chosen from different local area command to that of the involved officer(s)	**98%**	83	81	2	0	0
SCII chosen from different local area command both to where incident occurred and to that of the involved officer(s)	**96%**	83	80	3	0	0
SCII appointed was a commissioned officer	**63%**	83	52	31[124]	0	0

122 Calculated by dividing [(the number of strikeforces where evidence of compliance was located on e@gle.i) by (the number of strikeforces for which the requirement was applicable)] x 100.

123 Of the 125 NSWPF critical incidents understood to have occurred from 1 January 2009-30 June 2012, 83 critical incidents had records pertaining to their investigation stored on the NSWPF investigative information management system 'e@gle.i'. These records were stored under the investigation 'strikeforce' name. Documents for all 83 strikeforces were examined for information concerning compliance for each of the requirements.

124 Of the 31 strikeforces where there was evidence the rank of the SCII was below that of a 'commissioned officer', the ranks of the SCIIs ranged from detective senior constable to detective senior sergeant.

The case study below describes the circumstances of the strikeforce where the appointed SCII was from the same local area command as an involved officer.

> In the early hours of a morning in 2012, officers from a metropolitan command directed the driver of a stolen vehicle, stopped in heavy traffic on a major road, to pull over. The vehicle did not stop and proceeded to drive up onto the footpath colliding with two pedestrians.
>
> As police attempted to stop the stolen vehicle, one of the pedestrians was carried some distance on the bonnet of the car before it braked, causing the pedestrian to fall under the car. As the vehicle accelerated police discharged their firearms at the vehicle, hitting the driver and the front passenger in the vehicle. The four passengers in the rear of the stolen vehicle were unhurt.
>
> A critical incident was declared by the region commander and a CIIT and SCII appointed.
>
> The SCII chosen to lead the critical incident investigation was from the same local area command as one of the involved officers. However, the involved officers were from six
>
> metropolitan commands making it difficult to assign a SCII from a command that was different from the commands of all the involved officers.

6.5 COMPOSITION OF CRITICAL INCIDENT INVESTIGATION TEAM

6.5.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that to avoid conflicts of interest during the critical incident investigation members of the CIIT must be drawn from:

- a different command to the one in which the incident occurred, and
- a different command to that of the involved officers (NSWPF 2007a, p. 29).

The 2012 and 2016 Guidelines reiterate these criteria for the selection of the CIIT (NSWPF 2012a, p. 16; NSWPF 2016a, p. 12).

However, the 2007 Guidelines also outlined the possibility for critical incident investigations to be conducted locally in exceptional circumstances:

> On occasion, and having regard to the full circumstances of the incident, the public interest may be served through the implementation of an arrangement falling short of a CIIT. For example, the Region Commander may appoint an independent officer to monitor an investigation conducted locally (NSWPF 2007a, p. 29).

No further guidance was provided in the 2007 Guidelines to explain the specific circumstances under which such an exception would need to be made.

Both the 2012 and 2016 Guidelines state that in the case of remote locations the CIIT may need to be drawn locally from the LAC of the involved officers or where the incident occurred (NSWPF 2012a, p. 16; NSWPF 2016a, p. 13).

6.5.2 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement for CIIT members to be chosen from a command different to that of the involved officers and the location of the incident, applicable in all 83 strikeforces.

As can be seen in Table 6.2 below, 88% of the 83 strikeforces reviewed complied with the requirement to choose CIIT members from a local area command different to that of the involved officers and the incident location.

Table 6.2: Summary of compliance with requirements for selection of CIIT members

Requirements for selection of CIIT	%	Number				
	% of strikeforces on e@gle.i that complied[125]	Total strikeforces reviewed[126]	Evidence strikeforces complied	Evidence strikeforces did not comply	Unable to assess available information	Strikeforces where lestigative action not applicable
CIIT chosen from different local area command to where incident occurred	**93%**	83	77	6	0	0
CIIT chosen from different local area command to that of the involved officer(s)	**94%**	83	78	5	0	0
CIIT chosen from different local area command both to where incident occurred and to that of the involved officer(s)	**88%**	83	73	9[127]	0	0

6.6 IDENTIFICATION AND MANAGEMENT OF CONFLICTS OF INTEREST

6.6.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines made clear that in addition to ensuring the SCII and CIIT were drawn from different commands to that of the involved officers and incident location, other possible conflicts of interest must also be identified, declared and appropriately managed during the course of the investigation (NSWPF 2007a, p. 20). Such conflicts of interest may include financial or personal associations with officers, victims or suspects directly involved in the incident.

The identification and management of conflicts of interest was addressed in a number of different sections of the 2007 Guidelines. The region commander, when determining whether to classify a matter as a critical incident was asked to consider 'any actual or perceived conflicts of interest that may preclude local resources from investigating the matter' (NSWPF 2007a, pp. 7-8).

125 Calculated by dividing [(the number of strikeforces where evidence of compliance was located on e@gle.i) by (the number of strikeforces for which the requirement was applicable)] x 100.

126 Of the 125 NSWPF critical incidents understood to have occurred from 1 January 2009-30 June 2012, 83 critical incidents had records pertaining to their investigation stored on the NSWPF investigations management system 'e@gle.i'. These records were stored under the investigation 'strikeforce' name. Documents for all 83 strikeforces were examined for information concerning compliance for each of the requirements.

127 The total number of strikeforces that did not comply in this category (9), does not match the combined total number of strikeforces that did not comply in the other two categories in Table 6.2 (11). This is due to two strikeforces where the CIIT was chosen both from the same command as the involved officers and the location of the incident.

As the senior investigator in charge of the critical incident investigation team the SCII was, under these guidelines, directed to consider:

> how any conflicts of interest within the team will be identified and managed. Conflicts of interest can take many forms and include officers having personal or financial relationships with any officers, victims or suspects directly involved in the incident. Any undisclosed areas of conflict may lead to a perception that the investigation is tainted and have serious consequences, so officers must be encouraged to discuss any relevant conflict issues with the SCII. The SCII should work with the officer concerned to resolve any conflicts of interest including, if necessary, removing the officer from the investigation. The object of this action is to always protect the integrity of the investigation and the welfare of the officer concerned (NSWPF 2007a, p. 20).

More specific advice concerning the identification and management of conflicts of interest within the CIIT was outlined as follows:

> To manage conflicts of interests, they must be:
>
> - identified, including any actual, potential or perceived conflict of interests
> - determined by prior positive or negative associations
> - considered in terms of real or perceived impact upon the investigation
> - addressed in terms of risk management protocols and treatment options (NSWPF 2007a, p. 30).

No specific advice was provided in the 2007 Guidelines regarding how and where the identification and management of conflicts of interest were to be recorded.

The 2012 and 2016 Guidelines reiterate the above guidance found in the 2007 Guidelines (NSWPF 2012a, pp. 15-16, 26; NSWPF 2016a, pp. 12, 20). Both, however, also outline additional requirements for the SCII, CIIT and review officer in identifying and managing conflicts of interest.

The 2012 Guidelines stated that to manage conflicts of interest, the following must occur:

- Conflicts should be declared and documented utilising the attached P1103, *Critical incident – conflicts of interest declaration form.*[128]
- Each member of the CIIT must complete and sign the form, even where nil conflict is declared.

[128] The P1103, Critical incident – conflicts of interest declaration form is attached at the end of both the 2012 and 2016 Guidelines (NSWPF 2012a, p. 64; NSWPF 2016a, p. 51).

- 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.

- 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* (NSWPF 2012a, p. 27).

This advice is repeated in the 2016 Guidelines but introduced with the more forceful statement: 'No officer should investigate a critical incident with an undisclosed or unresolved conflict of interest' (NSWPF 2016a, pp. 20-21).

The 2012 and 2016 Guidelines also provide an expanded section regarding the review officer's responsibilities in monitoring the identification and management of conflicts of interest by the SCII, stating:

> The review officer will need to maintain close communication with the SCII during the course of the investigation and discuss any integrity concerns that may arise. If a probity issue is identified (e.g. non adherence to policies or procedures; conflicts or any other issue that may potentially impact the integrity of the investigation) the review officer should raise the matter immediately with the SCII. The discussion should take place in private, away from any witnesses or other investigators. If the matter cannot be resolved, the review officer is required to immediately report the matter via their chain of command for resolution (NSWPF 2012a, p. 35; NSWPF 2016a, p. 26).

The additional direction given below to the review officer in the 2012 Guidelines (NSWPF 2012a, pp. 36-37) is repeated in similar language in the 2016 Guidelines (NSWPF 2016a, p. 26):

> Review officers should monitor and review (including and not limited to matters such as) the following....
>
> - No conflict of interest was identified in the critical incident investigation or any conflicts identified were appropriately managed.

The 2012 Guidelines noted that the review officer should also:

- Liaise with the SCII and confirm the completion of the P1103, *Conflicts of interest declaration form*. Review any treatment strategies suggested by the SCII to address declared conflicts and risks. If a potential conflict is declared by the SCII, develop an appropriate treatment strategy which is to be recorded on the declaration form.

- Complete a separate conflict of interest declaration form. Where a conflict or risk is identified for a member of the review officer's team, develop and record a treatment strategy on the declaration

> form. If the review officer declares a conflict or identifies a risk, treatment strategies are to be discussed with the relevant region commander (NSWPF 2012a, p. 36).

The 2016 Guidelines repeat this advice but include it in the review officer checklist attached at the end of the main document (NSWPF 2016a, p. 41). Both the 2012 and 2016 Guidelines include a template for the review officer report not included in the 2007 Guidelines, in which space is provided under the title 'Review officer's general comment' where any issues concerning conflicts of interest can be raised (NSWPF 2012a, p. 63; NSWPF 2016a, p. 49).

6.6.2 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement to appropriately declare, identify and manage conflicts of interest by the CIIT and SCII applicable in all 83 strikeforces audited.

However, since the 2007 Guidelines provided no specific advice regarding how conflicts of interest should be identified and recorded, the Commission determined that the CIIR, review officer report and region commander report were the documents most likely to contain the relevant information. In its review of the 83 strikeforces the Commission sought to ascertain whether the CIIR, review officer report and region commander report mentioned whether they had considered the identification and management of conflicts of interest.

Given the stated importance of maintaining transparency, independence and impartiality the Commission expected that at least one of the three reports would outline the process used to identify whether or not any conflicts of interest had arisen. This might include the SCII addressing conflicts of interest with the CIIT during the initial handover briefing or discussions with individual members of the CIIT and the review officer.[129]

As can be seen in Table 6.3, only 10% of the 83 strikeforces documented any consideration of the identification and management of conflicts of interest in the CIIR. The review officer report raised the issue of the consideration of the identification and management of conflicts of interest in only 25% of the 83 strikeforces. None of the 27 region commander reports located on e@gle.i made mention of the issue of conflicts of interest at all.

[129] The 2007 Guidelines did not provide any advice concerning what steps or processes could be used to identify and manage conflicts of interest by either the CIIT or the SCII.

Table 6.3: Summary of the number of strikeforces that documented consideration of conflicts of interest in the CIIR, review officer report and region commander report

Report type reviewed	%	Number			
	% of strikeforces on e@gle.i that considered conflicts of interest[130]	Total applicable strikeforces[131]	Evidence strikeforces considered conflicts of interest[132]	Strikeforces where there was no evidence that conflicts of interest were considered[133]	Information unable to be located on e@gle.i[134]
Strikeforces that documented consideration of conflicts of interest in the CIIR	**10%**	83	8	60	15
Strikeforces that documented consideration of conflicts of interest in the review officer report	**25%**	83	21	35	27
Strikeforces that documented consideration of conflicts of interest in the region commander report	**0%**	83	0	27[135]	56

When looking at how many strikeforces documented consideration of the issue of the identification and management of conflicts of interest across all three critical incident report types the results were as follows. Of the 83 strikeforces reviewed:

- 27 strikeforces (33%) documented consideration of the issue of conflicts of interest in one or more of the three critical incident report types[136]
- 14 strikeforces (17%) did not document consideration of the issue of conflicts of interest in any of the three critical incident report types

130 Calculated by dividing [(the number of strikeforces where evidence of consideration of conflicts of interest was located on e@gle.i) by (the number of strikeforces for which the requirement was applicable)] x 100.

131 Total applicable investigations = (83 strikeforces reviewed) less (number of strikeforces where requirement was not applicable)

132 A strikeforce was placed in this category if it explained the process of identifying and/or managing conflicts of interest during the critical incident investigation, whether there were conflicts of interest or not.

133 A strikeforce was placed in this category if the relevant report made no reference to or consideration of whether or not conflicts of interest had been identified and/or managed.

134 A strikeforce was placed in this category if the relevant report was not located on e@gle.i.

135 Of the 27 strikeforces with some form of region commander report, 20 consisted solely of a signature and/or a brief comment by the region commander on either the review officer report or a report prepared by the region professional standards manager. Only seven strikeforces had a standalone report prepared and signed by the region commander.

136 This category seeks to identify the total number of strikeforces that provided evidence of consideration of the issue of conflicts of interest in one or more report types. Therefore, the number of strikeforces placed in this category does not match the combined total of strikeforces in Table 6.3 that provided evidence the issue of conflicts of interest were considered separately in the CIIR and the review officer reports. This is due to the fact that two strikeforces provided evidence of the consideration of the issue of conflicts of interest in both the CIIR and the review officer report.

- 13 strikeforces (16%) could not be assessed as none of the three critical incident report types could be located on e@gle.i
- 17 strikeforces (20%) had one report which was not located on e@gle.i and two reports which did not consider the issue of conflicts of interest
- 12 strikeforces (14%) had two reports which were not located on e@gle.i and one report which did not consider the issue of conflicts of interest.

Of the 27 strikeforces that did document their consideration of whether or not members of the CIIT had a conflict of interest:

- 25 strikeforces addressed the issue of conflicts of interest in one of the three critical incident report types
- two strikeforces addressed the issue of conflicts of interest in both the CIIR and review officer report but not the region commander report.[137]

The case study below outlines the circumstances of a strikeforce where the review officer report noted a conflict of interest identified by a CIIT member that was not raised by the SCII in the CIIR.

> This strikeforce concerned a man armed with a knife who died in a metropolitan shopping centre in 2012, after being pursued, confronted and shot by a police officer. Earlier that day the man had allegedly been involved in an armed robbery and theft of a vehicle which initiated a foot and vehicle pursuit by police.
>
> Once a critical incident was declared by the region commander, a SCII and CIIT were appointed from the Homicide Squad of State Crime Command. The SCII noted in the CIIR that no conflict of interest arose during the investigation. However, this statement was contradicted in the review officer report which noted that early in the investigation a conflict of interest was identified by a member of the CIIT who had a personal friendship with the involved officer. The CIIT officer removed himself from the CIIT to ensure the integrity of the critical incident investigation.

The following case study outlines the circumstances of a strikeforce where the review officer identified his own conflict of interest in the review officer report (being a duty officer from the command where the critical incident occurred). However the review officer did not further explain how the conflict was managed.

[137] In one of these two strikeforces, the CIIR and review officer report made conflicting statements regarding the identification of conflicts of interest, with the CIIR failing to note a conflict of interest later identified in the review officer report.

Early one evening in 2009, police officers from a metropolitan command engaged in a vehicle pursuit of two people in a van, who were suspected of having committed two armed robberies that afternoon. The police pursuit of the van was lengthy and involved a number of different police vehicles as well as the assistance of a police helicopter. During the pursuit, the alleged offenders' vehicle moved onto the wrong side of the road a number of times. In attempting to gain entry to the highway using an entry ramp the van swerved to miss two vehicles and subsequently hit another vehicle with three occupants. As a result of the collision one of the passengers in the vehicle hit by the van received severe head injuries and died. Shortly after the collision police officers arrested the two men as they attempted to flee the scene on foot. A critical incident was declared by the region commander that evening.

The duty officer from the local command where the incident took place was assigned responsibility for management of the incident scene as well as being appointed the review officer for the critical incident investigation, contrary to the 2007 Guidelines. In the review officer report the review officer identified and acknowledged this conflict of interest. However, no explanation was given as to how this conflict of interest was managed and whether the SCII or the region commander were informed. Neither the CIIR nor the region commander report were located on e@gle.i to determine if this conflict of interest was known and managed by the region commander.

The case study below describes the circumstances of a strikeforce where the review officer clearly stated in the review officer report that each of the SCII, CIIT and review officer had no conflicts of interest with the involved officers.

After midnight in 2011, two police officers responded to a report of a break in and an assault in progress at a suburban family home. The two officers, upon arriving at the location of the reported incident, were mistakenly identified by a resident as the offenders. Under this false apprehension the resident ran towards the officers armed with a makeshift weapon and was subsequently shot and injured by one of the police officers.

A critical incident was declared by the region commander and a CIIT and SCII appointed from a different command to that of the involved officers and the incident location. Although the SCII did not comment at all in the CIIR as to whether any conflicts of interest had been identified, the review officer report provided a clear and unambiguous statement that 'the directly involved officers were not previously known to the SCII, CIIT, Review Officer or Assistant Review Officer.'

Where no conflicts of interest have been identified, providing a clear and unambiguous statement as exemplified in the above review officer report, indicates that conflicts of interest were actively considered by the SCII, CIIT and review officer and supports the transparency of the critical incident investigation overall.

6.7 OBSERVATIONS

The 2007 Guidelines, whilst directing the SCII to consider the identification and management of conflicts of interest, did not clearly state how such considerations were to be undertaken and where they should be recorded (NSWPF 2007a, pp. 20, 30). Nor did the 2007 Guidelines outline the appropriate procedure if a review officer or SCII were to declare a conflict of interest.

Without specific guidance or direction, the recording and management of conflicts of interest during a critical incident investigation can be inconsistent or incomplete and may impair the transparency and independence of the critical incident investigation itself. This can be seen in the Commission's finding that only 33% of the 83 strikeforces considered the issue of conflicts of interest in at least one of the three critical incident report types.

This concern is partly addressed in the 2012 and 2016 Guidelines which incorporate significant additional guidance and requirements regarding the recording of conflicts of interest with the introduction of a 'Critical Incident – conflicts of interest declaration form' (NSWPF 2012a, p. 27; NSWPF 2016a, p. 20). The P1103, *Conflicts of interest declaration form*, is attached to the 2016 Guidelines and is essentially a blank table with the following four headings: Investigating Officer, Potential/Declared Conflict, Treatment Strategy and Investigator's Signature and date (NSWPF 2016a, p. 51).

The 2016 Guidelines also provide the following specific guidance:

> The SCII should work with the officer concerned to resolve any conflicts of interest including, if necessary, removing the officer from the investigation. Independence is the key to the successful CIIT. No officer should investigate a critical incident with an undisclosed or unresolved conflict of interest.
>
> To manage conflicts of interest in this process, the following steps must be followed:
>
> - Actual or perceived conflicts should be declared and documented utilising the attached P1103, *Critical incident - conflicts of interest declaration form*
> - Each member of the CIIT must complete and sign this form, regardless of whether a conflict is declared
> - 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
> - 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 (NSWPF 2016a, pp. 20-21).

In addition, the 2016 Guidelines provide guidance to the review officer concerning their role in monitoring and recording the management of conflicts of interest by the SCII as previously outlined.

Of particular interest is that the 2016 Guidelines direct the review officer to complete a conflict of interest declaration form. Additionally, the review officer report template provided at the end of the 2016 Guidelines contains a section entitled 'Review officers General Comment' where the review officer is guided to comment on matters such as:

> - no conflict of interest was identified in the critical incident investigation or if a conflict was identified that it was appropriately managed' (NSWPF 2016a, p. 49).

In addition, although the 2016 Guidelines direct the SCII and review officer to 'resolve' any conflicts of interest identified through the use of 'treatment strategies', there is no clear outline of what possible treatment strategies are open to the SCII and review officer, other than 'removing the officer from the investigation' (NSWPF 2016a, pp. 20-21). Some further advice detailing the relevant treatment strategies available to the review officer and SCII, once a conflict of interest has been identified, may assist in providing a more consistent approach to managing conflicts of interest.

An additional concern is the equivocal language used in the 2016 Guidelines which makes it difficult to determine whether the guidance concerning the management of conflicts of interest is mandatory or merely a suggestion to be considered by NSWPF officers.

The 'Essential Summary' at the beginning of the 2016 Guidelines notes there are both mandatory and optional actions raised in the 2016 Guidelines:

> Whilst some actions are mandatory in all critical incident investigations, the guidelines include information concerning resources and suggested investigative strategies that may not be necessary in all circumstances. Actions taken may differ, depending upon the exact nature, location, time, or other circumstances of the incident (NSWPF 2016a, p. 2).

However, the 'Commissioner's Message' emphasises the discretionary nature of the 2016 Guidelines:

> These guidelines have been developed to assist officers by providing an outline of the actions to be considered when managing, investigating and reviewing critical incidents. These guidelines are not an exhaustive instruction for investigators and have been developed to assist through the provision of suggested investigative processes that may be employed in the investigation of these matters (NSWPF 2016a, p. 6).

Given the above statements and without clear direction as to which investigative actions are mandatory and which are discretionary, an assumption could be made by NSWPF officers that the procedures for managing and recording conflicts of interest are optional rather than obligatory.

7. HANDOVER BY DUTY OFFICER OF INCIDENT SCENE TO SENIOR CRITICAL INCIDENT INVESTIGATOR

7.1 OVERVIEW

According to the 2007 Guidelines not only did the investigation of the critical incident need to be impartial, the investigation had to be conducted in 'an effective, accountable and transparent manner' and the 'decisions made and processes used' had to be 'appropriate and reasonable' (NSWPF 2007a, p. 1).

The 2007 Guidelines outlined a number of key investigative processes to ensure initial critical incident protocols at the incident scene were implemented, transparent and accountable. One of these processes was the appropriate handover of management of the incident scene from the duty officer to the senior critical incident investigator (SCII) (NSWPF 2007a, pp. 19, 21).

More specifically, the 2007 Guidelines required the following three actions to enable the appropriate handover of management of the incident scene:

1. The presence of an appropriate duty officer to take control of the scene of the critical incident prior to arrival of the SCII
2. The maintenance of a running sheet by the duty officer recording decisions made and directions given at the incident scene
3. The handover of the duty officer running sheet to the SCII.

This chapter describes what the Commission learnt from an audit of documents located on the NSWPF e@gle.i system about how these three actions were carried out for the 83 strikeforces under review. Each of these actions is described in a separate section of this chapter. The following information is outlined for each of these investigative actions:

- What did the guidelines say?
- What is the risk to the investigation if the guidelines are not followed?
- What did the Commission find?

Finally, the chapter will highlight the limited guidance provided to the SCII regarding the recording of the critical incident investigation after the handover of the incident scene. Unlike the duty officer, the SCII was not specifically required by the 2007 Guidelines to maintain a running sheet. This section will consider the utility of requiring the SCII to maintain a running sheet to ensure the critical incident investigation is adequately recorded.

Other investigative actions required to ensure the implementation, transparency and accountability of critical incident protocols are discussed in subsequent chapters as follows:

- steps to preserve the scene of the critical incident are discussed in Chapter 8
- the identification and obtaining information from involved officers and other witnesses are considered in Chapter 9
- exhibit handling is described in Chapter 10
- mandatory drug and alcohol testing is described in Chapter 11.

Summary of findings

Presence of an appropriate duty officer

- For 66 (84%) of the 79 applicable strikeforces, evidence of the presence of an appropriate duty officer was located on e@gle.i.
- For eight (10%) of the 79 applicable strikeforces, evidence was found of non-compliance with the 2007 Guidelines, where the duty officer was either an 'involved officer' (seven strikeforces) or where a duty officer was not present at the incident scene (one strikeforce).
- For five (6%) of the 79 applicable strikeforces, the Commission was unable to locate any documents on e@gle.i to establish the identity of the duty officer and was unable to locate any documents on e@gle.i that could be attributed to a duty officer.

Maintenance of a duty officer running sheet

- For 25 (32%) of the 79 applicable strikeforces, there was evidence that the investigation complied with the NSWPF critical incident guidelines by maintaining a duty officer running sheet.
- For 54 (68%) strikeforces, the Commission was unable to locate evidence on e@gle.i to confirm that a duty officer running sheet had been maintained.
- In only four (5%) of the 79 applicable strikeforces could it be confirmed that the duty officer running sheet had been handed over to the SCII at the incident scene.

7.2 DOCUMENTS REVIEWED AS PART OF AUDIT

The Commission commenced by reviewing, where available, critical incident investigation reports (CIIRs), duty officer statements and duty officer running sheets to establish if the requirements of the 2007 Guidelines in relation to the incident scene handover were recorded in any of these documents. If this information was not recorded in any of these documents, the Commission reviewed a number of additional documents[138] located on e@gle.i, most notably:

- review officer reports

138 The Commission reviewed a large number of documents that related to critical incident investigations and established that these documents were the most likely ones to contain the sought information.

- region commander reports
- SCII statements
- investigation running sheets
- situation reports.

The Commission relied solely on documents located on e@gle.i in its audit and subsequent assessment of compliance with certain aspects of the 2007 Guidelines.

7.3 PRESENCE OF APPROPRIATE DUTY OFFICER PRIOR TO ARRIVAL OF THE SCII

7.3.1 WHAT DID THE GUIDELINES SAY?

The duty officer plays a decisive role in initiating and completing key investigative actions prior to the arrival of the SCII and critical incident investigation team (CIIT) by taking initial command of the incident scene. These early investigative actions are vital in minimising any potential loss or contamination of information and evidence pertaining to the critical incident.

The 2007 Guidelines stated:

> A Duty Officer from the LAC where the incident occurred will be required to attend the scene of the incident and assume command of the scene, until relieved by the Local Area Commander or senior critical incident investigator (SCII). If the Duty Officer is an involved officer, another Duty Officer from a neighbouring LAC should undertake the relevant roles and functions. In country / remote areas, the next most senior officer in the LAC in which the incident occurred should perform the relevant tasks until relieved by the SCII (NSWPF 2007a, p. 17).

The above guidance was followed by a list of specific actions required of the duty officer upon arrival at the incident scene and included taking necessary action to preserve life and to ensure the safety of police and others; advising the duty operations inspector (DOI); commencing a running sheet noting relevant information including decisions made and directions given. Other additional but important responsibilities of the duty officer included:

- keep involved officers and other witnesses separated and ensure the evidence of these people is not cross-contaminated
- request involved officers to immediately and independently record observations in their notebook
- if possible obtain and record a version of events from an independent witness prior to speaking to involved officers
- identify any police and civilian vehicles involved in the critical incident and ensure that they remain in situ for later examination
- where the incident involves the discharge of a police firearm, arrange for the removal, labelling and independent security of appointment belts and

contents from involved officers for examination by the Forensic Ballistics Investigations section (NSWPF 2007a, pp. 17-18).

These responsibilities remain unchanged in the 2012 and 2016 Guidelines (NSWPF 2012a, pp. 23-24; NSWPF 2016a, pp. 19, 32-33).

7.3.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

In instances where a duty officer arrives late at the critical incident site or is not present at all there is the risk that key initial investigative actions may not be completed or recorded leading to:

- the incident scene not being preserved
- potential cross-contamination of evidence by witnesses and directly involved police officers, including possible collusion of involved officers in relation to the circumstances that led to the critical incident
- police firearms and appointment belts not being secured for forensic testing
- a version of events from independent witnesses not being recorded prior to the SCII and CIIT speaking with the involved officers
- drug and alcohol testing not being conducted on involved officers.

In addition there is the risk that an appropriate handover of the incident scene to the SCII may not occur and that the SCII is not thoroughly briefed on the status of actions to be completed at the critical incident scene. Ultimately both risks can result in the possible loss or contamination of information concerning the critical incident, limiting the effectiveness of the investigation.

7.3.3 WHAT DID THE COMMISSION FIND?

The Commission expected a duty officer would be present to take control of the incident prior to the arrival of an SCII in 79 of the 83 strikeforces examined. In the remaining four critical incidents a delay in declaring the event to be a critical incident precluded the presence of a duty officer at the incident scene.[139]

Of the 79 strikeforces where the presence of a duty officer was required:

- for 66 (84%) strikeforces, evidence of the presence of an appropriate duty officer was located on e@gle.i, that is, the investigation **complied** with the 2007 Guidelines[140]

---

139 For all four strikeforces the type of incident was such that a duty officer would not automatically be required to attend the scene unless a critical incident had been declared (e.g. an attempted suicide, minor injuries sustained during an arrest). Therefore the significant delay in declaring these incidents to be a 'critical incident' precluded the presence of a duty officer at the incident scene.

140 A strikeforce was placed in this category if documents on e@gle.i were located which stated that the duty officer was present at the incident scene.

- for eight strikeforces evidence was found of **non-compliance** with the 2007 Guidelines, where the duty officer was an 'involved officer' (seven strikeforces) or where a duty officer was not present and also no information located as to why there was no duty officer (one strikeforce)[141]
- for five strikeforces the Commission was **unable to locate any documents** on e@gle.i to establish the identity of the duty officer nor was it able to locate any documents on e@gle.i that could be attributed to a duty officer.

Outlined in the case study below are the circumstances of a strikeforce where an involved officer in a critical incident has also acted in the role of a duty officer.

In late 2010 police were called to a regional location by a nurse who expressed concern for the welfare of a man she had attended to earlier in the day. A short time later the man was observed to be sitting on the edge of a rock. Some concerned bystanders contacted police who arrived at the location soon after. Police commenced negotiations with the man who had moved from the rock ledge onto the cliff face where he became stuck. Police rescue operators continued their negotiations. When the man requested assistance, police abseiled down the cliff face to render assistance. However, the man panicked when police approached, moved away and fell to his death.

The duty officer was present when the man fell off the cliff and was listed as an 'involved officer' in the CIIR. According to the duty officer's statement the duty officer initiated the following actions prior to the man falling from the cliff:

- established a command post
- commenced an operation log
- briefed the Police Rescue Squad of the situation
- formulated an action plan with the Police Rescue Squad and Ambulance SCAT[142]
- briefed the police negotiator who arrived at the scene of the situation.

The duty officer statement provided information as to the following actions taken by the duty officer after the man had fallen from the cliff:

- contacted the duty operations inspector and advised him/her of the incident
- contacted the commander of the LAC where the incident had occurred and informed him of the situation
- gathered all involved officers in the incident and directed them not to discuss the specifics of the incident (the duty officer statement mentions that the duty officer was of the view that this matter would be declared a critical incident)
- briefed the commander of the LAC on the commander's arrival at the scene
- briefed the senior critical incident investigator via phone of the situation
- left the scene and returned to the police station.

The duty officer was present while the critical incident unfolded and, according to critical incident guidelines, was therefore an involved officer. There was a potential

141 A strikeforce was placed in this category if evidence was found on e@gle.i identifying the duty officer present at the incident scene as an involved officer or where a duty officer was declared not present at the incident scene and no reason was provided as to why.

142 SCAT refers to the Specialist Casualty Access Team of the Ambulance Service of NSW, who have specialist skills in survival, canyoning and navigation to treat patients and assist in rescue operations in remote areas and/or difficult environmental conditions.

conflict of interest insofar as it can be argued that the duty officer was also an involved officer.

However, whilst technically an 'involved' officer, the limited level of involvement by the duty officer prior to the incident minimised the potential risk of a conflict of interest.

The case study above reveals the difficulty in strictly complying with the direction that the duty officer managing the critical incident scene must not be an involved officer.

Firstly, it is not always clear immediately after an incident has occurred whether it is a critical incident requiring an independent duty officer. Secondly, the level of involvement in a critical incident by duty officers deemed to be 'involved officers' can often be quite limited, especially in circumstances where the victim was injured or died from self-harm. In the seven strikeforces where the duty officer was found to be an involved officer, the victim had been injured or died from self-harm, thereby minimising the risk from a possible conflict of interest. Finally, given the time-sensitive nature of completing initial critical incident tasks, it is not always practical or possible to secure the attendance of a non-involved duty officer.

Outlined in the case study below are the circumstances of the strikeforce where it appears that no duty officer was present at the site of the critical incident.

Early one morning in mid-2009 police from a metropolitan command responded to a report of an armed robbery in progress at a hotel, in which a man armed with a gun had taken several people hostage.

Upon arrival at the scene police officers entered the hotel and on sighting the armed offender one officer deployed a taser hitting the man in the chest area. The offender remained unhurt and fired a number of shots at police, hitting one of the officers in the shoulder. Police returned fire during which the offender was hit three times in the leg, abdomen and head. The offender, although wounded, remained inside the hotel with the hostages whilst police negotiators commenced a dialogue. The siege was successfully resolved when the tactical operations unit entered the hotel and arrested the offender.

A Commission audit of documents located on e@gle.i did not identify any evidence that a duty officer was present at the site nor any information explaining why no duty officer was present. The CIIR made no mention of a duty officer being present at the critical incident site, nor did the review officer report.

Without a duty officer present critical incident protocols were not enacted and involved officers were not separated immediately after the incident. This resulted in the involved officers being able to freely discuss the incident with each other, thereby contaminating their evidence.

7.4 MAINTENANCE OF DUTY OFFICER RUNNING SHEET PRIOR TO THE ARRIVAL OF THE SCII

7.4.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that, amongst other actions, the duty officer was required to:

> commence a running sheet/log. Note relevant information, including decisions made and directions given (NSWPF 2007a, p. 17; NSWPF 2012a, p. 23).

A template for the running sheet/log[143] was provided at the end of the 2007 Guidelines (NSWPF 2007a, p. 43). The template consisted of a table with three blank columns labelled respectively 'Time', 'Actions' and 'Result'. Above the table the author was prompted to provide information regarding the 'Incident', 'Location' and 'Time/Date'. A space was also provided to reference any relevant NSWPF 'Radio Channel'. A very similar template for the running sheet was provided at the end of the 2012 Guidelines (NSWPF 2012a, p. 42).

In contrast, the requirement for the duty officer to maintain a running sheet is not mentioned in the 2016 Guidelines. Instead, the following action is required to be taken as outlined in 'Appendix 3 – Checklist – Duty Officer':

> Document all action taken, advice given and create file notes of all relevant conversations (NSWPF 2016a, p. 32).

However, the 2016 Guidelines provide no additional guidance as to where or how the duty officer should document the above information and no template is provided for a running sheet.

7.4.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

The duty officer running sheet is essential to ensuring that the completion of initial critical incident protocols is recorded thereby reinforcing the transparency of the critical incident investigation.

Failure by the duty officer to maintain a running sheet can result in the inability of the SCII, review officer and any external oversight officer to:

- determine which investigative actions had been completed by the duty officer (such as the separation of involved officers, preservation of the incident scene and notifying the Duty Operations Inspector)
- verify which investigative decisions were made by the duty officer and what directions were given to attending police at the incident scene prior to the arrival of the SCII.

[143] The 'running sheet' can be referred to and labelled by police officers with a variety of titles. In the audit of the 83 strikeforces other titles used to label the running sheet included: 'Investigation Log', 'Investigation Chronology', 'Notes,' and 'Operation Log'.

7.4.3 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement to maintain a duty officer running sheet to be applicable in 79 of the 83 strikeforces. The remaining four critical incidents were considered not applicable as the duty officer would not be expected to attend the incident due to a delay in declaring the event a critical incident.[144]

Of the 79 strikeforces where a duty officer running sheet was required:

- for 25 (32%) strikeforces, there was evidence that the investigation complied with the 2007 Guidelines by maintaining a duty officer running sheet[145]
- for 54 (68%) strikeforces, the Commission was unable to locate evidence on e@gle.i to confirm that a duty officer running sheet had been maintained.[146]

Of the 25 strikeforces where a duty officer running sheet could be located on e@gle.i there was considerable variation as to the form taken by running sheets and the type and detail of information recorded. The forms of the different duty officer running sheets included handwritten notes in the duty officer's notebook, use of a running sheet template or operations log filled out by hand, a typed chronology and a typed report.

Outlined in the case study below are the circumstances of the strikeforce where there was no evidence a duty officer running sheet had been maintained.

> In the early hours one morning in 2010, two men were drinking at a suburban bar when they were refused service and were asked to leave the premises. After being escorted to the carpark by a security guard and the manager of the bar, one of the two men physically assaulted the manager. A melee ensued between the two men and the security guard. The security guard was able to restrain the men and notify local police. Police from a suburban command attended the location of the incident and arrested the two men who were face down on the ground and held by security. Upon handcuffing one of the men and attempting to place him in the police vehicle, officers noticed that he was unresponsive. Officers immediately removed the handcuffs from the man and started CPR until the arrival of an ambulance. Ambulance officers attended the scene and continued CPR upon the man whilst transporting him to hospital. The man was subsequently declared deceased at the hospital.
>
> A critical incident was declared by the region commander and a duty officer managed the incident scene prior to the arrival of the SCII.
>
> A Commission audit of documents located on e@gle.i did not identify any evidence of a duty officer running sheet having been maintained to log which critical incident protocols were completed by the duty officer.

144 For all four strikeforces the type of incident was such that a duty officer would not automatically be required to attend the scene unless a critical incident had been declared (e.g. an attempted suicide, minor injuries sustained during an arrest). Therefore the significant delay in declaring these incidents to be a 'critical incident' precluded the presence of a duty officer at the incident scene.

145 A strikeforce was placed in this category if a duty officer running sheet was located on e@gle.i.

146 A strikeforce was placed in this category if either no duty officer running sheet was located on e@gle.i or where a running sheet was located on e@gle.i but there was insufficient information to determine if it was a duty officer running sheet.

7.5 HANDOVER OF THE RUNNING SHEET TO THE SCII

7.5.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that the duty officer was required to:

> Hand over the running sheet. Have your official police notebook signed to that effect (NSWPF 2007a, p. 19; NSWPF 2012a, p. 24).

In addition the 2007 Guidelines stated that the SCII must:

> obtain a briefing from the officer previously in charge at the scene and take possession of the running sheet
>
> …
>
> ensure actions required by the first officer at the scene, scene guard and Duty Officer have been completed (NSWPF 2007a, p. 21; NSWPF 2012a, p. 27).

As already mentioned, a template for the running sheet/log was provided at the end of the 2007 and 2012 Guidelines, however, the 2016 Guidelines make no reference to a running sheet or the handover of the running sheet to the SCII (NSWPF 2007a, p. 43; NSWPF 2012a, p. 42).

Instead the 2016 Guidelines outline the following guidance for the duty officer, SCII and review officer regarding the handover of information concerning the management of the critical incident scene. In 'Appendix 3 – Checklist – Duty Officer' the duty officer is required to:

> Provide information, including details of the source of the information, to the SCII to assist in the preparation of a SITREP. Only the SCII is permitted to prepare the SITREP (NSWPF 2016a, p. 33).

The SCII is provided with a checklist of actions to complete in 'Appendix 5 – Checklist – Senior Critical Incident Investigator' including:

> Obtain a briefing from the officer previously in charge at the scene and obtain copies of any notes made by that officer.
>
> ……
>
> Ensure actions required by the first officer at the scene, scene guard and duty officer have been completed (NSWPF 2016a, p. 35).

The SCII is also prompted to discuss in the critical incident investigation report template the following:

> Summary of how the incident was initially responded to. Items covered should include…Handover briefing from duty officer or LAC to the SCII (NSWPF 2016a, p. 46).

Finally, the 2016 Guidelines state the review officer should 'monitor and review the following matters' including:

> That there was appropriate control of the incident scene (e.g. adequate hand over to the CIIT (NSWPF 2016a, p. 26).

7.5.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

Whilst the handover of the critical incident scene by the duty officer to the SCII could still occur without the benefit of a running sheet through a verbal briefing, the duty officer running sheet ensures there is also a written record of actions taken by the duty officer and attending police.

Failure by the duty officer to provide the running sheet to the SCII at the incident scene may result in the following:

- the inability of the SCII to verify the completion of critical incident protocols by the duty officer and other attending police
- critical incident protocols being overlooked and not implemented (such as the separation of involved officers and the preservation of the incident scene) leading to possible loss or contamination of evidence
- the inability of the review officer to confirm if a thorough briefing occurred between the SCII and duty officer at the incident scene.

7.5.3 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement to hand over the duty officer running sheet to the SCII at the incident scene to be applicable in 79 of the 83 strikeforces. The remaining four critical incidents were considered not applicable as the duty officer would not be expected to attend the incident due to a delay in declaring the event a critical incident.[147]

Of the 79 strikeforces where the handover of the duty officer running sheet to the SCII was required:

- for four (5%) strikeforces, there was evidence located on e@gle.i that indicated the investigation **complied** with the 2007 Guidelines and that the duty officer running sheet had been handed over to the SCII at the incident scene
- for 21 (27%) strikeforces, the Commission was **unable to locate any evidence** on e@gle.i to confirm the handover of the duty officer running sheet to the SCII at the incident scene[148]

---

147 For all four strikeforces the type of incident was such that a duty officer would not automatically be required to attend the scene unless a critical incident had been declared (e.g. an attempted suicide, minor injuries sustained during an arrest). Therefore the significant delay in declaring these incidents to be a 'critical incident' precluded the presence of a duty officer at the incident scene.

148 A strikeforce was placed in this category if a duty officer running sheet had been scanned to e@gle.i but no documents could be located on e@gle.i to confirm if the running sheet had been handed over directly to the SCII at the incident scene.

- for 54 (68%) strikeforces, there was **insufficient information to assess** whether the duty officer running sheet had been handed over directly to the SCII. In 52 strikeforces there was no running sheet located on e@gle.i. Whilst in two strikeforces there was insufficient information to identify the author of the running sheet as the duty officer.

The circumstances of the strikeforce where there was no evidence that the duty officer running sheet was handed over to the SCII at the incident scene is described below.

> One evening in 2012, members of a rural community attended the nearest police station to report an armed man threatening residents on their isolated property.
>
> Two officers attended the location where they were confronted by a man armed with a large knife. The man dropped the knife and fled into bushland, continuing to make threats to the police and the residents of the property.
>
> Whilst the police officers were in the process of arranging transport to evacuate residents from the property, the man returned armed with a loaded crossbow and proceeded to approach police. The two officers retreated behind some vehicles and asked the man to drop his weapon. The armed man continued walking towards police with the crossbow. One officer discharged a taser at the man which failed to stop him. The other officer then discharged a police firearm hitting the armed man a number of times. The man was subsequently subdued by one of the officers who then proceeded to attend to the man's wounds and perform CPR. However, the man died at the scene. The region commander subsequently declared a critical incident.
>
> Due to the isolated location of the property and the need to arrange for an SCII from the Homicide Squad, the arrival of the SCII was delayed by over 12 hours. The duty officer maintained a detailed running sheet of all actions taken at the incident scene during this time, however, it was unclear from documents reviewed on e@gle.i whether this running sheet was handed over to the SCII at the time of the briefing.
>
> Given the delay by the SCII in reaching the incident scene it was imperative that the SCII had possession of the duty officer's running sheet to verify the critical incident protocols that were completed and to ensure that no key investigative action was overlooked. It is therefore of concern that no documents located on e@gle.i can confirm whether such a handover took place.

7.6 RECORDING THE CRITICAL INCIDENT INVESTIGATION AFTER THE HANDOVER TO THE SCII

The 2007 Guidelines provided limited guidance to the SCII concerning the recording of the critical incident investigation after the handover of the incident scene.

The 2007 Guidelines did not specifically require the SCII to maintain a running sheet for the purposes of recording and documenting the critical incident investigation. Rather the 2007 and the 2012 Guidelines directed that a running sheet should be used by the SCII to record any relevant discussions. The 2007 Guidelines stated the SCII should:

> consult with the review officer as appropriate. Record your discussions on the running sheet (NSWPF 2007a, p. 22; NSWPF 2012a, p. 31).

As already mentioned in this chapter the 2016 Guidelines make no reference to a running sheet at all.

Requiring the SCII to maintain a running sheet may offer an effective solution to the limited guidance currently provided to the SCII regarding the recording of the critical incident investigation. The running sheet can provide a valuable chronological and central record of investigative actions taken, decisions made and discussions that have occurred once the SCII has taken command of the investigation. The running sheet can also provide a record for both the SCII and review officer to use to determine if critical incident protocols have been fully implemented at the incident scene by the CIIT. Such a record can thereby support the transparency and accountability of the critical incident investigation.

The possible utility of a running sheet is reinforced by the fact that, although not specifically required, the Commission found that of the 83 strikeforces under review:

- for 22 (27%) strikeforces, there was evidence located on e@gle.i that the SCII had maintained a running sheet.[149]

Featured below are two case studies. The first case study outlines the circumstances and possible implications of a strikeforce where the SCII did not maintain a running sheet. The second case study describes the circumstances of a strikeforce where the SCII maintained a detailed and thorough running sheet during the critical incident investigation.

Early one evening in late 2009, police officers from a suburban command engaged in a vehicle pursuit of two people in a van, who were suspected of having committed two armed robberies that afternoon. The police pursuit of the van was lengthy and involved a number of different police vehicles as well as the assistance of a police helicopter. During the pursuit, the alleged offenders' vehicle moved onto the wrong side of the road a number of times. In attempting to gain entry to the highway using an entry ramp the van swerved to miss two vehicles and subsequently hit another vehicle with three occupants. As a result of the collision one of the passengers in the vehicle hit by the van received severe head injuries and died. Shortly after the collision police officers arrested the two men as the men attempted to flee the scene on foot. A critical incident was declared by the region commander that evening.

This incident had multiple incident scenes, involved a large number of police officers and resulted in the death of an individual. The SCII did not maintain a running sheet to keep track of the complex investigative actions requiring implementation by the CIIT and attending police. Without the running sheet it is not possible to verify what decisions were made by the SCII, any conversations had with the review officer and whether all appropriate critical incident protocols were completed.

149 A strikeforce was placed in this category if a running sheet by the SCII was located on e@gle.i.

Early one morning in 2010 two men allegedly committed a series of offences, including theft of a vehicle, failing to stop after a collision, breaking and entering, burglary and assault.

After a witness reported sighting the stolen vehicle later that morning in a nearby suburban street, a number of police officers attended the reported location. Once at the location two officers noted a driver in the stolen vehicle and approached on foot with their service weapons drawn. One officer stood perpendicular to the driver's door of the stolen vehicle whilst the other officer stood directly in front of the vehicle. The driver of the stolen vehicle revved the engine and proceeded to drive forward at high speed towards one of the officers. Fearing for the officer standing in front of the stolen vehicle, the other officer discharged one round from a service weapon at the driver hitting him in the leg.

Despite being wounded the driver proceeded to flee the scene in the stolen vehicle pursued by police officers but was forced to stop after entering a cul de sac. The wounded driver got out of the vehicle but collapsed from his wounds before being arrested by police and taken to hospital under guard. A critical incident was declared by the region commander and an SCII, CIIT and review officer were appointed.

The SCII maintained a very detailed running sheet covering the initial three days of the critical incident investigation. The running sheet included the following information:

- date and time the critical incident was declared by the region commander
- date and time of arrival by SCII at the critical incident scene
- outline of briefing from duty officer regarding actions already taken at the incident scene, especially the security of the incident scene, appropriate notifications and the separation of involved officers
- date and time of attendance of specialist police officers such as the Forensic Services Group
- date and time of drug and alcohol testing of involved officers
- identification of CIIT members, review officer and involved officers
- a chronological outline of actions taken by SCII and CIIT to obtain evidence (for example: charge records, custody records, police rosters, ICV, CCTV, ballistics evidence, inspection of vehicles in situ)
- welfare provided to involved officers
- observations of the incident scene
- contact with media outlets
- date and time of interviews conducted with involved officers and possible witnesses
- any discussions with the region commander and review officer concerning the investigation.

7.7 OBSERVATIONS

According to the 2007 and 2012 Guidelines the following three key actions were required to ensure the appropriate handover of management of the incident scene from the duty officer to SCII:

- presence of the duty officer at the incident scene
- the maintenance of a duty officer running sheet
- handover of the duty officer running sheet to the SCII.

Duty officer running sheet

The duty officer plays an important role in the early stages of a critical incident. The duty officer running sheet provides confirmation that key initial investigative actions, including preservation of the incident scene, separation of involved officers and witnesses, obtaining a version of events from an independent witness prior to speaking to involved officers etc., have been completed.

The Commission's audit of 83 strikeforces was unable to locate evidence on e@gle.i to confirm that a duty officer running sheet had been maintained for 68% of applicable strikeforces.

The 2016 Guidelines no longer require the duty officer to maintain a running sheet. Instead the duty officer is directed to, 'Document all action taken, advice given and create file notes of all relevant conversations' (NSWPF 2016a, p. 32). The Commission is concerned that the absence of a duty officer running sheet weakens accountability and transparency of a critical incident investigation.

Handover of the duty officer running sheet to the SCII

The 2007 and 2012 Guidelines provided limited guidance concerning how the critical incident investigation should be recorded by the SCII once the incident scene was handed over from the duty officer. In both sets of guidelines the SCII was only directed to record discussions on the running sheet. The 2016 Guidelines no longer mention a running sheet at all. Instead the SCII is simply asked to: 'Consult with the review officer as appropriate. Record the details and outcomes of your discussions' (NSWPF 2016a, p. 35).

In only 5% of applicable strikeforces in the Commission's audit of 83 strikeforces could it be confirmed that the duty officer running sheet had been handed over to the SCII at the incident scene.

Given that both the duty officer and the SCII are responsible for implementing key critical incident protocols at different stages of the investigation the Commission is of the opinion that it is important that duty officers and SCIIs have access to corporate guidance concerning the recording of investigative actions taken by these officers.

8. PRESERVATION OF SCENE OF CRITICAL INCIDENT

8.1 OVERVIEW

The 2007, 2012 and 2016 Guidelines require the critical incident scene to be preserved for the collection and examination of physical evidence by the Forensic Services Group (FSG)[150] (NSWPF 2007a, p. 13; NSWPF 2012a, p. 38; NSWPF 2016a, p. 32). According to the 2007 Guidelines the preservation of the incident scene is a 'fundamental responsibility' of NSWPF officers when responding to any major incident or emergency, 'irrespective of whether or not the incident is deemed a 'critical incident'' (NSWPF 2007a, p. 2). The preservation of the incident scene is essential as it ensures that any physical evidence remains uncontaminated until it can be recorded and collected for forensic examination.

This chapter describes what the Commission learnt from an audit of documents located on the NSWPF e@gle.i system regarding the preservation of the incident scene for the 83 strikeforces under review. More specifically it provides information concerning compliance with the 2007 Guidelines in relation to six different processes associated with preserving the scene of the incident:

- securing the incident scene for examination by the FSG
- establishing an inner and outer perimeter
- placing incident scene guards at the incident scene
- maintaining an incident scene log
- preserving an original command post
- establishing a command post for the critical incident investigation team (CIIT), independent of an original command post.

Summary of findings

Of the 80 applicable strikeforces:

- 46 (58%) provided evidence confirming the incident scene had been secured for forensic examination
- 16 (20%) provided evidence confirming that both an inner and outer perimeter had been established at the incident scene
- 42 (53%) provided evidence confirming that incident scene guards had been placed at the incident scene
- 48 (60%) provided evidence confirming that an incident scene log had been maintained at the incident scene.

150 The Forensic Services Group is a command of the NSWPF that provides specialist forensic services to assist investigations including the collection and examination of evidence and the identification of individuals through the gathering of biometric data such as fingerprints and DNA.

Of the 18 strikeforces where the preservation of an original command post may have been applicable:

- none provided evidence to confirm that an original command post had been preserved at the incident scene
- two (11%) provided evidence to confirm that a command post for the CIIT had been established independent of an original command post.

8.2 WHAT INFORMATION DID THE COMMISSION CONSIDER?

To determine whether the 83 strikeforces complied with the six main duties identified in the 2007 Guidelines concerning the preservation of the critical incident scene, the Commission commenced by reviewing, where available, the following documents:

- critical incident investigation report (CIIR)
- incident scene log
- statement of duty officer
- statements of incident scene guards
- statement of first officer attending the scene.

If the above documents were not located on e@gle.i, or the information required was not recorded in any of these documents, the Commission then reviewed a number of additional documents including:

- duty officer running sheet
- critical incident investigation running sheet
- incident scene photos
- situation reports
- review officer report
- region commander report
- statements of involved officers.

Where available, the above documents were reviewed by the Commission for each of the 83 strikeforces to assess whether there was enough evidence to confirm that:

- the incident scene had been secured for forensic examination
- an inner and outer perimeter had been established
- incident scene guards were placed at the incident scene
- an incident scene log had been scanned to e@gle.i and was therefore maintained at the incident scene
- any original command post present at the incident scene had been preserved

- a command post had been established for the CIIT, independent from any original command post at the incident scene.

The Commission relied solely on documents located on e@gle.i in its audit and subsequent assessment of compliance with certain aspects of the 2007 Guidelines.

8.3 WHAT IS THE RISK IF THE SCENE OF THE INCIDENT IS NOT PRESERVED?

As noted in the 2007 Guidelines, ensuring the preservation of the incident scene is an essential part of the police response to any major emergency or incident. However, in the case of a critical incident where the actions of officers in the execution of their duty may have resulted in death of or serious injury to a member of the public, the necessity for maintaining the integrity of the incident scene and avoiding contamination of the physical evidence is paramount to avert concerns of impropriety or bias.

An incident scene that is not preserved in accordance with the requirements identified in the 2007 Guidelines can lead to:

- tampering with and/or fabrication of evidence by involved officers, civilians or other attending NSWPF officers leading to contamination of the incident scene
- loss of physical evidence and exhibits.

Broader implications include:

- loss of evidence that might have assisted in understanding the circumstances of the incident
- interference with or obstruction of the critical incident investigation
- the public perception of the critical incident investigation, its findings and recommendations as tainted or partial.

8.4 SECURING THE SCENE FOR EXAMINATION BY THE FORENSIC SERVICES GROUP

8.4.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines referred to securing the critical incident scene for examination by the FSG, as part of the specific requirements of the first officer at the scene, the incident scene guard and the duty officer.

The 2007 Guidelines stated that 'the first officer at the scene (the most senior officer, who first arrives at the incident whatever their rank)' should:

- preserve the scene and exhibits (including, where relevant, any/all police appointments) for examination by representatives of the FSG ...

- appoint an officer to secure the scene (incident scene guard) (NSWPF 2007a, p. 13).

The 2007 Guidelines also stated that the 'incident scene guard's role is to secure and preserve the integrity of the incident scene' and directed the incident scene guard to:

- secure the scene of the incident
- maintain the security of the scene
- prevent entry by unauthorised people
- record details of people entering or attempting to enter the scene in their notebook, including the time and reason for entry
- identify and record details of any officer removed from the scene and the reason
- assist the crime scene investigators by seeing that they are not disturbed unnecessarily by unauthorised people seeking entry to the location

> The incident scene guard will remain in position until relieved by the senior critical incident investigator (SCII) (NSWPF 2007a, p.14).

The 2007 Guidelines noted the duty officer was to 'assume command of the scene, until relieved by the Local Area Commander or senior critical incident investigator', and required the duty officer to 'ensure scene has been secured for FSG examination' (NSWPF 2007a, p. 17).

The same duties are repeated in the 2012 and 2016 Guidelines (NSWPF 2012a, pp. 23, 38, 39; NSWPF 2016a, pp. 27, 30, 32).[151]

8.4.2 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement to secure the incident scene for examination by the FSG to be applicable in 80 of the 83 strikeforces. In the three strikeforces considered not applicable, the gravity of the injuries sustained by the victim during the incident only became known to the NSWPF a significant time later by which time it was too late to secure and preserve the incident scene.

[151] The 2016 Guidelines, whilst reiterating the advice of the 2007 and 2012 Guidelines regarding preservation of the incident scene, place the duties and requirements for the first officer at the scene and the duty officer in checklists attached as an appendix rather than in the body of the guidelines. In addition the 2012 and 2016 Guidelines refer NSWPF officers to more detailed advice in the NSW Police Force Handbook regarding 'crime scene management processes' (NSWPF 2012a, p. 38; NSWPF 2016a, p. 27).

Of the 80 strikeforces audited:

- for 46 (58%) strikeforces, records located on e@gle.i confirmed that the investigation had **complied** with the 2007 Guidelines and secured the incident scene[152]
- for 30 strikeforces, there was **insufficient information to assess** whether or not the incident scene had been secured[153]
- for three strikeforces, records located on e@gle.i confirmed the investigation had **not complied** with the 2007 Guidelines and had not secured the incident scene[154]
- for one strikeforce, the Commission was **unable to locate any documents** on e@gle.i that included information as to whether or not the incident scene had been secured.

The circumstances of a strikeforce where the incident scene was not secured prior to forensic examination resulting in the contamination of physical evidence, are outlined in the case study below.

In the early hours of a morning in late 2010 a man armed with a knife called the NSW Ambulance Service from his suburban home threatening self-harm if drugs were not delivered to him. The NSW Ambulance Service sent units to the man's location and requested the attendance of NSWPF officers. After negotiations by NSWPF officers to disarm the man were unsuccessful, the man proceeded to stab himself in the stomach and the officers forced entry into the premises. On reaching him a NSWPF officer deployed a taser which then subdued the man, who was subsequently taken to hospital and treated for abdominal wounds as well as being given a mental health assessment. A critical incident was declared by the region commander later that morning and a CIIT, SCII and review officer appointed.

Prior to the attendance of the CIIT and the FSG, attending police officers took some initial photographs before departing, leaving the incident scene unsecured. These officers requested the man's father to attend and secure the property instead. However, on arrival at the incident scene the man's father commenced to clean the property, moving and cleaning the knife, broken glass and other physical evidence at the scene.

The incident scene was later secured by NSWPF officers and attended by the CIIT and the FSG, however, the incident scene had already been contaminated.

152 A strikeforce was placed in this category if in addition to general statements by attending police affirming that the incident scene had been secured, further supporting detail and evidence was located on e@gle.i, e.g. incident scene logs, duty officer logs, incident scene guard statements.

153 A strikeforce was placed in this category if the only reference to securing the incident scene was a statement by attending police that the incident scene had been secured and preserved for forensic examination, without additional supporting detail or documents being located on e@gle.i.

154 A strikeforce was placed in this category if there was a significant delay in attending and securing the scene after the critical incident, leaving the scene open to contamination or directly resulting in contamination of the scene.

The circumstances of a strikeforce where there was a significant delay in reporting the incident and securing the incident scene, are described in the following case study.

One evening in 2009, police from a rural command responded to a call for welfare from the owner of a local property who had discovered a man lying on the grounds of the property in minimal clothing and seemingly unconscious.

Believing the man's condition to be critical and considering the remote location, NSWPF officers placed the man in the caged section at the back of their police vehicle to convey him to a local hospital instead of waiting for an ambulance. At the hospital the man's condition was formally listed as critical and it was decided that he required treatment at a larger hospital to which he was subsequently transferred. The still unconscious man was then placed on life support.

At around midday the next day the duty officer at the same rural command was informed of the NSWPF involvement in transporting the unidentified man to hospital the previous evening but was unable to find any record on NSWPF IT systems or in the vehicle diaries.

Upon confirming with the local hospital that NSWPF officers had transported an unconscious man in a critical condition the previous evening and that it was possible the man could die, the duty officer then contacted the local area commander. At around 3pm a critical incident was formally declared by the region commander and the incident scene was subsequently secured and inspected.

Due to the delay in this incident being reported on NSWPF IT systems and to the duty officer, a critical incident was delayed in being declared as was the securing of the incident scene for evidence collection and examination.

The delay in securing the incident scene left the scene open to contamination for a significant period of time.

The following case study describes the circumstances of a strikeforce where insufficient information was located on e@gle.i to determine whether or not the incident scene had been secured for forensic examination.

> One evening in early 2011 a number of NSWPF officers attended a motor vehicle accident on a main suburban road involving a car and prime mover. In attending to traffic duties NSWPF officers requested the driver of the prime mover to move his vehicle off the main road. At the same time as the driver of the prime mover commenced to move his vehicle from the roadway, a NSWPF officer standing at the front nearside of the prime mover was hit by the vehicle and dragged under the truck. The NSWPF officer was subsequently taken to hospital sustaining serious leg injuries as a result of the incident. A critical incident was declared by the region commander and a CIIT, SCII and review officer appointed.
>
> The investigation scanned minimal documentation to e@gle.i concerning the security of the incident scene with only brief, general references made in two situation reports to a crime scene and attendance by the FSG. No other documentation was located on e@gle.i that could confirm if and how the incident scene was secured.

8.5 ESTABLISHING AN INNER AND OUTER PERIMETER

8.5.1 WHAT DID THE GUIDELINES SAY?

The direction to establish an inner and outer perimeter at the incident scene was referred to in the 2007 Guidelines within the specific duties assigned to the first officer at the scene and the duty officer.

The 2007 Guidelines stated that the first officer at the scene should:

- ensure that adequate inner and outer perimeters are identified and established. Where possible, define the perimeters with police barrier tape. The inner perimeter should define the full extent of the incident scene requiring incident scene examination
- appoint an officer to secure the scene (incident scene guard). Determine an entry/exit point to the inner perimeter, which has not been used by persons involved in the incident (NSWPF 2007a, p. 13).

The 2007 Guidelines required the duty officer to:

- ensure scene has been secured for FSG examination and an incident scene guard has been placed on the inner perimeter. Sufficient guards should be placed on the outer perimeter to maintain security and preserve the integrity of the scene (NSWPF 2007a, p. 17).

The same duties are repeated in the 2012 and 2016 Guidelines (NSWPF 2012a, pp. 23, 38; NSWPF 2016a, pp. 30, 32).[155]

8.5.2 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement to establish an inner and outer perimeter at the incident scene to be applicable in 80 of the 83 strikeforces. Once again, in the three strikeforces considered not applicable, the gravity of the injuries sustained by the victim during the incident only became known to the NSWPF a significant time later by which time it was too late to secure and preserve the incident scene.

Of the 80 strikeforces reviewed:

- for 16 (20%) strikeforces, records located on e@gle.i confirmed that the investigation had **complied** with the 2007 Guidelines and established an inner and outer perimeter at the incident scene[156]
- for 42 strikeforces, records were located on e@gle.i that the investigation **partly complied** with the 2007 Guidelines by confirming a general police cordon at the incident scene but not an inner and outer perimeter[157]
- for 20 strikeforces, there was **insufficient information to assess** whether or not an inner and outer perimeter had been established at the incident scene[158]
- for one strikeforce, records located on e@gle.i confirmed the investigation had **not complied** with the 2007 Guidelines and had not established an inner and outer perimeter[159]
- for one strikeforce, the Commission was **unable to locate any documents** on e@gle.i that included information as to whether or not an inner and outer perimeter had been established.

The circumstances of a strikeforce where the investigation did not record the presence of an inner and outer perimeter but did record a general cordon at the incident scene, are outlined in the case study below.

---

155 The 2016 Guidelines, whilst reiterating the advice of the 2007 and 2012 Guidelines regarding preservation of the incident scene, place the duties and requirements for the first officer at the scene and the duty officer in checklists attached as an appendix rather than in the body of the guidelines.

156 A strikeforce was placed in this category if both an inner and outer perimeter were directly referred to in the investigation documents located on e@gle.i.

157 A strikeforce was placed in this category if an inner and outer perimeter were not directly referred to in the investigation documents but a general physical securing of the incident scene was (for example, a cordon or road blocks).

158 A strikeforce was placed in this category if only a general statement was made in the investigation documents that implied the incident scene had been secured (for example, 'a Crime Scene was established'), without additional detail being provided to confirm a physical cordon or an inner and outer perimeter.

159 The single strikeforce in this category did not secure the incident scene with perimeters prior to forensic examination taking place leading to contamination of evidence at the scene. This strikeforce is outlined in more detail in the first case study provided in Section 8.4.2.

At around midday in late 2011 NSWPF officers responded to a report of a man in possession of a knife threatening self-harm on a platform in a metropolitan railway station. The man was seen to walk onto the railway tracks and hold the knife against his throat before inflicting a deep wound. NSWPF officers approached the man and one officer deployed a taser to prevent the man from further self-harm. The man fell backwards onto the tracks and was provided first aid by NSWPF officers and subsequently ambulance officers, however, was unable to be revived.

None of the documents located on e@gle.i refer directly to the presence of an inner and outer perimeter, however, the statement of the duty officer confirms that a general police cordon was erected at the incident scene.

The following case study outlines the circumstances of a strikeforce where the investigation clearly recorded in the duty officer statement located on e@gle.i the presence of an inner and an outer perimeter at the incident scene.

Early one evening in late 2009 two NSWPF officers from a metropolitan command responded to a report of a man causing malicious damage by throwing rocks at his neighbour's house and vehicle.

Upon arrival at the man's house NSWPF officers attempted to talk with him. With the arrival of the man's family outside the residence, he became abusive and threatened to stab attending police officers. NSWPF officers entered the premises and deployed Oleoresin capsicum (OC) spray as the man retreated to the kitchen grabbing a knife. The officers then attempted to disarm the man using baton strikes before discharging their firearms, striking the man multiple times. The man subsequently died of his injuries.

The statement of the duty officer which had been scanned to e@gle.i clearly confirmed that both an inner and outer perimeter were established at the incident scene.

8.6 PLACING INCIDENT SCENE GUARDS AT THE INCIDENT SCENE

8.6.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines referred to placing incident scene guards at the incident scene as part of the specific duties requested of the first officer at the scene, the incident scene guard and the duty officer.

The 2007 Guidelines stated that the first officer at the scene should:

- appoint an officer to secure the scene (incident scene guard)
- ...
- place sufficient guards on the outer perimeter to maintain security and preserve the integrity of the incident scene (NSWPF 2007a, p. 13).

The 2007 Guidelines directed the incident scene guard to:

- secure the scene of the incident
- maintain the security of the scene
- prevent entry by unauthorised people
- record details of people entering or attempting to enter the scene in their notebook, including the time and reason for entry
- identify and record details of any officer removed from the scene and the reason
- assist the crime scene investigators by seeing that they are not disturbed unnecessarily by unauthorised people seeking entry to the location

The incident scene guard will remain in position until relieved by the senior critical incident investigator (SCII) (NSWPF 2007a, p.14).

The 2007 Guidelines directed the duty officer to:

- ensure scene has been secured for FSG examination and an incident scene guard has been placed on the inner perimeter. Sufficient guards should be placed on the outer perimeter to maintain security and preserve the integrity of the scene (NSWPF 2007a, p. 17).

The same duties are repeated in the 2012 and 2016 Guidelines (NSWPF 2012a, pp. 23, 38, 39; NSWPF 2016a, pp. 27, 30, 32).[160]

8.6.2 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement to place incident scene guards at the incident scene to be applicable in 80 of the 83 strikeforces. In the three strikeforces considered not applicable, the gravity of the injuries sustained by the victim during the incident only became known to the NSWPF a significant time later by which time it was too late to secure and preserve the incident scene.

Of the 80 strikeforces reviewed:

- for 42 (53%) strikeforces, records located on e@gle.i confirmed that the investigation had complied with the 2007 Guidelines and placed incident scene guards at the incident scene[161]

[160] The 2016 Guidelines, whilst reiterating the advice of the 2007 and 2012 Guidelines regarding preservation of the incident scene, place the duties and requirements for the first officer at the scene and the duty officer in checklists attached as an appendix rather than in the body of the guidelines.

[161] A strikeforce was placed in this category if incident scene guard statements were located on e@gle.i.

    - of the 42 strikeforces that complied with the 2007 Guidelines by placing incident scene guards at the scene, only seven strikeforces clearly identified the number and names of the incident scene guards present at the incident scene

- for 19 strikeforces, there was insufficient information to assess whether or not incident scene guards had been placed at the incident scene[162]
- for 18 strikeforces, the Commission was unable to locate any documents on e@gle.i that included information as to whether or not incident scene guards were present at the incident scene
- for one strikeforce, records located on e@gle.i confirmed the investigation had **not complied** with the 2007 Guidelines by not placing incident scene guards at the incident scene.[163]

The case study below outlines the circumstances of a strikeforce where no information could be located on e@gle.i to confirm whether or not incident scene guards were present at the scene.

THIS SPACE DELIBERATELY LEFT BLANK.

162 A strikeforce was placed in this category if the presence of incident scene guards was briefly noted in investigation documents, (e.g. statements of attending police, situation reports) without any further corroborating evidence such as incident scene guard statement located on e@gle.i.

163 The single strikeforce in this category did not secure the incident scene with incident scene guards prior to forensic examination taking place leading to contamination of evidence at the scene. This strikeforce is outlined in more detail in the first case study provided in Section 8.4.2.

One evening in early 2010 NSWPF officers from a rural command responded to a report of an abandoned vehicle parked in a dangerous position on the roadway. Whilst driving to the location of the abandoned vehicle, NSWPF officers observed a car travelling towards them in an erratic manner with the headlights on. The officers turned their police vehicle around and proceeded to follow the car but were not in pursuit. A few minutes later the officers observed the car they were following had been involved in an accident having veered to the far left hand side of the road and into a tree. The NSWPF officers rendered assistance to a male passenger trapped inside the car, however, he died at the scene. The driver of the vehicle could not be located. Later that night a critical incident was declared by the region commander and a CIIT, SCII and review officer appointed.

None of the investigation documents reviewed on e@gle.i provided information as to whether or not incident scene guards were present at the incident scene.

The circumstances of a strikeforce where the investigation clearly recorded in documents located on e@gle.i the presence, number and identity of incident scene guards at the incident scene, are described in the case study below.

Early one morning in 2010 two men allegedly committed a series of offences, including theft of a vehicle, failing to stop after a collision, breaking and entering, burglary and assault.

After a witness reported sighting the stolen vehicle later that morning in a local suburban street, a number of police officers attended the reported location. Once at the location two officers noted a driver in the stolen vehicle and approached on foot with their service weapons drawn. One officer stood perpendicular to the driver's door of the stolen vehicle whilst the other officer stood directly in front of the vehicle. The driver of the stolen vehicle revved the engine and proceeded to drive forward at high speed towards one of the officers. Fearing for the officer standing in front of the stolen vehicle, the other officer discharged one round from a service weapon at the driver hitting him in the leg.

Despite being wounded the driver proceeded to flee the scene in the stolen vehicle pursued by police officers but was forced to stop after entering a cul de sac. The wounded driver got out of the vehicle but collapsed from his wounds before being arrested by police and taken to hospital under guard. A critical incident was declared by the region commander and an SCII, CIIT and review officer were appointed.

This strikeforce clearly documented the presence, number and identity of the incident scene guards on duty at the incident scene in incident scene guard statements, the incident scene log, and the CIIR which were located on e@gle.i.

8.7 MAINTAINING AN INCIDENT SCENE LOG

8.7.1 WHAT DID THE GUIDELINES SAY?

An important duty in preserving the incident scene identified in the 2007 Guidelines was recording the details, time and reason for entry of each person entering the incident

scene. This action formed part of the specific duties required of the incident scene guard which were outlined in the 2007 Guidelines as follows:[164]

> - record details of people entering or attempting to enter the scene in their notebook, including the time and reason for entry
> - identify and record details of any officer removed from the scene and the reason
> - assist the crime scene investigators by seeing that they are not disturbed unnecessarily by unauthorised people seeking entry to the location (NSWPF 2007a, p. 14).

Recording the details of people entering an incident scene perimeter is a key feature of the NSWPF response to preserving every major crime or incident scene.[165] This duty, referred to in the NSW Police Force Handbook as maintaining a 'log', can be recorded in a NSWPF officer's notebook or using templates entitled 'crime scene log' or 'incident scene log' in the case of critical incidents.[166]

The same duties noted in the 2007 Guidelines above are similarly described in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 39; NSWPF 2016a, p. 27).

8.7.2 WHAT DID THE COMMISSION FIND?

The Commission considered the requirement to maintain an incident scene log to be applicable in 80 of the 83 strikeforces. Once again in the three strikeforces considered not applicable, the gravity of the injuries sustained by the victim during the incident only became known to the NSWPF a significant time later by which time it was too late to secure and preserve the incident scene.

It should be noted that given the number of incident scene guards on duty over the course of a forensic examination at an incident scene, the incident scene log may be maintained across a number of individual notebooks or on separate incident scene log templates.

Of the 80 strikeforces reviewed:

- for 48 (60%) strikeforces, records located on e@gle.i confirmed that the investigation had **complied** with the 2007 Guidelines and maintained an incident scene log[167]
    - of the 48 strikeforces that complied with the 2007 Guidelines by maintaining an incident scene log, only 11 strikeforces clearly

---

164 In outlining the duties of the incident scene guard, the 2007 Guidelines also referred the reader to the FSG Investigator's Guide to Physical Evidence (Scene Responsibilities) which described the process of recording the details of each person entering a crime scene as the 'crime scene log' (NSWPS 1999, p.10).

165 The NSW Police Force Handbook lists the action of logging the details of persons entering an incident scene as a key requirement in maintaining the security of a major crime or incident scene. http://intranet.police.nsw.gov.au/policy_and_procedures/operational_policies/police_handbook/chapter_c/crime_scenes

166 The templates for the crime scene log and incident scene log are provided to NSWPF officers on the NSWPF Intranet.

167 A strikeforce was placed in this category if an incident scene log was located on e@gle.i. Please note that not all incident scene logs maintained at the incident scene for each strikeforce in this category were located on e@gle.i.

identified the number of separate incident scene logs maintained at the scene

- for 18 strikeforces, the Commission was **unable to locate any documents** on e@gle.i that included information as to whether or not an incident scene log was maintained at the incident scene
- for 11 strikeforces, there was **insufficient information to assess** whether or not an incident scene log was maintained[168]
- for two strikeforces, records located on e@gle.i confirmed the investigation had **not complied** with the 2007 Guidelines by not maintaining an incident scene log[169]
- for one strikeforce, records were located on e@gle.i that the investigation **partly complied** with the 2007 Guidelines by maintaining an incident scene log but only after the scene had been contaminated due to a delay in preserving the incident scene.

The following case study outlines the circumstances of a strikeforce where the investigation provided insufficient information on e@gle.i to determine whether an incident scene log was maintained at the incident scene.

One afternoon in early 2012 NSWPF officers attended a suburban residence after receiving a report of a man armed with a knife, barricaded in the bathroom of his home who had recently consumed a large amount of oxycontin.

NSWPF officers attempted to disarm the man by using verbal persuasion, a baton, OC spray and a taser to no avail. The man then entered the shower and cut his throat with the knife. NSWPF officers at the scene commenced first aid procedures but the man died of his injuries at the scene. A CIIT was assembled and later attended the incident scene.

In this strikeforce the presence of an incident scene log was referred to in the duty officer statement, however, an incident scene log was not located on e@gle.i making it difficult to confirm if one was actually maintained. Given the importance of the incident scene log in providing evidence of incident scene security, the failure to scan this document to e@gle.i diminishes the transparency of the investigation and the ability of the review officer to determine whether the incident scene was appropriately secured and preserved.

The case study below describes the circumstances of a strikeforce where only one of the incident scene logs maintained at the incident scene was located on e@gle.i.

168 A strikeforce was placed in this category if a statement was made in the investigation documents that an incident scene log was maintained at the incident scene without further corroborating evidence such as the incident scene log scanned on e@gle.i.

169 A strikeforce was placed in this category if the investigation documents located on e@gle.i noted that an incident scene log was not maintained at the incident scene.

Late one evening in early 2010 NSWPF officers stopped to speak with a woman and a man whom the officers had observed walking in the breakdown lane of a major urban highway. The officers were told by the pair that they had been travelling home in a car with a male driver when the driver had thrown them both out of the vehicle after an argument. The NSWPF officers informed the pair that they only had room in their police vehicle to take one person home but offered to call another police vehicle to take the other. The man became impatient, declining the offer of a lift and proceeded to walk away from the police along the breakdown lane. Later that evening the man was hit by a vehicle when crossing the same urban highway. A critical incident was declared by the region commander the following morning.

In this strikeforce a number of NSWPF officers completed separate incident scene logs as they relieved those incident scene guards coming off duty over the course of the morning that the forensic examination took place, as outlined in the CIIR. However, the investigation had only scanned a single incident scene log to e@gle.i, leaving the incident scene logs that were maintained in other periods of the morning by different incident scene guards unaccounted for.

The circumstances of a strikeforce where an incident scene log was not maintained, are described in the case study below.

One day in late 2010 two men in a rural location allegedly committed a series of offences including the theft of two vehicles and malicious damage. In the afternoon the two men entered a property and attempted to steal a number of items including an unregistered vehicle. As the two men were about to leave in the stolen vehicle they were approached by the two owners of the property who had returned home. One of the men in the stolen vehicle then produced a sharp metal object, inflicting a wound to the arm of one of the owners before fleeing the scene. NSWPF officers responded to the incident with police vehicles deployed to the area.

After a prolonged police pursuit, the stolen vehicle sped down a rural road where NSWPF officers were stationed and preparing to deploy road spikes. One of these officers observed the stolen vehicle approaching at speed seeming to directly target him. Fearing that he would be hit by the vehicle the officer then drew and fired two shots from his service pistol at the vehicle's tyres, however, the shots had no effect and the stolen vehicle sped away from the area. The stolen vehicle was later found abandoned 500 metres further down the road and the two offenders were subsequently arrested trying to escape on foot.

Although the CIIR stated that two crime scenes were established at the site of the abandoned vehicle and at the site of the shooting, the CIIR also noted that no formal incident scene logs were maintained. No reason was provided in the CIIR or any other document reviewed on e@gle.i as to why incident scene logs had not been maintained at either scene.

8.8 PRESERVING AN ORIGINAL COMMAND POST

8.8.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines specified the need to preserve an original command post at the incident scene as part of the specific duties of the duty officer:

> - Take steps to preserve the original command post for examination (NSWPF 2007a, p. 17).

The same duties are repeated in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 23; NSWPF 2016a, p. 32).[170]

8.8.2 WHAT DID THE COMMISSION FIND?

The Commission considered the direction to preserve the original command post at the incident scene to be applicable in only 18 of the 83 strikeforces reviewed. In the remaining 65 strikeforces the nature of the incident was such that an original command post would not be expected to be present at the incident scene.[171]

Of the 18 strikeforces where the preservation of an original command post was deemed to be applicable:

- for eight strikeforces, there was **insufficient information to assess** whether or not an original command post had been preserved[172]
- for ten strikeforces, the Commission was **unable to locate any documents** on e@gle.i that included information as to whether or not an original command post had been preserved at the incident scene.[173]

8.9 ESTABLISHING AN INDEPENDENT COMMAND POST FOR THE CRITICAL INCIDENT INVESTIGATION TEAM

8.9.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines referred to establishing a CIIT command post independent from any original command post as part of the specific duties required of the duty officer as follows:

---

170 The 2016 Guidelines, whilst reiterating the advice of the 2007 and 2012 Guidelines regarding preservation of the original command post, place this requirement for the duty officer in a checklist attached as an appendix rather than in the body of the guidelines.

171 For example, a number of the 65 strikeforces were incidents where a motor vehicle accident had occurred during a police pursuit.

172 For these eight strikeforces there was information located on e@gle.i confirming the presence of an original command post but insufficient information to assess whether the original command post had been preserved.

173 For these ten strikeforces there were no documents that referred to the presence of an original command post or its preservation located on e@gle.i. All ten strikeforces appear to present circumstances which may have led to an original command post being established (for example: a stand-off between an armed individual and police).

> establish a command post independent from any command post that may have been established prior to the critical incident (NSWPF 2007a, p. 17).

The same duties are repeated in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 23; NSWPF 2016a, p. 32).[174]

8.9.2 WHAT DID THE COMMISSION FIND?

The Commission considered the direction to establish a CIIT command post independent of the original command post to be applicable in only 18 of the 83 strikeforces reviewed. In the remaining 65 strikeforces the nature of the critical incident was such that an original command post would not be expected to be present at the incident scene thereby negating the need for an independent CIIT command post.[175]

Of the 18 strikeforces where establishing a CIIT command post independent of an original command post was deemed to be applicable:

- for two (11%) strikeforces, records located on e@gle.i confirmed that the investigation had **complied** with the 2007 Guidelines and established a command post independent from an original command post[176]
- for two strikeforces, there was **insufficient information to assess** whether or not the CIIT command post had been established independently from an original command post [177]
- for 14 strikeforces, the Commission was **unable to locate any documents** on e@gle.i that included information as to whether or not the CIIT command post had been established independently from an original command post.[178]

8.10 OBSERVATIONS

The preservation of the critical incident scene for forensic examination is a key requirement outlined in the 2007, 2012 and 2016 Guidelines. Given this guidance, and considering the risk of contamination of physical evidence if the incident scene is not secured, it is of concern that a substantial number of the strikeforces audited by the Commission did not adequately document or confirm on e@gle.i the completion of the following six duties, essential to the preservation of the incident scene.

---

174 The 2016 Guidelines, whilst reiterating the advice of the 2007 and 2012 Guidelines regarding an independent CIIT command post, place this requirement for the duty officer in a checklist attached as an appendix rather than in the body of the guidelines.

175 For example, a number of the 65 strikeforces were incidents where a motor vehicle accident had occurred during a police pursuit.

176 For these two strikeforces an original command post and an independent command post were present at the incident scene, however, it could not be determined whether the original command post had been preserved.

177 For two strikeforces there was insufficient information to assess whether an independent command post was required to be established as no original command post had been documented for either strikeforce. This is despite both strikeforces presenting circumstances which may have led to an original command post being established, (both concerned a stand-off between an armed person and police).

178 For 14 strikeforces there was no documentation recording the presence of an independent command post at the incident scene. In eight strikeforces neither an original nor an independent command post were documented. In six strikeforces an original command post was recorded in documents located on e@gle.i, however, an independent command post was not.

Of the 80 applicable strikeforces:

- for 31 (39%) strikeforces the Commission was unable to locate sufficient information on e@gle.i to assess whether or not the incident scene had been secured
- for 21 (26%) strikeforces the Commission was unable to locate sufficient information on e@gle.i to assess whether or not an inner and outer perimeter had been established at the incident scene
- for 37 (46%) strikeforces the Commission was unable to locate sufficient information on e@gle.i to assess whether or not incident scene guards had been placed at the incident scene
- for 29 (36%) strikeforces the Commission was unable to locate sufficient information on e@gle.i to assess whether or not an incident scene log was maintained.

Of the 18 applicable strikeforces:

- for 16 (89%) strikeforces the Commission was unable to locate sufficient information on e@gle.i to assess whether or not the CIIT command post had been established independently from an original command post
- for 18 (100%) strikeforces the Commission was unable to locate sufficient information on e@gle.i to assess whether or not an original command post had been preserved at the incident scene.

For critical incident investigations to be seen as transparent and accountable, the actions taken by NSWPF officers to secure the incident scene need to be clearly recorded and available on e@gle.i. However, the NSWPF critical incident guidelines do not specify how such actions are to be documented except to direct the incident scene guard to record the details of people entering the incident scene in a police notebook. None of the other important actions taken to preserve and secure the incident scene are specifically required to be documented. In addition, the NSWPF critical incident guidelines do not specify which documents need to be located on e@gle.i, providing general guidance only. This is evidenced in the 2016 Guidelines which state: 'The SCII will ensure that the investigation is recorded on e@gle.i which will be the primary storage facility for all documents relating to the critical incident investigation' (NSWPF 2016a, p. 21).

Of additional concern is the following statement from the 2016 Guidelines:

> These guidelines are not an exhaustive instruction for investigators and have been developed to assist through the provision of suggested investigative processes that may be employed in the investigation of these matters (NSWPF 2016a, p. 6).

The Commission notes that the 2016 Guidelines state that officers shall 'consider' these actions and that some of the suggested investigative processes 'may' be employed. This view is further reinforced in the 2016 Guidelines with key responsibilities of the duty officer and first officer at the scene (including actions to preserve the incident scene) being presented in checklists attached as an appendix to the guidelines rather than in the main body of the text.

The Commission's view is that while not all investigative processes will be applicable to all critical incidents, there are some, such as the preservation of the incident scene that must be employed and should not be left to the discretion of individual officers.

9. INVOLVED OFFICERS AND OTHER WITNESSES

9.1 OVERVIEW

Accounts of the people who have witnessed all or some parts of an incident assist investigators to understand the circumstances of the critical incident. Possible witnesses to the events leading to the death or serious injury might include police officers who were directly involved in the incident, other police who were not directly involved in the incident, as well as members of the community (such as passers-by or other spectators, friends or family of the victim(s), and paramedics).

The NSWPF has used the term 'witness' differently across the three sets of critical incident guidelines that are examined in this report. The different types of witnesses and ways the term 'witness' has been used in the three sets of guidelines are discussed in Section 9.2.1 of this chapter.

There are many reasons one would not expect all witnesses to give identical accounts of any incident. Some of these reasons are that different witnesses would have:

- seen different aspects of the incident because they:
    - viewed the incident from different physical positions and hence would have had a clearer line of sight of different aspects of the incident
    - gave more attention to some of the people involved in the incident or other aspects of the incident (for example, one person may have focussed on a particular police officer, another may have focussed on one of the victims, another may have been watching a paramedic and another may have watched a car driving past)
    - interpreted the events or actions differently because they:
    - differed in their expectations of what was likely to be occurring (based on their previous experiences) and these different expectations would have provided the basis for their interpretations
    - been able to recall different aspects and different amounts of the incident depending on:
    - the amount of attention they were paying to specific aspects of the incident
    - the strength of their memory.

The available research on human memory has highlighted that memory does not provide a perfect recording of a past event. Memory fades with time. Also individuals' memories can alter when they hear the recollections of others of the same event and seek to incorporate any additional information into their own recollection. A very brief outline of some key aspects of this research is provided in Section 9.2.2 of this chapter.

Since different witnesses may be able to provide information on different aspects of the incident it is important to obtain the accounts of all key witnesses and examine these accounts for both similarities and discrepancies. To minimise the memory fading it is

important to obtain these accounts as soon as possible after the incident had occurred. Since individuals' memories can alter when they hear the recollections of others, it is important that witnesses provide their accounts separately and that any discussion is minimised until after each has provided his or her account.

Following this background information, this chapter describes what can be learnt from an audit of documents located on the NSWPF e@gle.i system regarding the ways NSWPF officers undertake the following actions as part of their investigations of critical incidents:

1. identify involved officers
2. separate involved officers
3. obtain immediate and independent notebook records of involved officers
4. undertake interviews with involved officers
5. identify witnesses and take witness statements
6. ensure evidence of witnesses is not cross-contaminated
7. record a version of events from independent witnesses prior to speaking to involved officers.

Summary of findings

Identification of involved officers

Of the 81 strikeforces where the requirement to identify all involved officers was applicable:

- for all 81 (100%) strikeforces the Commission formed the view, from the available documentation located on e@gle.i, that all involved officers had been correctly identified
- the number of 'involved officers' in these 81 strikeforces ranged from one to 18.

Separation of involved officers

Of the 65 strikeforces where the requirement to separate involved officers was applicable:

- for 32 (49%) strikeforces, evidence was located on e@gle.i that the investigation complied with the 2007 Guidelines and that involved officers had been separated to ensure their evidence was not cross-contaminated
- for 25 strikeforces the Commission was unable to locate any documents on e@gle.i that included information as to whether or not involved officers had been separated by the duty officer
- for five strikeforces documents were located on e@gle.i that the investigation partly complied with the 2007 Guidelines. By this the Commission means that while the involved officers were not separated, they

were told not to speak to each other to ensure their evidence was not cross-contaminated

- for one strikeforce there was insufficient information to assess whether involved officers had been immediately separated
- for two strikeforces evidence was located on e@gle.i that the investigation had not complied with the 2007 Guidelines.

Immediate and independent notebook records of involved officers

Of the 76 strikeforces where the requirement to obtain immediate and independent notebook records of involved officers was applicable:

- for ten (13%) strikeforces notebook records of all officers involved in the critical incident evidence were located on e@gle.i indicating that the investigation complied with the 2007 Guidelines
- for 25 strikeforces some, but not all, involved officers had notebook records located on e@gle.i suggesting that the investigation partly complied with the 2007 Guidelines
- for 41 strikeforces the Commission was unable to locate any notebook records of any of the involved officers on e@gle.i.

Interviews with involved officers

Of the 80 strikeforces where the requirement to conduct interviews with involved officers was applicable:

- for 74 (93%) strikeforces all involved officers provided either statements or were interviewed by members of the CIIT, indicating that the investigation complied with the 2007 Guidelines
- for four strikeforces some, but not all, of the involved officers were interviewed or provided statements[179], suggesting that the investigation partly complied with the 2007 Guidelines
- for two strikeforces, the Commission assessed that the investigation had not complied with the 2007 Guidelines.

Identification of witnesses[180] and taking of witness statements

Of the 66 strikeforces where the requirement to identify witnesses and to take witness statements was applicable:

- 64 (97%) strikeforces had complied with the requirement of the 2007 Guidelines to obtain all witness statements
- two strikeforces had complied with identifying witnesses but had not complied with obtaining witness statements.

179 By way of example, for one critical incident there were ten involved officers. The Commission's audit only located eight statements on e@gle.i.

180 Including police witnesses not deemed to be involved officers.

Ensuring evidence of witnesses is not cross-contaminated

Of the 56 strikeforces where the requirement to ensure that the evidence of witnesses is not cross-contaminated was applicable:

- for six (11%) strikeforces the Commission located documents on e@gle.i that referred to the efforts that had been made to ensure that the evidence of witnesses was not cross-contaminated
- for 43 strikeforces the Commission was unable to locate any documents on e@gle.i that mentioned taking steps to ensure that the evidence of witnesses was not cross-contaminated
- for three strikeforces the Commission identified documents on e@gle.i that acknowledged that the evidence of witnesses had been contaminated
- for four strikeforces there had been an initial delay in declaring an incident as critical and consequently the 2007 Guidelines were not immediately implemented.

Record a version of events from independent witnesses prior to speaking to involved officers

Of the 55 strikeforces where the requirement to record a version of events from independent witnesses prior to speaking to involved officers was applicable:

- for three (5%) strikeforces the Commission located documents on e@gle.i that provided evidence that the requirement to record a version of events from independent witnesses prior to speaking to involved officers had been complied with
- for three strikeforces the Commission located documents on e@gle.i that provided evidence that the requirement to record a version of events from independent witnesses prior to speaking to involved officers had not been complied with
- for 49 (89%) strikeforces where witnesses were mentioned in either the CIIR, duty officer statements or other documents, the Commission was unable to locate any documents on e@gle.i that mentioned that the requirement to record a version of events from independent witnesses prior to speaking to involved officers had been complied with.

9.2 BACKGROUND: WITNESSES AND MEMORY

9.2.1 DIFFERENT TYPES OF WITNESSES TO CRITICAL INCIDENTS

In broad terms, it is possible to consider three different categories of witness to critical incidents: involved officers[181], other police officers and civilians. The use of the term 'witness' varies across the 2007 Guidelines, 2012 Guidelines and 2016 Guidelines.

The 2007 Guidelines distinguished 'involved officers (including officers from external agencies)' from 'other witnesses' when they stated that the duties of the duty officer included the following:

> Keep involved officers (including officers from external agencies) and other witnesses separated and ensure the evidence of these people is not cross-contaminated. It is important that involved officers are informed of the reasons for their separation. Ensure that the officers have sufficient welfare support (NSWPF 2007a, p. 18).

This distinction between 'involved officers' and 'other witnesses' was maintained in the 2007 and 2012 Guidelines in relation to the responsibilities of the local area commander, the first officer at the scene and the duty officer (NSWPF 2007a, pp.11, 13, 18; NSWPF 2012a, pp. 19, 24, 38).

The term 'civilian witnesses'[182], was introduced in relation to the responsibilities of the senior critical incident investigator (SCII) (NSWPF 2007a, p.21; NSWPF 2012a, p. 29; NSWPF 2016a, p. 24).

The term 'witness officer' is defined and used in the 2012 Guidelines and the 2016 Guidelines:

> A witness officer is an officer involved in the incident, but not considered to be a directly involved officer. It is expected that witness officers will provide any information that is in their knowledge to give, in an admissible format, whether or not there is any suggestion of police misconduct and whether the officer was on or off duty at the time of the incident (NSWPF 2012a, p. 32; NSWPF 2016a, p. 24).

Other related terminology that is used within the three sets of guidelines include 'independent witness'[183], 'crucial witness'[184], 'key witness'[185] and 'relevant witness'.[186]

---

181 'Involved officers' were also referred to as 'directly involved officers' within the NSWPF guidelines.

182 The term 'civilian witness' is not specifically defined in any of the sets of guidelines, possibly because the term is considered to be self-explanatory.

183 While not specifically defined, the term 'independent witness' would appear to refer to a witness who was not employed by the NSWPF (NSWPF 2007a, p. 18; NSWPF 2012a, p. 24; NSWPPF 2016a, p. 33).

184 While the term 'crucial witness' has not been defined its usage within the three sets of NSWPF guidelines suggests that it may be used synonymously with the term 'involved officer' (NSWPF 2007a, p. 21; NSWPF 2012a, p. 24; NSWPF 2016a, pp. 29, 37, 41).

185 NSWPF 2007a, pp. 40, 41.

186 NSWPF 2012a, p. 32; NSWPPF 2016a, pp. 24, 37.

9.2.2 MEMORY AND RECALL

Research on memory has indicated that 'rather than being an accurate video recording of a moment in in your life, it is a fragile brain state from a bygone time that must be resurrected for you to remember' (Eagleman 2015, p. 22). It has also been established that memories can be manipulated and it is possible to implant entirely false memories (Loftus 1997; Eagleman 2015, pp. 25-26).

Loftus's research has shown that when people who witness an event are later exposed to new and misleading information about it, their recollections often become distorted. Furthermore, memories are more easily modified when the passage of time allows the original memory to fade (Loftus 1997, p. 71).

Those who witness an event can be exposed to 'misinformation' by talking to others about the event, through media coverage of the event or by the wording of the questions that are put to them about the event. Loftus's work and that of her colleagues has provided evidence that 'people can be led to remember their past in different ways, and they can even be coaxed into "remembering" entire events that never happened' (Loftus 1997, pp. 72-73). Loftus has observed that memories are constructed by combining actual memories with the content of suggestions received from others. During the process, individuals may forget the source of the information (Loftus 1997, p. 75).

Eagleman has observed that not only was it possible to implant false new memories, but people embraced and embellished them, unknowingly weaving fantasy into their memories (Eagleman 2015, p. 25).

9.3 DOCUMENTS REVIEWED AS PART OF AUDIT

The Commission commenced by reviewing, where available, duty officer statements, critical incident investigation reports (CIIRs) and/or senior critical incident investigator (SCII) statements to establish if the requirements of the 2007 Guidelines in relation to selected investigation processes were recorded in any of these documents. If this information was not recorded in any of these documents, the Commission reviewed a number of additional documents[187] located on e@gle.i, most notably:

- review officer report
- region commander report
- first officers at the scene statements
- statements of involved officers
- crime scene guard statements
- crime scene logs
- critical incident operation logs
- duty officer logs

[187] The Commission reviewed a large number of documents that related to critical incident investigations and established that these documents were the most likely ones to contain the sought information.

- VKG incident logs
- NSWPF radio log books
- investigation chronology
- running sheets/logs
- notebook entries of involved officers
- duty operations inspector (DOI) critical incident notification form
- situation reports.

The Commission relied solely on documents located on e@gle.i in its audit and subsequent assessment of compliance with certain procedural requirements of the 2007 Guidelines.

9.4 IDENTIFICATION OF INVOLVED OFFICERS

9.4.1 WHAT DID THE GUIDELINES SAY?

While the 2007 Guidelines did not provide a definition of 'involved officer', the Appendix to the 2007 Guidelines stated that as a result of discussions with the NSW Coroner, an 'involved officer' was considered to be:

> '…*any officer who by words, actions or decisions has had the ability to impact on the outcomes of the matter.*' It was reaffirmed that an officer who is present, and does not involve themselves in activities which have had the ability to impact upon the outcome, is not directly involved. Presence at the scene is insufficient (NSWPF 2007b, p. 2).

The 2012 Guidelines and the 2016 Guidelines each also reaffirm that an officer who is present and does not involve themselves in activities which have had the ability to impact on the outcome is not a directly involved officer:

> The SCII will determine if an officer is to be considered a **directly involved officer** or a **witness**.
>
> A directly involved officer is any officer who by words, actions or decisions, in the opinion of the SCII, contributed to the critical incident under investigation. An officer who is present, and does not involve themselves in activities which has contributed to the incident occurring is not directly involved. Mere presence at the scene is insufficient (NSWPF 2012a, p. 31; NSWPF 2016a, p. 22)

The various sets of guidelines each state that the SCII must, amongst other responsibilities, 'establish the identity and location of all police and civilian witnesses' as well as '[e]nsure that the evidence of these people is not cross-contaminated' (NSWPF 2007a, p. 21; NSWPF 2012a, p. 29; NSWPF 2016a, p. 37).

9.4.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

The potential risks to the investigation will differ in their impact depending on whether one or more of the involved officers is not recognised as being an involved officer or whether there is a delay in identifying an officer as being 'directly involved'. In critical incidents where not all involved officers are identified, potential risks to the investigation include the loss of:

- the perspectives of any involved officers who were not identified, potentially resulting in a poorer understanding of the circumstances of the critical incident and a less thorough investigation
- the opportunity to collect additional evidence from these officers such as ballistic and forensic testing of the officers and their clothing; drug and alcohol testing of the officers.

Where there is a delay in identifying involved officers, potential risks to the investigation include the risks that:

- the officers may collude to create a shared (and possibly more favourable) account of what happened, which may also omit specific details that would have been included by individual officers from their personal recollections, reducing the information available for any subsequent investigation
- officers' recollection of events may change with the passage of time[188]
- the results of forensic testing and/or drug and alcohol testing might be less reliable given the delay in undertaking the testing.

9.4.3 WHAT DID THE COMMISSION FIND?

The Commission's review of 83 strikeforces identified that:

- for two strikeforces there were no involved officers. One of these strikeforces related to the shooting of a police officer by a civilian The second related to the suicide of a police officer
- for the remaining 81 strikeforces the Commission has formed the view, from the available documentation, that all involved officers were correctly identified.

The number of individuals identified as 'involved officers' in these 81 strikeforces ranged from one to 18 officers.

[188] See Section 9.2.2 in this chapter.

9.5 SEPARATION OF INVOLVED OFFICERS

9.5.1 WHAT DID THE GUIDELINES SAY?

As noted in Chapter 7, the 2007 Guidelines stated that the duty officer from the local area command where the incident occurred was required to attend the scene of the incident and assume command of the scene, until relieved by the local area commander or SCII. Amongst other responsibilities, the duties of the duty officer included:

> Keep involved officers (including officers from external agencies) and other witnesses separated and ensure the evidence of these people is not cross-contaminated. It is important that involved officers are informed of the reasons for their separation. Ensure that the officers have sufficient welfare support (NSWPF 2007a, p. 18).

While this information is replicated in the 2012 Guidelines (NSWPF 2012a, p. 24) and the 2016 Guidelines (NSWPF 2016a, pp. 32-33), it should be noted that in the 2016 Guidelines this advice is provided in one of the checklists appended to the guidelines, rather than in the body of the guidelines themselves, which runs the risk that this requirement may be overlooked.

9.5.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

In instances where involved officers are not immediately separated after a critical incident there is the risk that these officers may collude to create a shared (and possibly more favourable) account of what happened.

A shared account may also omit specific details that would have been included by individual officers from their personal recollections. This, in turn, may reduce the information available for any subsequent investigation.

9.5.3 WHAT DID THE COMMISSION FIND?

The Commission considered separation of the involved officers to be applicable in only 65 of the 83 strikeforces. Of the 18 strikeforces where the Commission considered that separation of the involved officers was not applicable:

- for eight strikeforces, there was a delay in declaring the event to be a ‘critical incident’ which provided no opportunity to separate the officers immediately following the incident
- for five strikeforces, no involved officers attended the site of the critical incident and hence there were no officers to separate (for example: one critical incident involved a woman telephoning the NSWPF prior to her committing suicide, another critical incident related to police inaction in terms of locating a person whose car had been reported to be seen on the highway, however, police did not instigate a land search and three days later the person was found dead)
- for three strikeforces, there was only one officer involved in the critical incident (and hence, there were no officers to separate)

- as stated earlier, for two strikeforces there were no involved officers.

Of the 65 strikeforces where separation of the officers was applicable:

- for 32 (49%) strikeforces, documents located on e@gle.i to confirm that the investigation **complied** with the 2007 Guidelines and that involved officers had been separated to ensure their evidence was not cross-contaminated[189]
- for five strikeforces records were located on e@gle.i that the investigation **partly complied** with the 2007 Guidelines. By this the Commission means that while the involved officers were not separated, they were told not to speak to each other to ensure their evidence was not cross-contaminated
- for 25 strikeforces the Commission was **unable to locate any documents** on e@gle.i that included information as to whether or not involved officers had been separated by the duty officer
- for one strikeforce there was **insufficient information to assess** whether or not the two involved officers were immediately separated after the critical incident had occurred. The CIIR stated that, due to the traumatic circumstances of the incident, the involved officers were allowed to recover before undergoing interviews
- for two strikeforces documents were located on e@gle.i that the investigation had **not complied** with 2007 Guidelines and that involved officers were not separated.[190]

The circumstances of the two strikeforces where it is known that the involved officers were not separated are described below. These descriptions illustrate the difficulty associated with separating officers following some critical incidents.

One strikeforce concerned a man who died in a metropolitan location in early 2011 after being pursued, restrained and handcuffed by up to 15 police officers[191]. The officers deployed tasers, OC spray, handcuffs and a baton. During this pursuit and restraint the man experienced breathing difficulties at which point the police officers removed the handcuffs and commenced CPR. An ambulance was summoned and upon its arrival the man was found to have died.

This death occurred shortly after 6am. The officer appointed as the SCII was informed at 7.00 am that a critical incident had been declared and has stated that he arrived at the site of the critical incident at 8.30 am. After speaking to a number of officers he proposed to postpone interviewing the involved officers until the following days due to the length of time the officers had been on shift. Documents located on e@gle.i indicated that the interviews of the 15 involved officers occurred over a five-day period, commencing the following day.

189 The information relating to the separation of involved officers (in 32 strikeforces) or to officers being told not to speak to each other (in five strikeforces) was located in a variety of document types: critical incident investigation reports (CIIRs) for 15 strikeforces; duty officer statements for 14 strikeforces; senior critical incident investigator (SCII) statements for five strikeforces; record of interview with duty officer for one strikeforce; SCII investigation log for one strikeforce; and in the review officer report for one strikeforce.

190 For one strikeforce this information was located in a duty officer statement, for the second strikeforce it was located in a SCII statement.

191 Different documents pertaining to this strikeforce referred to different numbers of involved officers. These numbers ranged from 11 to 15 involved officers.

While no duty officer statement was able to be located on e@gle.i, the duty officer completed a six-page handwritten 'Operations Log'. In this log, the duty officer made no mention of separating the involved officers prior to the arrival of the SCII at the scene.

The second strikeforce concerned a man who died at a regional location in 2012 as the result of a gunshot wound received in the course of a police operation. The coroner subsequently found that the officer who fired the shot had acted in the course of his duty.

In his statement, the SCII recorded that he spoke to a number of officers at the police station by phone to obtain further details and, where appropriate, to advise them how he required the incident to be managed until his arrival at the scene. He reported that one issue he addressed at this time was the separation of the two involved officers prior to their being formally interviewed. However, he was advised that the two officers, who were in a de-facto relationship, had been on their own for approximately two hours following the shooting prior to any other police arriving. On the basis of this information the SCII formed the view that there was no benefit in subsequently separating the officers prior to their being interviewed.

The circumstances of a strikeforce where a significant number of officers attended the scene of a critical incident, illustrating the difficulties involved in keeping them all separated, is described below.

In early 2012 police sighted a stolen car in a metropolitan location. A total of nine police officers attempted to stop the car, however, it sped off. At the time police were pursuing the car there was a large number of pedestrians on the footpath who were forced to either jump or move quickly out of the way of the car to avoid being hit. At this stage there were six police officers in foot pursuit. One officer used his retractable baton to punch a number of holes in the driver's window. The car drove onto the footpath striking two women, both of whom were thrown onto the bonnet of the vehicle. One of the women was carried approximately six metres before being thrown onto the footpath. One officer, fearing that the woman was in danger of being run over, discharged two rounds of his police firearm at the car intending to stop it. Another officer, also believing that the woman may be killed or seriously injured, drew his police firearm and discharged one round aimed at the driver of the car. The car continued for some time before colliding with a taxi. Police used their batons to smash the front passenger window and also deployed capsicum spray through the smashed front passenger window. There were a total of six men in the car. Two of the six men received bullet wounds and were conveyed to hospital in a critical condition.

NSWPF critical incident investigation

There was a large number of police officers who played a part in this incident. There were nine officers who were directly involved in this critical incident. A review of e@gle.i records identified a further 63 officers who attended the scene of the critical incident and assisted in the aftermath of this incident.[192] Roughly 12 officers were part of the Operations Support Group (OSG) which is a specialist group within the NSWPF that provides operational support on a 24 hour basis to all police to resolve public order incidents.[193] The remaining officers came from four different metropolitan commands. The majority of these

192 E@gle.i document entitled 'Synopsis of non-involved Police statements'

193 *Operations Support Group (OSG) Management & Operational Guidelines*, March 2014. The OSG can be activated for the following public order and specialist situations: Riots, Protests, Parades & Demonstrations, Large Crowd Events, Support of Local, Region & Specialist Command Operations, Execution of Search Warrants, First Responders for Chemical, Biological, Radiological & Nuclear incidents, High Visibility Policing and Violent Prisoner Facilitation (pp. 4-5).

officers provided statements in relation to their involvement in this matter; some of them submitted emails detailing their involvement. In addition the critical incident investigation team interviewed more than 50 civilian witnesses.

A review by a local area commander mentioned that witness accounts of police, offenders and civilians all differed. According to the local area commander this was not surprising as a lot was happening over a relatively short period of time. With not one witness statement the same and no CCTV that captured the exact time when the two officers discharged their firearms, it was left to investigators to piece together CCTV, expert evidence and versions of witnesses to provide an overview of what had most likely happened.[194]

The SCII concluded that the actions of the involved officers were justified and recommended no further action against any of the involved officers.

9.6 IMMEDIATE AND INDEPENDENT NOTEBOOK RECORDS OF INVOLVED OFFICERS

9.6.1 WHAT DID THE GUIDELINES SAY?

The guidance provided to officers investigating critical incidents has changed over the years in relation to requesting involved officers to immediately and independently record observations in their notebooks. This guidance has moved from in the 2007 Guidelines being a requirement for involved officers to record contemporaneous notes in their Police Notebook to, in the 2012 and 2016 Guidelines, it being an optional activity which the involved officers might choose to do.

The 2007 Guidelines, which were in operation at the time the critical incidents subject to this audit occurred, stated that one of the responsibilities of the duty officer from the local area command, who was required to assume command of the critical incident scene until relieved by the LAC commander or SCII, was to:

> request involved officers to immediately and independently record observations in their notebook (NSWPF 2007a, p.18).

The following caveat, however, was placed on this responsibility:

> **NOTE:** Prior to questioning involved officers be mindful of a suspect's right to silence. For example, if a police officer is suspected of committing a criminal offence and has indicated that he/she does not wish to be interviewed criminally do not ask the officer to record observations (NSWPF 2007a, p.18).

In the 2012 Guidelines the requirement for involved officers to record observations in their notebook changed to something that involved officers might choose to do if they desired:

194 The information pertaining to the review of a local area commander was included in an Annexure to a CIIR.

> Allow directly involved officers an opportunity to immediately and independently record observations in their official police notebook if they wish (NSWPF 2012a, p. 24).

The same responsibility is allocated to the duty officer in the 2016 Guidelines as was allocated in the 2012 Guidelines. Both the 2012 and the 2016 Guidelines also included the caveat (incorporated as part of the duty officer checklist) that had been in the 2007 Guidelines.

Guidance regarding recording contemporaneous notes in Police Notebook in circumstances other than events declared to be critical incidents

It is interesting to compare the guidance provided in the 2012 and the 2016 Guidelines concerning directly involved officers making immediate observations about critical incidents in their notebooks with the guidance provided more generally to NSWPF officers concerning recording contemporaneous observations about other incidents in their notebooks. The *Police Handbook* provides the following information:

> All police irrespective of rank or duty type will be issued with an official Police Notebook … All particulars after an incident should be recorded as soon as practical. Any issue of a serious or contentious nature may be recorded in a notebook or duty book, as soon as practical …
>
> …
>
> Remember, making notes at the time of an incident is a professional approach to policing, providing a valuable tool for you in many ways. Not only can you refer to the notes during evidence, but they also help you recall incidents and might help if you have to justify your actions …[195]

The information in the *Police Handbook* continues to outline the matters that should be recorded in an officer's notebook. The following types of information were listed, amongst others, as a minimum for what should be recorded:

- the exercise of power (e.g.: arrest, handcuffing, searching), and why the power was exercised
- warning given, including the offence
- execution of formal process (warrant, summonses)
- incidents where action will be taken later (summons, breach reports)
- complaints
- property damaged in the course of your duties
- any issue you determine to be of a serious or contentious nature.

In some training materials concerning investigations and case management, the NSWPF has provided a resource to operational police officers entitled *IN042 Importance of*

[195] Current at time downloaded from the NSWPF intranet on 19/4/2016. At the time it was downloaded, this Section of the Police Handbook was annotated 'Reviewed June 2013'.

Notebook Use.[196] This resource includes a section headed, *Why is a notebook so important?,* which states:

> - Your notebook is designed to assist you in the construction of your narratives, fact sheets and statements; it is a tool which you are expected to use to record your contemporaneous notes.
>
> - If notes are made in a contemporaneous manner then you may be able to refer to your notebook to refresh your memory in court.

9.6.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

If involved officers do not immediately complete independent notebook records of their knowledge in relation to the critical incident there are the risks that:

- officers' recollection of events may change with the passage of time[197]
- where involved officers do not independently complete their notebook records, there is the risk that these officers may collude to create a shared (and possibly more favourable) account of what happened
- a shared account may also omit specific details that would have been included by individual officers from their personal recollections, reducing the information available for any subsequent investigation
- officers may provide a misleading or untruthful account of their actions in later evidence, i.e. in their statements or records of interviews.

By way of example, one critical incident that occurred in late 2009 involved police officers attending a suburban residence following a report of an individual committing self-harm. Whilst being treated by ambulance staff at the scene, the individual became agitated. Upon seeing the individual in question in an agitated state and holding a knife, a police officer at the scene withdrew a service pistol and fired a single shot at the individual. The individual was later pronounced dead at the hospital. The coroner in his report of the coronial inquest findings observed that the notebook entries of a probationary constable, who was one of the involved officers, made no mention of any attempt by the man, who was subsequently shot, to stab or otherwise attack him. Nor was there any mention of that probationary constable wrestling or struggling with the man who was subsequently shot or being in close physical contact with him or being threatened by him. This is in direct contrast to this involved officer's later version which was incorporated in the CIIR. The later version stated that this involved officer was totally focussed on holding the deceased, struggling with him, screaming out himself (all of which was happening so suddenly) and then seeing that the other officer had produced her firearm (NSW Office of the State Coroner 2012, pp. 142, 151).

It is also noteworthy that, when questioned by senior counsel representing the family of the deceased at the inquest, the probationary constable said that he had been aware of

---

196 Current at time downloaded from the NSWPF intranet on 14/4/2016. At the time it was downloaded, this Section of the Police Handbook was annotated 'Last reviewed: Wed 3 June, 2015'.

197 See Section 9.2.2 in this chapter.

the importance of his notes in any investigation of this incident (NSW Office of the State Coroner 2012, p. 142).

9.6.3 WHAT DID THE COMMISSION FIND?

The Commission considered having the duty officer 'request involved officers to immediately and independently record observations in their notebook' to be applicable in only 76 of the 83 strikeforces. For seven strikeforces the officers determined to be 'involved officers' were not physically present at the scene of the critical incident. (By way of example, one critical incident related to the suicide of a police officer. No other police officers were present when this occurred or in any way contributed to the death of this officer. Another critical incident involved a woman telephoning the NSWPF prior to her committing suicide).

Of the 76 strikeforces where it was applicable for the duty officer to request that involved officers immediately and independently record observations in their notebook:

- for 10 (13%) strikeforces notebook records of all officers involved in the critical incident were located on e@gle.i indicating that the investigation complied with the 2007 Guidelines[198]
- for 25 strikeforces some, but not all, involved officers had notebook records located on e@gle.i. For example, one particular strikeforce identified four involved officers but only one of these officers had notebook records located on e@gle.i, suggesting that the investigation partly complied with the 2007 Guidelines
- for 41 (54%) strikeforces the Commission was unable to locate any notebook records of any of the involved officers on e@gle.i.

The relatively low percentage of strikeforces where all involved officers' notebook records were located on e@gle.i (13%) should be considered in the context that the critical incident investigations occurred at a time when involved officers were required to record such contemporaneous notes in their police notebooks. It is unlikely that the percentage of strikeforces with involved officers' notebook records located on e@gle.i would have increased in later years where recording contemporaneous notes became more discretionary on the part of the involved officer.

9.7 INTERVIEWS WITH INVOLVED OFFICERS

9.7.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that the SCII should:

> initiate inquiries with involved officers. Interviews with crucial witnesses should be conducted at the first available opportunity. If, for any reason, you decide not to interview an involved officer until a later stage (e.g. due to the mental or physical state of the officer, amount of time the officer has been

198 Information about the request to officers to make immediate and independent notebook records was documented in: duty officer statements for two strikeforces and in CIIRs for two strikeforces. However, the Commission was unable to locate any documents concerning this request for six of the ten strikeforces where notebook records for all involved officers had been located on e@gle.i.

> on duty or other relevant factor), consider what could be lost or potentially compromised by following this course of action. If the decision is based on the welfare of the involved officer, consultation with the EAP[199] on call psychologist is recommended (NSWPF 2007a, pp. 21-22).

While the same messages are provided in the 2012 Guidelines (NSWPF 2012a, p. 29) and the 2016 Guidelines (NSWPF 2016a, p. 37), it should be noted that in the 2016 Guidelines this advice is provided in one of the checklists appended to the guidelines, rather than in the body of the guidelines themselves.

9.7.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

The risks in not interviewing involved officers at the first available opportunity are the same as the risks of involved officers not immediately completing independent notebook records of their knowledge in relation to the critical incident. As discussed earlier, these risks are that:

- officers' recollection of events may change with the passage of time[200]
- in instances where involved officers are not interviewed at the first available opportunity, there is the risk that these officers may collude to create a shared (and possibly more favourable) account of what happened
- a shared account may also omit specific details that would have been included by individual officers from their personal recollections, reducing the information available for any subsequent investigation
- officers may provide a misleading or untruthful account of their actions in later evidence, i.e. in their statements or records of interviews.

9.7.3 WHAT DID THE COMMISSION FIND?

The Commission considered that interviews with involved officers were applicable in 80 of the 83 strikeforces. The Commission considered that interviews with involved officers would not have been applicable for the following three strikeforces: one where a person died in hospital, one that involved the suicide of a police officer and a third which was de-escalated by the deputy state coroner four days after it had been declared to be a critical incident.

Of the 80 strikeforces where the Commission considered interviews with involved officers to be applicable:

- for 74 (93%) strikeforces all involved officers provided either statements or were interviewed by members of the CIIT, indicating that the investigation **complied** with the 2007 Guidelines

---

199 Employee Assistance Program (EAP). The New South Wales Police Force provides personal counselling services for all staff and their immediate families via an external counselling organisation. EAP employs registered psychologists who are located throughout the State and provide emergency help for all employees. Crisis telephone counselling can be accessed 24 hours a day, 7 days a week (Information downloaded from NSWPF Intranet on 20/1/2017).

200 See Section 9.2.2 in this chapter.

- for four strikeforces some, but not all, of the involved officers were interviewed or provided statements[201], suggesting that the investigation **partly complied** with the 2007 Guidelines
- for two strikeforces, the Commission assessed that the investigation had **not complied** with the 2007 Guidelines:
    - for one strikeforce only one of nine involved officers willingly cooperated with members of the CIIT. The remaining officers made statements after written direction by investigators. The CIIR mentioned that the statements provided by these officers were inadmissible in that format
    - for the second strikeforce there were no statements or records of interviews of involved officers located on e@gle.i nor were there any recorded reasons as to why this was the case.

The critical incident where there were no statements or records of interview with involved officers located on e@gle.i is described below.

> Early one morning in late 2010 a motor vehicle collision occurred which resulted in serious and lifelong injuries to the driver of the car. Shortly before the collision a NSWPF highway patrol (HWP) officer drove past the vehicle which was travelling at high speed. The HWP officer attempted to catch up to the vehicle but prior to being able to do this the vehicle left the road and collided with a tree.
>
> Approximately four hours after the accident occurred this incident was declared to be a critical incident by the NSWPF. A duty officer attended the accident scene and assumed command. The duty officer, in accordance with NSWPF critical incident guidelines, separated the two involved officers.
>
> However, there were no statements or records of interviews of either of the two involved officers or the duty officer located on e@gle.i. No records could be located on e@gle.i that provided information as to why there were no statements by these officers.

9.8 IDENTIFICATION OF WITNESSES AND TAKING OF WITNESS STATEMENTS

9.8.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that the SCII must:

> Establish the identity and location of all police and civilian witnesses. Ensure that the evidence of these people is not cross contaminated (NSWPF 2007a, p. 21).[202]

201 By way of example, for one critical incident there were ten involved officers. The Commission's audit located only eight statements on e@gle.i.

202 The same requirement is included in the 2012 Guidelines (NSWPF 2012a, p. 29) and the 2016 Guidelines (NSWPF 2016a, p. 37).

9.8.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

The risk in not taking witness statements is a loss of the perspectives of witnesses from whom a statement was not taken, potentially resulting in a poorer understanding of the circumstances of the critical incident and a less thorough investigation.

9.8.3 WHAT DID THE COMMISSION FIND?

The number of witnesses identified in individual strikeforces ranged from one witness to over 130 witnesses. In critical incidents where large numbers of witness statements were taken, the Commission's audit was unable to confirm whether or not all relevant witnesses had been interviewed. Nevertheless, the Commission's assessment in respect to the identification of witnesses and taking of witness statements is based on whether or not the results of the Commissions' audit indicated that the efforts by the CIIT were satisfactory in regard to this requirement. The Commission considered that the identification of witnesses and taking of witness statements was applicable in only 65 of the 83 strikeforces. Of the remaining 18 strikeforces the Commission considered that the identification of witnesses and taking of witness statements:

- was **not applicable** for nine strikeforces as NSWPF records indicated that there were no witnesses to the critical incident
- was **not applicable** for one strikeforce which was de-escalated by the deputy state coroner four days after it had been declared to be a critical incident
- was **not able to be determined** for eight strikeforces as there were no documents located on e@gle.i that referred to any witnesses.

Of the 65 strikeforces where the identification of witnesses and taking of witness statements were applicable:

- 64 strikeforces **had complied** with the requirement of the 2007 Guidelines to identify all witnesses and to obtain their statements
- one strikeforce had **complied** with identifying witnesses but had **not complied** with obtaining witness statements. The CIIR referred to a statement made by one witness to the critical incident, however, because the witness statement was not located on e@gle.i the Commission was unable to assess compliance for this strikeforce.

9.9 ENSURE EVIDENCE OF WITNESSES IS NOT CROSS-CONTAMINATED

9.9.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that it is the responsibility of the duty officer to 'keep involved officers (including officers from external agencies) and other witnesses separated and ensure the evidence of these people is not cross contaminated' (NSWPF 2007a, p. 18).[203]

The 2007 Guidelines further specified that it is the responsibility of the SCII to 'establish the identity and location of all police and civilian witnesses' and to 'ensure that the evidence of these people is not cross contaminated'. The 2007 Guidelines also stated that 'interviews with crucial witnesses should be conducted at the first reasonable opportunity' (NSWPF 2007a, p. 21).[204]

9.9.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

The risk of not keeping involved officers and civilian witnesses separated is that they may discuss the incident to create a shared (and possibly more favourable) account of what happened.

A shared account may also omit specific details that would have been included by individual witnesses from their personal recollections. This, in turn, may reduce the information available for any subsequent investigation.

9.9.3 WHAT DID THE COMMISSION FIND?

The Commission considered that the requirement to ensure that the evidence of witnesses was not cross-contaminated to be applicable in only 56 of the 83 strikeforces.

Of the 56 strikeforces where cross-contamination of witness evidence was applicable:

- for six (11%) strikeforces the Commission located records on e@gle.i that mentioned that **efforts were made** to ensure that the evidence of witnesses was not cross-contaminated[205]
- for 43 strikeforces where witnesses were mentioned in either the CIIR, duty officer statement etc. the Commission was **unable to locate** any documents on e@gle.i that mentioned that the requirement to ensure that the evidence of witnesses was not cross-contaminated had been complied with

---

203 The same requirement is included in the 2012 Guidelines (NSWPF 2012a, p. 24) and the 2016 Guidelines (NSWPF 2016a, p. 19).

204 The same requirement was included in the 2012 Guidelines (NSWPF 2012a, p. 29). The 2016 Guidelines include this requirement in the Appendix, rather than in the main body of the Guidelines (NSWPF 2016a, p. 37).

205 The information was recorded in the following documents: three strikeforces recorded this information in the duty officer statement; one strikeforce recorded this information in the SCII statement; for one strikeforce this information was included in the coroner's findings; one strikeforce recorded this information in a transcript of interview with the victim of the critical incident.

- for three strikeforces the Commission located documents on e@gle.i that mentioned that the evidence of witnesses **had been contaminated**[206]
- for four strikeforces there had been an initial delay in declaring an incident as critical and consequently the 2007 Guidelines were not immediately implemented.

Of the 27 strikeforces where the Commission considered that cross-contamination of witness evidence was either not applicable or was unable to be assessed:

- for ten strikeforces there was only one witness listed in each of these strikeforces. The risk of witness evidence being cross-contaminated was therefore **not applicable**
- for 17 strikeforces there were either **no witnesses** to the critical incident or the Commission **was unable to assess,** from the documents located on e@gle.i if there were witnesses to the critical incident.[207]

An example of a strikeforce where a delay by the CIIT in obtaining statements from witnesses may have resulted in the evidence of witnesses being cross-contaminated is presented below.

> In early 2012, a NSWPF sergeant pursued a vehicle carrying four civilians. During the pursuit the civilian car crashed into another car. The sergeant did not witness the collision but arrived at the scene almost immediately afterwards. One of the passengers in the car that caused the accident was pronounced dead at hospital.
>
> The SCII returned to the scene of the incident eight hours later to obtain statements from witnesses. It is possible that in that time period witnesses may have been talking to each other and that their evidence may have been contaminated.

An example of a strikeforce where the CIIR mentioned that witnesses had discussed the events surrounding the incident is presented below.

> In late 2011 police responded to reports of a break-in by armed men at a house in a metropolitan location. A nineteen-year old man, who was armed with a vertical blind track assembly, approached police. A police officer shot the young man in the stomach. The young man recovered from his injuries.
>
> The CIIR mentioned that during an interview with the young man's girlfriend, she stated that she and other witnesses had discussed the circumstances surrounding the shooting prior to providing statements to the NSWPF.

206 This information was recorded in the following documents: one strikeforce recorded this information in the SCII statement; one strikeforce recorded this information in the CIIR.

207 While the CIIT took witness statements, they did not provide information in relation to the critical incident itself but to events or occurrences surrounding the critical incident. By way of example, the CIIT may have taken a statement from a witness who 'heard police sirens' but did not see or witness the actual accident etc.

The following case study illustrates the risk that a witness to a critical incident may be influenced by others.

In late 2011 a man and his nephew were approached by two men in a metropolitan location. The man produced a gun and pointed it at the two men who returned to their own vehicle and contacted the police. As a result police went to investigate this matter and approached the vehicle with their firearms drawn. Police communicated with the man trying to control the situation. However, the man pointed his firearm toward one of the officers which prompted the other two officers to discharge their firearms. One bullet hit the man in the head, wounding him fatally.

The resulting critical incident investigation and subsequent coronial inquest determined that the use of firearms by the involved officers was justified as they believed that the man was going to kill or seriously injure their colleague.

Of interest in relation to this incident is the possible contamination of the evidence of a key witness, a relative of the deceased, by members of the deceased's family.

The relative was initially interviewed by police a few hours after the incident had occurred. According to the relative's evidence in his first interview, the deceased had allegedly mentioned to the relative that if the two men were 'trying to be smart to me...' he would shoot them. The relative told police that the deceased had told him that he wanted to drive to the home of the two men. A short time later the deceased dropped off the relative to supposedly drive to the home of the two men.

Approximately three weeks after the incident had occurred the relative participated in a second interview with police, with the deceased's brother as his support person. During the course of his second interview with police he provided information that contradicted comments made in his first interview. Whereas in his first interview the relative had stated that the deceased had been angry at the two men and had expressed thoughts of shooting them, in his second interview he stated that the deceased had been 'scared', 'petrified', 'shivering' and 'frightened'. Also in the second interview he stated that the deceased had unloaded his firearm prior to pointing it at the two men. A further inconsistency was that the deceased allegedly had said that he was going to report this incident at the police station, which is inconsistent with the information provided in the first interview.

The SCII observed in the CIIR that it was apparent that the witness had been influenced by someone to portray the deceased differently from what he told police in his first interview.

9.10 RECORD A VERSION OF EVENTS FROM INDEPENDENT WITNESSES PRIOR TO SPEAKING TO INVOLVED OFFICERS

9.10.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that the duty officer from the local area command where the incident occurred would be required to attend the scene of the incident and assume command of the scene, until relieved by the local area commander or SCII. The responsibilities of the duty officer included the following:

> If possible obtain and record a version of events from an independent witness prior to speaking to involved officers (NSWPF 2007a, p. 18).

The 2012 Guidelines included the same requirement, but, in addition to the 2007 Guidelines, stated that this may assist the duty officer in determining whether a matter is a critical incident and to correctly identify which officers are directly involved in the critical incident (NSWPF 2012a, p. 24). The 2016 Guidelines are identical to the 2007 Guidelines in relation to this requirement and omitted the passage outlined in the 2012 Guidelines (NSWPF 2016a, p. 33).

9.10.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

In instances where there are no independent witnesses to a critical incident, or where they are spoken to at a later stage, there is the risk that the duty officer may not immediately identify all involved officers. As a consequence, the duty officer may not separate all involved officers which can impact on the ensuing investigation in terms of contamination of evidence, delay in drug and alcohol testing being conducted etc. Recording the evidence of an independent witness(es) prior to interviewing involved officers may also allow the CIIT to obtain information about the critical incident which can inform questions to be asked of the involved officers.

9.10.3 WHAT DID THE COMMISSION FIND?

None of the three sets of guidelines provide a definition of what constitutes an 'independent witness'. The Commission, in its assessment of compliance with this particular procedural requirement, determined that an 'independent witness' is any person other than an involved officer who had any knowledge of the critical incident.

The Commission considered that the requirement to record a version of events from an independent witness prior to speaking to involved officers to be applicable in only 55 of the 83 strikeforces.

Of the 55 strikeforces where the Commission considered that recording a version of events from an independent witness prior to speaking to involved officers was applicable:

- for three (5%) strikeforces the Commission located records on e@gle.i that mentioned that the requirement to record a version of events from independent witnesses prior to speaking to involved officers had been **complied with**
- for three strikeforces the Commission located records on e@gle.i that mentioned that the requirement to record a version of events from independent witnesses prior to speaking to involved officers had **not been complied** with
- for 49 strikeforces where witnesses were mentioned in either the CIIR, duty officer statements or other documents the Commission was **unable to locate** any documents on e@gle.i that mentioned that the requirement to record a version of events from independent witnesses prior to speaking to involved officers had been complied with.

Of the 28 strikeforces where the Commission considered that recording a version of events from an independent witness prior to speaking to involved officers was not applicable:

- for 17 strikeforces there were either **no witnesses** to the critical incident or there were no documents located on e@gle,i that referred to any witnesses and the Commission **was unable to assess** whether or not there were any witnesses to the critical incident
- for six strikeforces the Commission located records on e@gle.i that there were witnesses interviewed as part of the critical incident investigation, however, **none of these persons had witnessed the critical incident** and were therefore not required to provide a version of events prior to investigators speaking to involved officers
- while the CIIT identified witnesses and took witness statements for two strikeforces there was an **initial delay in declaring an incident as critical** and consequently the NSWPF critical incident guidelines were not immediately implemented, which affected the requirement to record a version of events from independent witnesses prior to speaking to involved officers
- one strikeforce was de-escalated four days after it had been declared a critical incident. While there is information located on e@gle.i that witnesses were identified, there was no further information whether or not independent witnesses had been spoken to prior to involved officers
- in one strikeforce, the involved officers had no direct contact with the deceased and did not contribute to the death of this person
- one strikeforce related to the suicide of a police officer and there were no involved officers.

An example of a strikeforce where witnesses were interviewed days and, in some instances, weeks after the involved officers were interviewed, is presented below.

One strikeforce concerned a man who died in a metropolitan location in early 2011 after being pursued, restrained and handcuffed by a large number of police officers[208]. The officers deployed tasers, OC spray, handcuffs and a baton. During this process the man experienced breathing difficulties at which point the police officers removed the handcuffs and commenced CPR. An ambulance was summoned and upon its arrival the man was found to have died. It later became known that, at the time of the chase and the attempted arrest, the man was in a LSD-induced psychotic state.

In terms of recording a version of events from independent witnesses prior to speaking to involved officers the following information was available. A total of 15 police officers were involved in this critical incident. The interviews with these 15 officers were completed over a five-day period.

The Commission's audit of documents located on e@gle.i identified six persons who had directly witnessed the chase and tasering of the man. The interviews of these six witnesses occurred days, and in some instances, weeks after the interviews with the involved officers had been conducted.

208 Different documents pertaining to this strikeforce referred to different numbers of involved officers: ranging from 11 to 15 involved officers.

9.11 OBSERVATIONS

As discussed at the beginning of this chapter, accounts of those who have witnessed all or some parts of the incident assist investigators to understand what was happening leading up to and during the critical incident. The procedural requirements examined in this chapter assist members of the CIIT to obtain valuable information from witnesses (both civilian and police) to ensure that:

- the accounts of all key witnesses are obtained to inform the investigation (by identifying and interviewing the involved officers and by identifying witnesses and taking witness statements)
- the accounts are obtained as soon as possible (by obtaining immediate notebook records of involved officers and interviewing crucial witnesses at the first available opportunity)
- witnesses provide their accounts separately and that any discussion is minimised until after they have provided their accounts (by separating involved officers, obtaining independent notebook records of involved officers, and taking steps to safeguard that the evidence of witnesses is not cross-contaminated).

The Commission's audit ascertained that there was a high compliance rate with a number of these procedural requirements. High compliance rates occurred in relation to correctly identifying involved officers to a critical incident (100%), conducting interviews or obtaining statements from involved officers (93%) and identifying witnesses and taking of witness statements (97%).

However, the Commission's audit also identified procedural requirements that either had a low level of compliance or where the Commission was unable to locate any records on e@gle.i to confirm if these requirements had been complied with. Compliance with the requirement to obtain immediate and independent notebook records of involved officers was at 13 per cent; compliance with the requirement to ensure that the evidence of witnesses was not cross-contaminated was at 11 per cent and compliance with the requirement to record a version of events from independent witnesses prior to speaking to involved officers was at five per cent.

While the 2007 Guidelines stated that the duty officer 'request' that involved officers provide independent notebook records, the 2016 Guidelines state that the duty officer 'allow involved officers an opportunity to immediately and independently record their observations in their official police notebook if they wish'. In the 2016 Guidelines this requirement is now discretionary and refers to an involved officer's 'right to silence' if he/she is suspected of having committed a criminal offence.[209]

The three sets of guidelines mention that a duty officer from the local area command where the incident occurred must attend the scene of the incident and assume command of the scene until relieved by the local area commander or the SCII. It is therefore the

[209] While the 2007 Guidelines stated that the duty officer 'request' that involved officers provide independent notebook records, the 2016 Guidelines state that the duty officer 'allow involved officers an opportunity to immediately and independently record their observations in their official police notebook if they wish'. In the 2016 Guidelines this requirement is now discretionary and refers to an involved officer's 'right to silence' if he/she is suspected of having committed a criminal offence.

responsibility of the duty officer to carry out some of the initial requirements aimed at protecting the evidence of involved officers and any witnesses and to ensure that it is not cross-contaminated.

The Commission acknowledges that, at times, it will be difficult for the duty officer to request compliance with some of the procedural requirements outlined above. There will be incidents where it may not be possible for the duty officer to immediately separate all involved officers and witnesses due to the circumstances of the situation. Similarly it may not always be possible for the duty officer to request immediate and independent notebook records of all involved officers due to emotional state of the involved officers. Nonetheless, compliance with these procedural requirements provides assurance to the public that the NSWPF has examined the facts and circumstances that led to a critical incident and investigated such incidents in an effective manner.

10. EXHIBIT HANDLING

10.1 OVERVIEW

One aspect of a good critical incident investigation is effective exhibit management including the collection, security, continuity and integrity of all exhibits.

This chapter describes what can be learnt from an audit of documents located on the NSWPF e@gle.i system in relation to the documentation of the appointment of an exhibit officer and the management of specific types of exhibits including:

a) identification of any police or civilian vehicles involved in the incident so that they remain in situ for later examination

b) taking possession of police records relating to the incident as soon as possible

c) securing police issued firearm or other appointment for later examination.

Summary of findings

Appointment of exhibit officer

Of the 80 strikeforces where the appointment of an exhibit officer was applicable:

- for six (8%) strikeforces the Commission located records on e@gle.i that included the name of the exhibit officer who had been appointed
- for 74 strikeforces (92%) the Commission was unable to locate any documentation on e@gle.i that provided information as to the identity of the exhibit officer.

Identification of police and civilian vehicles involved in critical incidents

Of the 38 strikeforces where the identification of vehicles was applicable:

- 25 strikeforces (66%) complied with the 2007 Guidelines and included documentation on e@gle.i that involved vehicles were secured for later examination
- 13 strikeforces did not include documentation on e@gle.i that involved vehicles were secured for later examination.

Taking possession of police records

Of the 82 strikeforces where taking possession of police records was applicable:

- for 79 (95%) strikeforces the Commission was unable to assess whether these strikeforces had attached all relevant police records to e@gle.i
- two strikeforces had no police records that could be located on e@gle.i
- for one strikeforce the Commission identified that at least one police record could not be located on e@gle.i.

Securing police issued firearm or other appointment

Of the 28 strikeforces where securing a police issue firearm or other appointment was applicable:

- 26 (93%) strikeforces complied with the 2007 Guidelines and documents pertaining to securing appointments could be located on e@gle.i
- two strikeforces did not provide documentation on e@gle.i that the police issued appointments were secured for later examination.

Consistency of documentation

- Information regarding compliance with the appointment of an exhibit officer and in relation to the management of specific types of exhibits was not consistently recorded on e@gle.i. Where the information was located, for some strikeforces this information was recorded in CIIRs, for others it was recorded in SCII statements, duty officer statements or review officer reports.

10.2 DOCUMENTS REVIEWED AS PART OF AUDIT

While all three sets of guidelines indicate that it is the role of the senior critical incident investigator (SCII) to appoint an exhibit officer, they do not specify where information in relation to exhibit management is to be recorded.

The Commission commenced by reviewing, where available, critical incident investigator reports (CIIR), review officer reports, duty officer statements and statements of critical incident investigation team (CIIT) members to establish the extent to which exhibit management was documented and recorded in critical incident investigations. The findings presented in this chapter are derived from these documents.

The Commission relied solely on documentation that was located on e@gle.i in its audit and subsequent assessment of compliance with exhibit management of NSWPF critical incident guidelines for the 83 strikeforces audited for this project.

Table 10.1: Exhibit management: Summary of compliance concerning specific actions for the 83 critical incidents for which documentation was located on e@gle.i

Investigative action	%	Number							
	% of strikeforces on e@gle.i that complied[210]	Total strikeforces reviewed[211]	Evidence strikeforces complied	Evidence strikeforces partly complied	Evidence strikeforces did not comply	Unable to assess available information	Information unable to be located on e@gle.i	Total applicable strikeforces[212]	Strikeforces where Investigative action not applicable
Appointment of an exhibit officer	**8%**	83	6	0	0	7[213]	67	80	3[214]
Identification of police and civilian vehicles involved in critical incident	**66%**	83	25	0	0	0	13	38	45[215]
Take possession of police records relating to the incident as soon as possible	?[216]	83	0	0	3[217]	79[218]	0	82	1[219]
Securing police issued firearm or other appointment for later examination	**93%**	83	26	0	0	0	2[220]	28	55[221]

210 Calculated by dividing [(the number of strikeforces where evidence of compliance was located on e@gle.i) by (the number of strikeforces for which the investigative action was applicable)] x 100.

211 Of the 125 NSWPF critical incidents understood to have occurred from 1 January 2009-30 June 2012, 83 critical incidents had records pertaining to their investigation stored on the NSWPF investigative information management system 'e@gle.i'. These records were stored under the investigation 'strikeforce' name. Documents for all 83 strikeforces were examined for information concerning compliance for each of the specific investigative processes audited as part of Project Harlequin.

212 Total applicable investigations = (83 strikeforces reviewed) less (number of strikeforces where investigative action was not applicable).

213 For seven strikeforces there was no CIIR available. The Commission abstained from assessing compliance by the SCII with the requirement of appointing an exhibit officer as this information may be included in the outstanding CIIR.

214 For three strikeforces, on the face of it, there was no requirement to appoint an exhibit officer. One strikeforce was de-escalated four days later by the Deputy State Coroner. Two incidents were retrospectively deemed to constitute critical incidents and therefore no exhibit officer was appointed at the time of the incident.

215 For 44 strikeforces, no vehicles were involved in the incident. For one strikeforce, which may have involved a civilian vehicle, the deputy state coroner declared that this incident did not fit the criteria of a critical incident four days after it had been declared a critical incident.

216 It was not possible to calculate the percentage of strikeforces that complied because the Commission was not able to identify whether the CIIT had taken possession of all relevant police records.

217 For one strikeforce, information located on e@gle.i indicates that a member of the CIIT made a request for radio logs as there were allegations that a police pursuit resulted in a fatal motor vehicle accident, however, no records of these radio logs are located on e@gle.i. (Also of interest, is that the review officer report did not identify any issues with this investigation). For two strikeforces there were no police records listed.

218 For 79 strikeforces the Commission identified a number of police records located on e@gle.i. The number of police records varied significantly among strikeforces, ranging from one police record to more than 60 police records.

219 For one strikeforce, the deputy state coroner declared that the incident did not fit the criteria of a critical incident four days after it had been declared a critical incident.

220 For two strikeforces there were no records as to whether or not police issued appointments were secured for later examination.

221 For 55 strikeforces, no police appointments were used.

10.3 APPOINTMENT OF AN EXHIBIT OFFICER

10.3.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that the SCII must:[222]

> ensure that an exhibit officer is appointed to assist the forensic investigators and other FSG personnel in the collection, security, continuity and integrity of all exhibits (NSWPF 2007a, p. 21).

When the Commission sought additional information about the role of the exhibit officer, the NSWPF advised that an exhibit officer is 'any police officer appointed to collect, record and manage the gathered exhibits'. The NSWPF further advised that usually an investigator attached to the investigation performs the role of exhibit officer.[223]

10.3.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

Exhibits play a pivotal role in establishing the facts in relation to a critical incident. It is the role of the exhibit officer to collect all relevant exhibits. Where no exhibit officer is appointed, or where an exhibit officer fails to collect all relevant exhibits:

- vital evidence may be lost or degraded
- continuity and integrity of exhibits may be compromised, rendering the information unreliable.

10.3.3 WHAT DID THE COMMISSION FIND?

Appointment of an exhibit officer

The Commission considered that an exhibit officer would be required to be appointed in 80 of the 83 strikeforces.[224] The Commission's audit of these 80 strikeforces identified:

- six strikeforces (8%) that included the name of the exhibit officer who had been appointed by the SCII[225]
- 74 strikeforces (84%) where the Commission was **unable to locate any documentation** or records by the SCII, or others that provided information as to the identity of the exhibit officer.

---

222 The 2012 Guidelines and the 2016 Guidelines do not use the word 'must' but only state: 'ensure that…' (NSWPF 2012a, p. 29; NSWPF 2016a, pp. 36-37). In the 2016 Guidelines this requirement is included in an Appendix to the Guidelines.

223 Letter from the NSWPF Assistant Commissioner Professional Standards Command received on 29 April 2016.

224 For three strikeforces, on the face of it, there was no requirement to appoint an exhibit officer. One incident was de-escalated four days later by the deputy coroner and no records were located on e@gle.i as to whether or not the SCII had appointed an exhibit officer at the initial stages of the critical incident investigation. The remaining two incidents were retrospectively deemed to constitute critical incidents and as a consequence no exhibit officers were appointed at the time of the incidents.

225 The information was recorded in SCII statements (two strikeforces); CIIRs (two strikeforces); duty officer statement (one strikeforce) and a review officer report (one strikeforce).

Exhibit management

At the outset of its audit the Commission sought to examine whether all relevant evidence or exhibits had been obtained by members of the CIIT for each of the 83 strikeforces audited. The number of exhibits located on e@gle.i varied significantly, ranging from only a few exhibits to over 223 exhibits. The Commission was unable to locate any specific documents on e@gle.i that provided an account of all exhibits collected by the exhibit officers. It was therefore not possible for the Commission to determine whether or not all appropriate exhibits/evidence had been collected by members of the CIIT for the 83 strikeforces.

One of the few strikeforces where the SCII mentioned the name of the exhibit officer and provided an account of exhibits seized during the investigation is described below.

> In 2012 members of an alternative commune attended a police station requesting police assistance at a property. According to these members, a man had been threatening people with a knife. Two police officers attended the location. Upon arriving at the property police spoke to the man who was armed with a large carving knife. The man made threats towards the two police officers. The officers retreated behind vehicles and challenged the man to drop his weapon. The man continued to advance and police retreated until they could not retreat any further. One of the officers discharged his firearm a number of times hitting the man. Police, with the help of some civilians, tried to treat the man's wounds but he died at the scene.
>
> The SCII mentioned in his statement that following the shooting incident a detective sergeant, who was a member of the Forensics Services Group, was contacted and was responsible for examining the scene and exhibits seized. The SCII statement mentioned that the exhibit officer attended the Police Station and took possession of the two involved officers' clothing and appointments. The SCII further stated that the detective sergeant examined and recorded the various scenes, taking notes, measurements, photographs and videos and further examined and collected various items.

10.4 IDENTIFICATION OF POLICE AND CIVILIAN VEHICLES INVOLVED IN CRITICAL INCIDENT

10.4.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that the SCII must:[226]

> identify any police and civilian vehicles involved in the critical incident and ensure that they remain in situ for later examination (NSWPF 2007a, p. 21).

[226] In the 2012 Guidelines the word 'must' had been omitted and the guidelines simply stated: 'identify any…'.The 2016 Guidelines are identical to the 2012 Guidelines. In addition, this requirement is not in the main body of the 2016 Guidelines but mentioned in Appendix 5 which is a checklist for the SCII for action required to be taken (NSWPF 2012a, p. 29; NSWPF 2016a, p. 36).

10.4.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

If police and civilian vehicles involved in the critical incident are not identified or if they are moved then information that assists to understand the circumstances leading up to the incident may be lost. If, for example, a vehicle that has been involved in a critical incident is moved prior to examination it would not be possible for the Crash Investigation Team to examine the angle of impact or the relationship to skid marks on the road.

10.4.3 WHAT DID THE COMMISSION FIND?

Only 38 of the 83 strikeforces involved police and/or civilian vehicles. The Commission's audit of these 38 strikeforces identified:

- 25 (66%) out of 38 strikeforces **complied** with the 2007 Guidelines and included documentation that involved vehicles were secured for later examination[227]
- 13 out of 38 strikeforces where the Commission was **unable to locate any documentation** to confirm that involved vehicles were secured for later examination.

10.5 TAKE POSSESSION OF POLICE RECORDS RELATING TO THE INCIDENT AS SOON AS POSSIBLE

10.5.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that the SCII must:[228]

> take possession of police records relating to the incident including, but not limited to COPS reports, radio tape transcripts, staff rosters, CIDS documentation, custody records etc. as soon as possible (NSWPF 2007a, p. 22).

The 2016 Guidelines are identical to the 2012 Guidelines with the addition of the following records: 'ICV, Body Worn Video, Tasercam Footage, CCTV' (NSWPF 2016a, p. 37).[229]

10.5.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

Police records relating to the critical incident including (but not limited to) COPS reports, radio tape transcripts, staff rosters, custody records etc. assist the CIIT to establish the events leading up to and during the critical incident. Police records help to corroborate some of the information provided by involved officers and witnesses. In circumstances

---

227 This information was included in the CIIR (for 14 strikeforces), in the SCII statement (for five strikeforces), in the review officer report for (two strikeforces), and in the duty officer statement (for three strikeforces).

228 The 2012 Guidelines did not use the word 'must' but simply stated: 'take possession…..' (NSWPF 2012a, p. 30).

229 This requirement is included in a checklist attached to the 2016 Guidelines.

where the CIIT does not make applicable police records available on e@gle.i there is the risk that not all relevant evidence is considered, potentially resulting in flawed investigative findings.

10.5.3 WHAT DID THE COMMISSION FIND?

The Commission's audit of 83 strikeforces identified:

- 79 (95%) strikeforces where the Commission was **unable to assess** whether these strikeforces had complied with the 2007 Guidelines. While the Commission located some police records on e@gle.i it was not able to determine if all relevant police records were located on e@gle.i [230]
- two strikeforces that had **not complied** with the 2007 Guidelines and no police records could be located on e@gle.i
- one strikeforce that indicated that a member of the critical incident investigation team (CIIT) had requested radio logs. This incident related to a police pursuit that resulted in a fatal motor vehicle accident. While the request for radio logs is located on e@gle.i, no response to this request could be located on e@gle.i, that is to say, at least one of the relevant police records was not located on e@gle.i. There are, however, a number of other police records located on e@gle.i.

One strikeforce, though originally declared a critical incident, was de-escalated four days later by the region commander as the deputy state coroner had determined that this incident did not fit the criteria of a critical incident. This strikeforce had a number of police records located on e@gle.i.

The 2007 Guidelines clearly stated that the SCII must take possession of police records relating to the critical incident including, but not limited to, COPS reports, radio tape transcripts, staff rosters, CIDS documentation, custody records etc. as soon as possible (NSWPF 2007a, p. 22). It is therefore anticipated that any critical incident requires certain types of police records that are relevant such as, at a minimum, COPS reports of the incident and staff rosters.

An example of one of the two strikeforces for which no police records could be located on e@gle.i, and therefore did not appear to comply with the 2007 Guidelines in relation to taking possession of police records relating to the incident as soon as possible, is described below.

> In mid-2010 a police vehicle engaged in a police pursuit of a stolen motor vehicle and activated its light bar and siren. The stolen vehicle went through a red traffic control signal and shortly after collided with another vehicle before crashing into a telegraph pole. The driver of the stolen vehicle was trapped inside the car and sustained serious leg injuries.
>
> The CIIR referred to a review of the VKG radio tape which allegedly indicated that the police pursuit lasted a mere 20 seconds. No record of the VKG radio tape, mentioned in the CIIR, was located on e@gle.i. There were only nine records

[230] The number of police records located varied significantly among strikeforces, ranging from one police record to more than 60 records.

located on e@gle.i and none of them were police records. Neither the review officer, in the review officer report, raised any concerns in relation to the fact that only nine records were located on e@gle.i, nor did the region commander in his endorsement of the review officer report and CIIR.

10.6 SECURE POLICE ISSUE FIREARM OR OTHER APPOINTMENT FOR LATER EXAMINATION

10.6.1 WHAT DID THE GUIDELINES SAY?

The 2007 and 2012 Guidelines stated that the duty officer from the local area command where the incident occurred would be required to attend the scene of the incident and assume command of the scene, until relieved by the local area commander or SCII. The responsibilities of the duty officer were stated to include the following:

> If the incident involves the discharge of a police firearm, arrange for the removal, labelling and independent security of appointment belts and contents from directly involved officers for examination by the Forensic Ballistics Investigation Section (FBIS). Instruct all police present when the incident occurred to remain available for assessment and examination by the FBIS. In any case, liaise with the forensic investigator and the FBIS for advice. Be aware that those directly involved officers whose firearms have been removed are no longer operational.
>
> Where the serious injury or death results from the use of a police issue appointment other than a firearm, the relevant appointment must be similarly secured for examination by the Crime Scene Services Branch (NSWPF 2012a, p. 24).

There was a section in the Appendix to the 2007 Guidelines that explained the role of the Forensic Ballistics Investigation Section (FBIS) in relation to firearms. It indicated that:

> The primary role of the FBIS is the forensic investigation of serious crime involving the use of firearms state-wide. This is achieved by attending crime scenes, post mortems and the macroscopic identification of ammunition components. The FBIS also contains a laboratory where firearms and prohibited weapons are examined and expert certificates produced for court proceedings (NSWPF 2007b, p. 7).

The 2016 Guidelines provide the same guidance as the 2007 and 2012 Guidelines with the exception that the sentence in the second paragraph: 'Be aware that those directly involved officers whose firearms have been removed are no longer operational' has been removed (NSWPF 2016a, p. 33).

10.6.2 WHAT IS THE RISK FOR THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

If the police appointment is not immediately secured:

- it could be misplaced, meaning that primary evidence could be lost
- with the passing of time it may become more difficult for investigators to determine who was in possession of the police appointment (i.e. firearm, OC spray, taser, baton etc.) at the time of the incident.

10.6.3 WHAT DID THE COMMISSION FIND?

Only 28 of the 83 strikeforces involved a police issue firearm or other police issue appointment. The Commission's audit of these 28 strikeforces identified:

- 26 (93%) strikeforces **complied** with the 2007 Guidelines and documents pertaining to securing the police issue appointment for later examination were located on e@gle.i[231]
- two strikeforces where the Commission was **unable to locate any documentation** on e@gle.i to confirm that police issue appointments were secured for later examination.

10.7 OBSERVATIONS

The exhibit officer plays an important role in any critical incident investigation. As stated earlier in this chapter, where no exhibit officer is appointed, or where an exhibit officer fails to collect all relevant exhibits from the scene of the critical incident, there is the risk that the investigation will be compromised through vital evidence being lost or degraded, or through the continuity and integrity of exhibits being compromised.

In 67 of the critical incident strikeforces that it audited, the Commission was not able to verify the identity of the exhibit officer from the information located on e@gle.i. As a consequence, the Commission was not able to verify that an exhibit officer had been appointed or, if one had been appointed, verify who was accountable for the collection security, continuity and integrity of the exhibits.

The Commission acknowledges that it is possible that this information may have been stored on a different NSWPF computer base (such as the Exhibits, Forensic Information and Miscellaneous Property System). However, to ensure accountability and transparency of a critical incident investigation are maintained it is important that the identity of the exhibit officer and a comprehensive record of all exhibits seized by this officer are available on the primary investigations management system for these types of investigations (currently e@gle.i).

---

231 This information was documented in duty officer statements (for 14 strikeforces), in CIIRs (for 12 strikeforces), in SCII statements (for three strikeforces) and in a review officer report (for one strikeforce). For a number of strikeforces, the information relating to the securing of police issue appointments for later examination was recorded in the duty officer statement as well as the CIIR.

11. MANDATORY DRUG AND ALCOHOL TESTING

11.1 OVERVIEW

According to the 2007 Guidelines, one of the major implications of an incident being classified as a critical incident included:

> … consideration to drug and alcohol testing of involved officers in accordance with section 211A of the Police Act and the NSW Police Drug and Alcohol policy (NSWPF 2007a, p. 2).

This chapter provides a discussion of the purpose of mandatory drug and alcohol testing, the risks where testing is not undertaken, and presents the Commission's findings with respect of compliance with mandatory drug and alcohol testing.

Set out below is an overview of the Commission's findings regarding these issues.

Summary of findings

- Not all critical incidents require that officers undergo mandatory drug and alcohol testing. Mandatory testing incidents are defined in legislation, and include incidents where a person is killed or seriously injured:

  (a) as a result of the discharge of a firearm by a police officer, or
  (b) as a result of the application of physical force by a police officer, or
  (c) while detained by a police officer, or while in police custody, or
  (d) in circumstances involving a police aircraft, motor vehicle or vessel.

- There is a NSWPF Drug and Alcohol Policy. Additional information on the requirements of mandatory drug and alcohol testing is contained within the NSWPF critical incident guidelines.
- The Commission found that drug testing was undertaken in all 49 (100%) mandatory testing strikeforces, with all officers in each of the 49 strikeforces returning a negative result. Forty seven (96%) of these strikeforces complied within the desired timeframe for drug testing of involved officers to be undertaken within 24 hours of the incident.
- The Commission found that alcohol testing was undertaken in 43 (88%) of the 49 mandatory testing strikeforces, with all officers in each of the 43 strikeforces returning a negative result. Six (14%) mandatory alcohol testing strikeforces complied within the desired timeframe for alcohol testing to be undertaken within two hours of the incident.

11.2 UNDERSTANDING MANDATORY DRUG AND ALCOHOL TESTING

Mandatory drug and alcohol testing was introduced by way of legislative amendment in July 1998, and is reflected in s211(2A) of the *Police Act 1990* (NSW)[232] and within current NSWPF policies.[233] While current legislation and policies set out the requirements for how drug and alcohol testing is to be undertaken, the purpose of this testing is not (Police Integrity Commission 2005a, p. 301).

According to s211A (2A) of the *Police Act 1990* (NSW):

> 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.

11.2.1 PURPOSE OF MANDATORY DRUG AND ALCOHOL TESTING

The NSWPF Drug and Alcohol Policy states that all forms of drug and alcohol testing of NSWPF officers, including mandatory drug and alcohol testing, are:

> aimed at deterring and detecting prohibited drug use by police officers at any time or impairment by alcohol whilst undertaking police duties (NSWPF 2007c, p. 6).

In passing the *Police Service Amendment (Alcohol and Drug Testing) Act 1998* (NSW), the, then, Minister of Police indicated that such testing would remove one cause of doubt that a death in police custody occurred as a result of impairment by drugs or alcohol at the time of an incident.[234] The, then, Minister of Police further stated that the mandatory testing of officers also served to:

- provide accountability and consistency of approach in the investigation of deaths in custody; and
- protect public safety as well as the safety and wellbeing of police officers (NSW Legislative Assembly Hansard, Police Service Amendment (Alcohol and Drug Testing) Bill, Second Reading Speech, 27 May 1998, pp. 5328-5329 cited in Police Integrity Commission 2005a, p. 301).

---

232 Accessed 9 May 2016, http://www.austlii.edu.au/au/legis/nsw/consol_act/pa199075/s211a.html

233 NSW Police Force Drug and Alcohol Policy 2007; NSW Police Force Critical Incident Guidelines (2007, 2012 and 2016).

234 Media Release from the Office of the Hon. Paul Whelan, Minister for Police, 20 May 1998 in Police Integrity Commission (2005a, p. 298).

This legislation was itself introduced as a result of recommendations made by the, then, state coroner D. W. Hand at the conclusion to the February 1998 – March 1998 inquest into the death of Mr. Roni Levi, who was shot by NSWPF officers in Bondi in June 1997. At the time of this shooting, there had been no statutory requirement compelling officers involved in shooting deaths such as this to undergo drug and alcohol testing.[235] The death was, however, classified as a death in a police operation and was therefore referred to the NSW state coroner for consideration.

On 11 March 1998 coroner Hand made a number of recommendations arising from evidence given. With respect to policing, nine recommendations were made, one which related directly to drug and alcohol testing. This was:

> In order that police officers may answer any allegations that they may have been affected by alcohol or drugs at the time of an incident, I am of the opinion that it is imperative that legislation be amended to provide for such officers to be mandatorily alcohol/drug tested as soon as possible following such an incident. I see this provision as being an important form of protection for police officers particularly when unfounded allegations are made. I MAKE THAT RECOMMENDATION.[236]

In the past, the Commission has observed 'from the wording of the Coroner's recommendation, the stated rationale for mandatory drug and alcohol testing is as a 'form of protection for police officers particularly when unfounded allegations are made' (Police Integrity Commission 2005a, p. 301).

11.2.2 WHAT IS A MANDATORY TESTING INCIDENT?

A mandatory testing incident is one where the death to or serious injury of a person occurs under specific circumstances. These incidents are defined within s211A (7) of the *Police Act 1990* (NSW) as:

> An incident where a person is killed or seriously injured:
>
> (a) as a result of the discharge of a firearm by a police officer, or
>
> (b) as a result of the application of physical force by a police officer, or
>
> (c) while detained by a police officer, or while in police custody, or
>
> (d) in circumstances involving a police aircraft, motor vehicle or vessel.

While described slightly differently in the 2007 Guidelines from the 2012 and 2016 Guidelines (NSWPF 2007a, p. 6; NSWPF 2012a, p.14; NSWPF 2016a p. 52), the categories provided in all three sets of guidelines pertain to the death or serious injury of an individual under the following scenarios:

- the discharge of a firearm by police
- the use of police appointments
- the application of physical force

---

235 Police Integrity Commission, Operation Saigon, 2001, p. i.

236 D.W.Hand, Inquest into the death of Roni Levi: Recommendations, 11 March 1998, cited in Police Integrity Commission, Operation Abelia, 2005a, Volume 3, p. 298.

- a police vehicle pursuit
- a motor vehicle collision
- while in police custody.

In addition, the categories identified in the 2012 Guidelines and 2016 Guidelines contain reference to 'death', 'imminent death' and 'serious injury', whereas the 2007 Guidelines contained categories that referred only to 'death' or 'serious injury'.

Imminent death is defined in both the 2012 Guidelines and 2016 Guidelines as an injury that is 'likely to result in the death of a person, and that advice has been provided by a qualified medical practitioner to that effect' (NSWPF 2012a, p. 10; NSWPF 2016a, p. 10).

11.2.3 TESTING IN INCIDENTS WHERE TESTING IS NOT MANDATORY

The 2007 Guidelines specified ten incident categories to which mandatory drug and alcohol testing provisions did not apply (NSWPF 2007a, p. 6), while a total of five (identical) incident categories where mandatory drug and alcohol testing did not apply are identified within the 2012 and 2016 Guidelines (NSWPF 2012a, p. 14; NSWPF 2016a, p. 52). Some examples of critical incidents where mandatory drug and alcohol testing did not apply include:

- suicide or attempted suicide by police officer or member of the public resulting from the discharge of a police firearm
- discharge of a firearm by police in high risk operational circumstances (no injury)
- death or serious injury arising from police operation.

The 2007 Guidelines made a distinction between death or serious injury arising from a police operation on the basis of whether police were 'at the scene' or whether police 'were not at the scene'. Both scenarios were classified as incidents where testing was not mandatory. The 2016 Guidelines do not make this distinction, and refer only to the one category of death or serious injury arising from a police operation.

As described in Sections 11.5.2 and 11.6.2, in the period 2009, 2010, 2011 and up to 30 June 2012, the Commission identified 13 strikeforces where drug and alcohol testing was undertaken, although such testing was not mandatory.

11.3 WHAT INFORMATION DID THE COMMISSION CONSIDER?

The Commission examined a range of information sources from the NSWPF to determine whether and how drug and alcohol testing is undertaken; under what circumstances testing should occur; and to evaluate NSWPF compliance in respect of the 83 critical incident investigations audited by the Commission.

As a first step to identifying expected mandatory drug and alcohol testing practices and procedures, a search of the NSWPF intranet was undertaken. This search identified the NSWPF Drug and Alcohol Policy, the NSWPF Handbook, the 2007, 2012 and 2016 Guidelines, and the *Police Act 1990* (NSW) as sources that contain relevant information.

In April 2013, the Commission made an initial request for information from the NSWPF pertaining to drug and alcohol tests undertaken for the investigations of the 83 critical incidents audited by the Commission.[237] At that time, the audit sample consisted of 81 incidents. Information was sought concerning whether drug and/or alcohol testing had been undertaken, and if so, the date and the time of testing.

Telephone and email correspondence between the Commission and the NSWPF continued until July 2013[238], during which time the Commission requested, and was provided with, the following additional information:

- whether testing was conducted by the NSWPF Drug and Alcohol Testing Unit or by a locally authorised officer or at a local hospital
- the location of testing (by suburb)
- the number of involved officers tested
- the names of involved officers tested
- the results of the drug and alcohol tests.

Information was provided for 58 of the (then) 81 critical incidents. Advice received from the manager, NSWPF Drug and Alcohol Testing Unit, with respect to information that was not provided for 23 incidents[239] was:

> … the drug testing database and all mandatory testing incident files have been searched in an endeavour to find any records, with no avail. It is more than likely that the 23 strike forces were critical incidents but not ones that required mandatory drug and alcohol testing.[240]

An officer from the NSWPF Professional Standards Command (PSC) further advised:

> … we provide a service only and do not compile information on critical incidents….we can only respond to an incident if requested by the DOI, PSM [Professional Standards Manager] or SCIIT (sic) [Senior Critical Incident Investigator] investigator.[241]

Subsequently, an additional two strikeforces were identified by the Commission for inclusion within the audit sample. These strikeforces were not initially included as the Commission had not been advised of the strikeforce names by NSWPF. Information pertaining to drug and alcohol testing of involved officers for these two additional strikeforces was requested by the Commission in August 2013[242] and supplied by the NSWPF in November 2013.[243]

---

237 Email to NSWPF Professional Standards Command, 15 April 2013.

238 Emails from NSWPF Professional Standards Command, 27 May 2013 and 17 July 2013.

239 Information was not received for 21 of the non-mandatory testing incidents. For the two mandatory testing incidents in which information was not received, the Commission was able to determine, using additional information sources located on e@gle.i, that testing was not undertaken.

240 Email received from NSWPF Professional Standards Command, 16 July 2013.

241 Email received from NSWPF Professional Standards Command, 16 July 2013.

242 Email to NSWPF Professional Standards Command, 28 August 2013.

243 Emails received from NSWPF Professional Standards Command, 5 November 2013.

The Commission also conducted a search of the documents located on e@gle.i for each strikeforce. This search sought to identify documentation that confirmed drug and alcohol testing had been undertaken, and where possible, to determine the test time and location. Documentation such as correspondence between the NSWPF Drug and Alcohol Testing Unit and the senior critical incident investigator (SCII); breathalyser printouts; and information contained within SITREPs[244], officer statements, and any CIIRs was matched to the information provided to the Commission by the NSWPF Drug and Alcohol Testing Unit.

As part of the analysis undertaken for drug and alcohol testing, it was necessary for the Commission to differentiate between those incidents within the sample which were mandatory testing incidents as opposed to those where testing was not mandatory. Consistent with s211A (7) of the *Police Act 1990* (NSW), incidents were categorised as mandatory testing incidents where they involved the death of or serious injury to a person:

> (a) as a result of the discharge of a firearm by a police officer, or
>
> (b) as a result of the application of physical force by a police officer, or
>
> (c) while detained by a police officer, or while in police custody, or
>
> (d) in circumstances involving a police aircraft, motor vehicle or vessel.

11.4 WHAT IS THE RISK IF MANDATORY TESTING IS NOT UNDERTAKEN?

In the event that a member of the public is killed or seriously injured while interacting with officers of the NSWPF, questions may arise as to the appropriateness of the force used, and whether the behaviour was within prescribed guidelines for the given circumstances. Questions around the legality of the action taken may also arise.

Where mandatory drug and alcohol testing is not undertaken in accordance with the legislation and guidelines, police officers are not protected against any false allegations concerning the possible contribution of drug or alcohol use to the critical incident.

The Commission considers it a major risk to community confidence if it cannot be ruled out that the death of or serious injury to a person by a NSWPF officer was the result of impairment caused by prohibited drug and/or alcohol use. As the Commission has previously stated, it is important to recognise that drug and alcohol testing can only 'play a very limited role in determining the aspects of an incident that led to a person's death,' and 'a complete investigation is important to determine the causes of the critical incident whether the result of the drug test is negative or positive' (Police Integrity Commission 2005a, p. 323).

11.5 DRUG TESTING

The legislative requirements for mandatory drug and alcohol testing are described in Section 11.2 of this chapter. The material below summarises available guidance in

[244] Situation Reports.

relation to the initiation of drug testing; who is to undertake the testing; and when drug testing should occur.

11.5.1 WHAT DID THE GUIDELINES SAY?

Initiation of drug testing

The Appendix to the 2007 Guidelines stated 'it is the responsibility of the SCII to determine who are the directly involved police officers that should be tested in accordance with the NSW Police Drug and Alcohol policy' (NSWPF 2007b, p. 2). This responsibility was transferred to the duty officer if 'there is a delay in the SCII from attending' (NSWPF 2007b, p. 2). This same information is also provided within the Drug and Alcohol Policy (NSWPF 2007c, pp. 16-17). The 2007, 2012 and 2016 Guidelines indicate that in addition to the SCII and duty officer, the duty operations inspector can also initiate drug testing (NSWPF 2007a, pp.16, 18, 21; NSWPF 2012a, pp. 21, 24, 36; NSWPF 2016a, pp. 19, 33, 36).

In the 2012 and 2016 Guidelines, reference is also made to the review officer being involved in the monitoring and reviewing of drug testing (NSWPF 2012a, p. 36; NSWPF 2016a, p. 26).

Who can undertake drug testing?

The Appendix to the 2007 Guidelines indicated that 'drug tests can only be administered by authorised officers[245] due to the need to comply with Australian Drug Testing Standards for urine tests' (NSWPF 2007b, p. 3) and that 'authorised drug testers attached to the NSWPF Health & Wellbeing Section are available on call at all times to undertake testing' (NSWPF 2007b, p. 3). The Appendix to the 2007 Guidelines also stated that drug testing can occur if an involved officer attends, or is admitted to a hospital as a result of the incident by way of blood, urine or hair testing under either the *Road Transport (Safety and Traffic Management) Act 1999* (NSW) or s211A of the *Police Act 1990* (NSW) (NSWPF 2007b, p. 3).

Similarly, the Drug and Alcohol Policy states 'where an officer has been hospitalised as a result of the incident and a blood sample has been taken in compliance with any legislation, then written consent may be obtained from the officer to use any such blood sample to comply with the testing requirements of this policy' (NSWPF 2007c, p. 17).

The 2012 Guidelines did not specify who could undertake drug testing, rather they indicated that the SCII should 'liaise with PSC regarding the appropriateness of drug and alcohol testing' (NSWPF 2012a, p. 27), while the 2016 Guidelines state that 'an authorised officer from the Professional Standards Command, Drug and Alcohol Testing Unit will attend to complete the mandatory testing of officers' (NSWPF 2016a, p. 11). There is no mention of hospitalisation, or the *Road Transport (Safety and Traffic Management) Act 1999* (NSW) in either the 2012 Guidelines or 2016 Guidelines.

---

[245] Division 4 of both the *Police Regulation 2000* and the *Police Regulation 2008* provides for the appointment of authorised persons. Clause 60 (1) of the *Police Regulation 2000* and Clause 89 (1) of the *Police Regulation 2008* each provide that 'The Commissioner may, by instrument in writing, appoint any person to be an authorised person for s211A or 211AA of the Act and this Part. For those purposes, the Commissioner may appoint a police officer or any other person.

When should drug testing occur?

Section 211A (4A) of the *Police Act 1990* (NSW) provides that an authorised person must require an officer directly involved in a mandatory testing incident to undergo a test or provide a sample 'as soon as practicable after the mandatory testing incident concerned'.[246] Similarly, the Appendix to the 2007 Guidelines indicated that involved officers should be tested 'as soon as possible after the incident and while they are still on duty' (NSWPF 2007b, p. 2), while the NSWPF Drug and Alcohol Policy is more specific, and states that 'mandatory drug testing will only be carried out by authorised drug testing officers, as soon as practical after the incident and preferably within 24 hours' (NSWPF 2007c, p. 17).

No timeframe is provided in the 2012 Guidelines or 2016 Guidelines as to when drug testing should occur.

11.5.2 WHAT DID THE COMMISSION FIND?

The Commission's findings with regard to the number of strikeforces where drug tests were undertaken, and the timeframes under which such testing occurred, can be found in Table 11.1.

Mandatory drug testing incidents

Number and result of mandatory drug tests

Of the 83 strikeforces included in the Commission's audit, 49 fell into one of the following incident categories and were thus classified as mandatory (drug) testing incidents:

- the discharge of a firearm by police
- the use of police appointments
- the application of physical force
- a police vehicle pursuit
- a motor vehicle collision
- while in police custody.

The Commission found that drug testing was undertaken in all 49 (100%) of these strikeforces:

- in 44 strikeforces testing was completed by the NSWPF Drug and Alcohol Testing Unit
- in four strikeforces testing was undertaken at a medical facility
- in one strikeforce testing was undertaken by both the NSWPF Drug and Alcohol Testing Unit (for five officers) and at a medical facility (for one officer).

[246] Accessed 19 July 2016, http://www.austlii.edu.au/au/legis/nsw/consol_act/pa199075/s211a.html.

All of the involved officers (100%) from the 49 strikeforces in which mandatory drug testing was undertaken returned a negative result.[247]

Timeliness of drug testing

Of the 49 mandatory testing strikeforces in which drug testing was undertaken, 47 (96%) of these incidents **complied with the desired timeframe** for drug testing to be undertaken within 24 hours of the incident.

In one strikeforce the Commission was **unable to determine** the time that testing was undertaken. In this strikeforce, testing was undertaken at an accredited health facility.[248]

In another strikeforce, testing was completed by the NSWPF Drug and Alcohol Testing Unit **48 hours after the incident occurred**. This was due to the incident being declared a critical incident some 24 hours after it had occurred.[249] The circumstances of this critical incident are described in the case study below.

> On a morning in 2010 in regional NSW, NSWPF officers arrested a man in relation to drug offences. It is alleged the man resisted arrest and significant efforts were taken by the NSWPF officers to restrain him. The man was treated by Ambulance officers at the scene for decontamination of OC spray.
>
> The man was taken to a local police station and whilst in police custody, was seen to be in pain. NSWPF officers observing the man called for an Ambulance to attend. Treating paramedics determined the man should be transported to hospital. A medical examination undertaken in hospital the next day, some 24 hours after the arrest took place, determined that the man was suffering from 11 broken ribs, three fractured vertebrae and a fractured nose. At this time the region commander declared a critical incident.
>
> Information contained within the critical incident investigation report for this strikeforce indicated that consideration was given to drug and alcohol testing the involved officers, but due to the time lapse between the incident and the initiation of the critical incident investigation, it was not useful for alcohol testing to be undertaken. Drug testing was undertaken, some 48 hours after the incident occurred.

Incidents where drug testing is not mandatory

Of the 83 strikeforces included in the Commission's audit, 34 were incidents where drug testing was not mandatory. For two of these strikeforces, there were no involved officers.[250] The Commission found that drug testing was undertaken in 13 of the 32 strikeforces where drug testing was not mandatory but would have been possible. Some examples of the types of circumstances where such drug testing was undertaken include:

---

247 Information of negative results is contained within laboratory reports sourced from e@gle.i and/or correspondence provided to SCII from the NSWPF Drug and Alcohol Testing Unit for some strikeforces.

248 Unspecified medical facility- results printout sourced from e@gle.i contains the insignia of the 'NSW Health Division of Analytical Laboratories' but no time is listed.

249 Critical incident declared only after a medical assessment that revealed the seriousness of injuries, which took 24 hours to occur.

250 One of these strikeforces related to the shooting of a NSWPF officer by a civilian. The second related to the suicide of a NSWPF officer where no other NSWPF officer was present at the scene.

- discharge of a NSWPF firearm – high risk circumstances (non-injury)
- suicide of a civilian (NSWPF officers at scene) – classified as a death in police operation
- serious injury arising from police operation – police at scene.

Of these 13 strikeforces in which drug testing was undertaken, testing of involved officers in all 13 (100%) was undertaken within 24 hours of the incident, and all officers tested returned a negative result.[251]

Table 11.1: Drug testing

	Mandatory testing incident	Not a mandatory testing incident	Total number of strikeforces
Drug testing of involved officers undertaken within desired timeframe	47	13	60
Involved officers drug tested but not within desired timeframe	1	0	1
Involved officers not drug tested	0	19	19
Information not available concerning when officers were drug tested	1	0	1
Drug testing not applicable as no involved officers were associated with the incident	0	2	2
Total	**49**	**34**	**83**

11.6 ALCOHOL TESTING

The legislative requirements for mandatory drug and alcohol testing are described in Section 11.2 of this chapter. The material below summarises available guidance in relation to the initiation of alcohol testing; who is to undertake the testing; and when alcohol testing should occur.

11.6.1 WHAT DID THE GUIDELINES SAY?

Initiation of alcohol testing

The Appendix to the 2007 Guidelines stated 'it is the responsibility of the SCII to determine who are the directly involved police officers that should be tested in accordance with the NSW Police Drug and Alcohol policy' (NSWPF 2007b, p. 2). This responsibility was transferred to the duty officer if 'there is a delay in the SCII from attending' (NSWPF 2007b, p. 2). This same information is also provided within the Drug

[251] Refer to email advice saved at 25258/251-1 Information of negative results is contained within laboratory reports sourced from e@gle.i and/or correspondence provided to SCII from the NSWPF Drug and Alcohol Testing Unit for some strikeforces.

and Alcohol Policy (NSWPF 2007c, pp. 16-17). The 2007, 2012 and 2016 Guidelines indicate that, in addition to the SCII and duty officer, the duty operations inspector can also initiate alcohol testing (NSWPF 2007a, pp.16, 18, 21; NSWPF 2012a, pp. 21, 24, 36; NSWPF 2016a, pp. 19, 33, 36).

In the 2012 and 2016 Guidelines, reference is also made to the review officer being involved in the monitoring and reviewing of alcohol testing (NSWPF 2012a, p. 36; NSWPF 2016a, p. 26).

Who can undertake alcohol testing?

In regard to who can undertake alcohol testing, the Appendix to the 2007 Guidelines stated:

> Alcohol testing must be carried out by an authorised person attached to a different LAC from that of the involved officer(s). Where this is not practicable, an independent and authorised officer from the LAC may be used. If this is not possible, advice should be sought from the Safety Command on call drug and alcohol testing officer (NSWPF 2007b, p. 2).
>
> and
>
> Authorised persons must be appointed, and be in possession of a Certificate of Appointment. A full list of authorised people can be accessed via the Health and Wellbeing page on the HRS [Human Resources] website on the NSW Police intranet (NSWPF 2007b, p. 3).

However, no further information on what constitutes a 'local independent authorised officer' from the local area command (LAC) was provided.

The 2012 Guidelines did not indicate who could undertake alcohol testing, while the 2016 Guidelines indicate that alcohol testing should be undertaken by an authorised officer from the Professional Standards Command, Drug and Alcohol Testing Unit (NSWPF 2016a, p.11). The 2016 Guidelines further state 'in the event that an authorised Drug and Alcohol Testing officer will be delayed in attending, a local, independent authorised officer may complete the required alcohol tests' (NSWPF 2016a, p. 11). Again, no further information on what constitutes 'a local independent authorised officer' is provided.

When should alcohol testing occur?

As discussed previously, s211A (4A) of the *Police Act 1990* (NSW) provides the same requirements for when alcohol tests should be undertaken as for when drug tests should be undertaken. That is, an authorised person must require an officer directly involved in a mandatory testing incident to undergo a test or provide a sample 'as soon as practicable after the mandatory testing incident concerned'.[252]

The NSWPF Drug and Alcohol Policy indicates that a two-hour timeframe for alcohol testing is desirable, stating:

> Mandatory alcohol testing should be undertaken as soon as reasonably practicable after the incident has occurred. It is desirable that an authorised

[252] Accessed 19 July 2016, http://www.austlii.edu.au/au/legis/nsw/consol_act/pa199075/s211a.html.

> BAS Operator[253] conduct this testing preferably within 2 hours of any mandatory testing incident occurring (NSWPF 2007c, p. 17).

The Appendix to the 2007 Guidelines reiterated this timeframe, where it indicated that involved officers should be tested 'as soon as possible after the incident and while they are still on duty' (NSWPF 2007b, p. 2), and went on to state that while no timeframe is set out in the legislation, 'absent any legislative direction, in the interests of best practice, every effort should be made to conduct these tests within two hours of a critical incident, wherever possible' (NSWPF 2007b, p.3).

The 2007 Guidelines indicated:

> … some investigative actions are best completed within 2 hours of the incident (e.g. alcohol testing) (NSWPF 2007a, p. 20).

This same information is repeated in the 2012 (NSWPF 2012a, p. 27) and 2016 Guidelines (NSWPF 2016a, p. 35).

11.6.2 WHAT DID THE COMMISSION FIND?

The Commission's findings with regard to the number of strikeforces where alcohol testing was undertaken, and the timeframes under which such testing occurred, can be found in Table 11.2.

Mandatory alcohol testing incidents

Number and results of mandatory alcohol tests

As observed earlier in this chapter, of the 83 strikeforces included in the Commission's audit, 49 fell into one of the following incident categories and were thus classified as mandatory (alcohol) testing incidents:

- the discharge of a firearm by police
- the use of police appointments
- the application of physical force
- a police vehicle pursuit
- a motor vehicle collision
- while in police custody.

Of these 49 strikeforces, available information confirmed alcohol testing was undertaken for 43 (88%) strikeforces as follows:

- in 20 strikeforces testing was completed by the NSWPF Drug and Alcohol Testing Unit

[253] Breath Analysis Operator

- in 20 strikeforces testing was undertaken by a NSWPF officer from a local area command[254]
- in one strikeforce testing was undertaken at an accredited medical facility
- in one strikeforce testing was undertaken by both the NSWPF Drug and Alcohol Testing Unit and a NSWPF officer from a local area command[255]
- in one strikeforce testing was undertaken by both the NSWPF Drug and Alcohol Testing Unit (for four officers) and at an accredited medical facility (for one officer).[256]

Of the remaining six strikeforces:

- information was located for one strikeforce confirming alcohol testing **was not undertaken** due to the critical incident not being declared until 24 hours after the time of the incident[257]
- for a further five strikeforces, **information was not available** concerning whether alcohol testing was undertaken.[258]

Of the 43 mandatory testing strikeforces in which alcohol testing was undertaken, all involved officers (100%) returned a negative result.[259]

Timeliness of alcohol tests

Of the 43 mandatory testing strikeforces in which the Commission could determine that alcohol testing was undertaken:

- six strikeforces (14%) **complied with the desired timeframe** for testing to be undertaken within two hours of the incident[260]
- for 28 strikeforces (65%) testing was undertaken **more than two hours** after the critical incident. Timeframes ranged from just over two hours to over sixteen hours after the incident[261]

---

254 The Commission has not been able to assess whether or not this officer was an 'independent officer', as no clarification was provided within the 2007 Guidelines or Appendix to the Guidelines as to what constituted an 'independent officer'.

255 The Commission has not been able to assess whether or not this officer was an 'independent officer', as no clarification was provided within the 2007 Guidelines or Appendix to the Guidelines as to what constituted an 'independent officer'.

256 No advice could be found as to what hospital.

257 Critical incident declared 24 hours after the time of the incident on the basis of a medical assessment that revealed the seriousness of the injuries sustained. CIIR indicated that a decision was made not to undertake alcohol testing as a result of this delay.

258 No information was supplied by NSWPF Drug and Alcohol Testing Unit and no information was located on e@gle.i.

259 Advice contained in an email from NSWPF Professional Standards Command of 17 July 2013 where available information of negative results is also contained within laboratory reports sourced from e@gle.i and/or correspondence provided to SCII from the NSWPF Drug and Alcohol Testing Unit.

260 In three strikeforces testing was completed by the NSWPF Drug and Alcohol Testing Unit and in another three strikeforces testing was undertaken by an officer from a local area command. The Commission has not been able to assess whether or not this officer was an 'independent officer', as no clarification was provided within the 2007 Guidelines or Appendix to the Guidelines as to what constituted an 'independent officer'.

261 In 17 strikeforces testing was undertaken by the NSWPF Drug and Alcohol Testing Unit; in one strikeforce testing was undertaken at an accredited medical facility; and in ten strikeforces testing was undertaken by an officer from a local area command. The Commission has not been able to assess whether or not this officer was an 'independent officer', as no clarification was provided within the 2007 Guidelines or Appendix to the Guidelines as to what constituted an 'independent officer'.

- for nine strikeforces, **no information was available** concerning the timeframe in which alcohol testing was undertaken.[262]

The following case study is an example of a strikeforce where alcohol testing was undertaken, and where the Commission was able to identify the appropriate records to corroborate this testing, however, the testing did not occur within the two-hour timeframe.[263]

> On a morning in 2010 in regional NSW, a mandatory testing incident occurred whereby a person was seriously injured as a result of the discharge of a police firearm by a NSWPF officer. Reports had been received of a stolen vehicle and two officers set out to find the vehicle, which was located a short time later.
>
> A person was located in the driver's seat, and the two officers approached the vehicle with their pistols drawn, calling for the person to get out of the vehicle. The person drove towards one of the officers. Fearing for his safety, this officer discharged one round from his pistol, shooting the driver in the right leg. A critical incident was declared by the region commander and drug testing was undertaken by the NSWPF Drug and Alcohol Testing Unit later that day. Alcohol testing was undertaken by a local Highway Patrol Officer five-and-a-half hours after the incident, which was not within the desired two-hour timeframe.
>
> The Commission was able to identify a typed statement by a NSWPF officer detailing the alcohol tests, as well as breathalyser printouts signed by the two involved officers who underwent testing. The test results were negative.

Below is a case study of a strikeforce where alcohol testing was undertaken, but the time of this testing cannot be corroborated, and it is therefore not known whether testing was undertaken within the desired two-hour time limit.

> In late 2011, NSWPF officers commenced pursuit of a speeding car containing a driver and two passengers in rural NSW. The pursuit crossed into Victoria, where the vehicle rolled, and the rear passenger was ejected and killed. The driver of the vehicle was airlifted to a Melbourne hospital in a critical condition, and the remaining passenger was taken to a local hospital with minor injuries. The incident was deemed to be a critical incident by an Assistant Commissioner of the NSWPF approximately one hour after the accident had occurred.
>
> There were five involved officers. The NSW coroner deemed the incident to be a Victoria-based investigation, and the primary investigation was conducted by VICPOL Major Crash Investigation. Assistance was provided by a NSWPF critical incident investigation team. Alcohol testing was arranged by VICPOL and occurred for each of the five involved officers on the day of the accident. The test results, which were negative, were forwarded to the NSW senior critical incident investigator and made available to the relevant strikeforce on e@gle.i.

262 Information located on e@gle.i did not indicate the time that alcohol testing had been undertaken.

263 Testing was completed by an officer from a local area command. The Commission has not been able to assess whether or not this officer was an 'independent officer', as no clarification was provided within the 2007 Guidelines or Appendix to the Guidelines as to what constituted an 'independent officer'.

While the test results provided the names of the officers who underwent testing, the date and type of testing, and the negative result obtained; the time of the testing was not recorded. A review of additional documentation stored on e@gle.i could not locate any further documentation pertaining to the testing. It therefore remains unclear as to whether the alcohol testing was undertaken within the desired two-hour time limit.

A third case study, provided below, is of a strikeforce where alcohol testing was undertaken within the desired two-hour timeframe.

Early one morning in 2009, a mandatory testing incident occurred whereby five officers from a metropolitan command were involved in a police pursuit. This pursuit resulted in a motor vehicle collision in which two people suffered serious injuries that required hospitalisation for one week.

A critical incident was declared by the region commander that same morning. Information contained within the critical incident investigation report for this strikeforce indicated that drug and alcohol testing was undertaken one hour and 51 minutes after the critical incident occurred. This was corroborated by information supplied to the Commission by the NSWPF Drug and Alcohol Testing Unit.

The Commission could not, however, locate information such as a breath analysis printout, that proved testing had been undertaken at this time. It would have been advantageous for this type of information to be located on e@gle.i to verify the timeframe.

Incidents where alcohol testing is not mandatory

As described in Section 11.5.2, of the 83 strikeforces, 34 were incidents where testing was not mandatory. For two of these strikeforces, there were no involved officers.[264] Hence alcohol testing could have been undertaken for a possible 32 critical incidents where testing was not mandatory.

Of these 32 strikeforces, alcohol testing results were found for 14 strikeforces. In one strikeforce, the involved officers were tested within two hours of the incident.[265] The remaining 13 of the 14 non-mandatory alcohol tests were undertaken outside of the desired two-hour timeframe.

Table 11.2: Alcohol testing

	Mandatory testing incident	Not a mandatory testing incident	Total number of strikeforces
Alcohol testing of involved officers undertaken within desired timeframe	6	1	7
Involved officers alcohol tested but not within desired timeframe	28	10	38

264 One of these strikeforces related to the shooting of a police officer by a civilian. The second related to the suicide of a police officer while no other NSWPF officer was in attendance at the scene.

265 Testing for this strikeforce was completed at a local hospital. No information could be found on e@gle.i as to that name/ location of this hospital.

	Mandatory testing incident	Not a mandatory testing incident	Total number of strikeforces
Involved officers not alcohol tested	1	4	5
Information not available concerning when officers were alcohol tested	9	2	11
Information not available concerning whether officers were alcohol tested	5	14	19
Information regarding alcohol testing available only for some involved officers (not undertaken within appropriate timeframe)	0	1	1
Alcohol testing not applicable as no involved officers were associated with the incident	0	2	2
Total	**49**	**34**	**83**

11.7 OBSERVATIONS

As set out within the *Police Act 1990* (NSW), drug and alcohol testing is a requisite component of the management of mandatory testing incidents. Not all critical incidents fall into the category of mandatory testing incidents, and on this basis, it is not automatic that an involved officer will undergo testing for prohibited drugs and/or alcohol in the event of the death or serious injury to a person.

Of the 83 critical incidents audited, 49 were identified as mandatory testing incidents. The Commission found that drug testing was undertaken for the involved officers in all 49 (100%) of these strikeforces, and alcohol testing was undertaken for the involved officers in 43 (88%) of them.

Increase to mandatory testing incident categories

On the basis that serious injury or death can occur in the absence of police officers at the scene, the Commission acknowledges that it is not beneficial for drug and alcohol testing to be undertaken for all critical incidents. The Commission, therefore, does not agree that all critical incidents should be classified as mandatory testing incidents. The Commission does consider, however, that some expansion to mandatory testing incident categories may be desirable.

For example, the 2016 Guidelines classify the 'death or serious injury to a person arising from a NSW Police Force operation' (NSWPF 2016a, p. 52) as an incident where testing is not mandatory. Some examples of police operations include foot pursuits and siege situations. The Commission suggests that any death or serious injury to a person arising from a NSWPF operation involve the mandatory drug and alcohol testing of the involved

officers. This would remove any potential risk that an incident may be (mis)classified as a 'police operation' to circumvent the need for the mandatory drug and alcohol testing of involved officers.

Guidance

The NSWPF Drug and Alcohol Policy is most descriptive when it comes to the required processes and desired timeframes for the mandatory drug and alcohol testing of NSWPF officers. The Appendix to the 2007 Guidelines also detailed who could undertake mandatory testing and the desired timeframes under which it should occur.

In contrast, the 2016 Guidelines do not include the following information, which the Commission considers a useful addition to any future guidelines:

- advice as to who an 'authorised officer' is
- advice as to what constitutes a 'local independent authorised officer'
- desirable timeframes within which mandatory drug and alcohol testing should occur
- reference to the *Road Transport (Safety and Traffic Management) Act 1999* (NSW).

In addition, it is the Commission's view that any future guidelines would be enhanced if the information which appears within the mandatory testing incident section of the NSWPF Drug and Alcohol Policy were replicated within the guidelines. This would ensure that all relevant information pertaining to mandatory testing is readily available to NSWPF officers involved in the investigation of critical incidents, within the one document.

Information location and storage

The Commission found the sourcing, gathering and analysis of information relating to the mandatory drug and alcohol testing of officers within the audit to have been difficult. Even with the significant investment of time directed to this exercise, no information could be found relating to alcohol testing for five of the 49 mandatory testing incidents.

Currently, some of the information associated with mandatory drug and alcohol testing is stored as investigative documentation on e@gle.i, which is accessible to only those officers who are undertaking the investigation, and some of the information is stored within the IT systems of the NSWPF Drug and Alcohol Testing Unit. In some instances where testing was not undertaken, a reason is documented as to why testing was not undertaken. This was not always the case, however. Where a reason was not provided, it is unknown whether consideration was given to the mandatory drug and alcohol testing of involved officers.

The Commission considers it necessary for the accountability and transparency of critical incident investigations that all information pertaining to the mandatory drug and alcohol testing of officers, where it is undertaken and where it is not, be recorded in a systemic and accessible way. The most appropriate mechanism for achieving this is a decision for the NSWPF.

12. INDEPENDENT REVIEW

12.1 OVERVIEW

The identification of an incident as a 'critical incident' activates an independent investigative process by the NSWPF to be conducted by a specialist and independent critical incident investigation team, and a review of that investigation by an independent review officer (NSWPF 2007a, p. 1).

One of the safeguards built into the requirements for the investigation of a 'critical incident' is the review of the NSWPF investigation by an independent 'review officer'. The review officer is seen to perform the 'function of risk manager' (NSWPF 2007a, p. 26) for the investigation.

After first describing the role of the independent review officer, this chapter describes what can be learnt from an audit of documents located on the NSWPF e@gle.i system concerning NSWPF compliance with the 2007 Guidelines in regard to the:

- choice of an independent review officer
- review officer's running sheet
- contents of review officer reports.

Summary of findings

The Commission's audit established:

- region commanders had appointed a review officer for each of the 83 strikeforces (100%) audited.
- 21 strikeforces (25%) did not comply with the 2007 Guidelines either in terms of the command from which the review officer was chosen or in terms of the rank of the review officer.
- for 56 strikeforces a review officer report was located on e@gle.i. This is less than the 68 review officer reports the Commission would have expected had there been a review officer report available for each of the 68 strikeforces where a critical incident investigation report was available.

The 2007 Guidelines outlined that review officer reports should provide an overview of the investigation, including comments on the quality, timeliness and probity of the investigation as well as identify and report on any deficiencies of a systemic nature that must be addressed by the NSWPF.

Of the 56 review officer reports identified by the audit:

- 13 (23%) did not provide an overview of the investigation

- 13 (23%) did not comment on the quality of the investigation conducted by the critical incident investigation team
- 29 (52%) did not comment on the timeliness of the investigation conducted by the critical incident investigation team
- 33 (59%) did not comment on the probity of the investigation conducted by the critical incident investigation team
- 14 (25%) did not document broader lessons and improvements to systems, policies, processes, practices and training. The Commission was not in a position to assess whether or not the review officer report should have considered broader lessons and improvements in these areas
- none complied with all five requirements.

The Commission identified only one (1%) strikeforce where a review officer running sheet was located on e@gle.i.

12.2 WHAT INFORMATION DID THE COMMISSION CONSIDER?

The Commission's audit of the 83 strikeforces identified 56 review officer reports on e@gle.i. The Commission examined all 56 review officer reports to assess if review officers complied with the requirements of the 2007 Guidelines.

To determine whether the review officer had been selected in accordance with the 2007 Guidelines, the Commission identified the name, rank and location of review officers for the 83 strikeforces included in this audit by examining review officer reports, critical incident investigation reports (CIIR) and conducting a search on e@gle.i for the words 'review officer'. In instances where the Commission identified the name of a review officer, it cross-referenced the name with internally held police records that provide historical information as to officers' rank and location. In strikeforces where the Commission was unable to locate the name of review officers it contacted the NSWPF to seek clarification in relation to the name, rank and location of the review officer at the time of the critical incident investigation.

To assess whether review officer running sheets were maintained for the 83 critical incidents, the Commission examined e@gle.i to ascertain if each running sheet was located on e@gle.i. The Commission relied solely on those running sheets located on e@gle.i in its audit and subsequent assessment of compliance regarding the maintenance of running sheets during a critical incident investigation.

12.3 ROLE OF REVIEW OFFICER

The 2007 Guidelines stated that the review officer 'performs the function of risk manager for the investigation of critical incidents' (NSWPF 2007a, p. 26). The 2007 Guidelines specified that the review officer should:

- attend the scene of the incident and advise the DOI[266] on arrival
- obtain a briefing from the SCII regarding the action taken up to the time of arrival (e.g. immediate actions required of the SCII, Duty Officer). Advise SCII of any areas of concern and seek to have those concerns addressed
- maintain a close working relationship with the SCII during the investigation
- maintain a running sheet (separate to the investigation running sheet) documenting all action taken, advice given and create file notes of all relevant conversations
- ensure the Local Area Commander, where the incident occurred, is kept informed
- identify and advise the SCII and Region Commander of any matters that may constitute a complaint under Part 8A of the *Police Act*
- render such assistance and perform duties as required by the on duty State/Deputy State Coroner and counsel assisting the on duty State/Deputy State Coroner
- attend the inquest and give evidence as required (NSWPF 2007a, p. 27).

The 2012 Guidelines and the 2016 Guidelines, in addition to the above, each mention the independence of the review officer from the investigation and specify that:

> The review officer is to monitor and review the probity and transparency of the investigation and should not become involved in making investigative decisions or setting investigative directions (NSWPF 2012a, p. 35; NSWPF 2016a, p. 25).

All three sets of guidelines specify that at the conclusion of the critical incident investigation the review officer should submit a final report to the commander of the region where the critical incident took place (NSWPF 2007a, p. 27; NSWPF 2012a, p. 36; NSWPF 2016a, p. 41). This requirement is discussed in more detail in Section 12.6 of this report.

12.4 CHOICE OF AN INDEPENDENT REVIEW OFFICER

12.4.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that:

> The commander of the region where the incident occurred is required to nominate a suitably experienced officer to perform the review officer role. The review officer should, as a minimum, be of the same rank as the senior critical incident investigator (SCII). To ensure independence, the review officer should also come from a different command to the:

[266] The duty operations inspector is situated at VKG, the police communications centre in Sydney.

- members of the critical incident investigation team (CIIT)
- command where the incident occurred
- involved officers (NSWPF 2007a, p. 26).

The 2007 Guidelines stated that in incidents 'involving the death or serious injury arising from the use of any police appointments, including injury from the discharge of a firearm by police, or the homicide of a police officer, an officer from the Investigations Unit, Professional Standards Command (PSC) will perform the review officer role' (NSWPF 2007a, p. 26).

The same requirements are reiterated in the 2012 Guidelines (NSWPF 2012a, p. 35) and 2016 Guidelines (NSWPF 2016a, pp. 25-26).

12.4.2 WHAT IS THE RISK TO THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

In instances where the review officer comes from the same command as the involved officers or members of the CIIT there is the potential risk of a conflict of interest which may jeopardise the independence and integrity of the review process. If a conflict of interest inhibits the review officer from bringing an independent perspective to the critical incident investigation and the review officer fails to declare this conflict of interest there is the risk that the review process would be flawed, or perceived to be flawed by the public and/or the courts.

The NSWPF operates on a hierarchical command structure. If the review officer were of a lower rank than the SCII, the risk exists that the review officer may not exert his/her role as an independent reviewer and be reluctant to voice any criticism or concern in relation to the integrity and/or quality of the critical incident investigation conducted by a higher-ranked officer.

12.4.3 WHAT DID THE COMMISSION FIND?

The Commission's audit established that for each of the 83 strikeforces reviewed, a review officer had been appointed by the relevant region commander. The results as to compliance with the 2007 Guidelines in relation to some of the specific requirements of the choice of review officer are provided below.

Review officer compliance in relation to rank of review officer

- 72 (87%) strikeforces **complied** with the 2007 Guidelines which required that the review officer was, as a minimum, of the same rank as the SCII
- 11 strikeforces did **not comply** with the 2007 Guidelines and the review officer was of a lower rank than the SCII.

Review officer compliance in relation to review officer local area command (LAC)

- 73 (88%) strikeforces **complied** with the 2007 Guidelines which required that the review officer came from a different command to members of the CIIT, command where the incident occurred and that of the involved officers

- ten strikeforces **did not comply** with the 2007 Guidelines and the review officer came from the same command as either members of the CIIT, the command where the incident occurred or the involved officers.[267]

Review officer compliance in relation to both rank of review officer and review officer LAC

- 62 (75%) strikeforces **complied** with the 2007 Guidelines which required that the review officer should be, as a minimum, of the same rank as the SCII and come from a different command to the members of the CIIT, command where the incident occurred and involved officers
- 21 strikeforces **did not comply** with the 2007 Guidelines and the review officer was either from a lower rank than the SCII or came from the same command as members of the CIIT, command where the incident occurred or involved officers.

12.5 REVIEW OFFICER'S RUNNING SHEET

12.5.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines and the 2012 Guidelines stated that the review officer should 'maintain a running sheet (separate to the investigation running sheet) documenting all action taken, advice given and create file notes of all relevant conversations' (NSWPF 2007a, p. 27; NSWPF 2012a, p. 36).

The 2016 Guidelines do not include a specific requirement for the review officer to maintain a running sheet but simply state that the review officer is required to 'document all action taken, advice given and create file notes of all relevant conversations' (NSWPF 2016a, p. 41).

12.5.2 WHAT IS THE RISK TO THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

The 2007 Guidelines stated that 'NSW Police is committed to demonstrating its professionalism by investigating all such incidents in an effective, accountable, and transparent manner' (NSWPF 2007a, p. 1).

Failure to maintain a review officer running sheet can result in reduced transparency and accountability with:

- important actions and decisions by the review officer both at the incident scene and during the investigation not being recorded and therefore unable to be verified

[267] More precisely there are five strikeforces where the review officer came from the same LAC as the SCII and the CIIT; two strikeforces where the review officer came from the same LAC as involved officers; two strikeforces where the review officer came from the same LAC as members of the CIIT (in these two strikeforces the SCII came from a different LAC to the CIIT) and one strikeforce where the review officer came from the same LAC as where the incident occurred as well as the LAC of the SCII and the CIIT members.

- important conversations with the SCII, the duty officer and other police officers at the scene of the incident not being recorded and therefore unable to be verified.

Given the stated importance of transparency and accountability in critical incident investigations, the inability to access running sheets of review officers is of concern as it significantly impedes the ability to assess whether appropriate investigative actions and decisions have taken place.

12.5.3 WHAT DID THE COMMISSION FIND?

Of the 83 critical incidents audited the Commission found that:

- one strikeforce (1%) **complied** with the 2007 Guidelines[268] by scanning a review officer running sheet onto e@gle.i.
- 82 strikeforces **did not comply** with the 2007 Guidelines, that is, did not scan a review officer running sheet onto e@gle.i.

A review officer running sheet was located on e@gle.i for only one critical incident investigation. This review officer running sheet was typed using an Investigation Log template with three columns labelled 'Time/Date', 'Issue/Event' and 'Decision/Result'.

The circumstances of this strikeforce where the review officer maintained a detailed running sheet reflecting best practice are provided below.

Late one evening in 2009 police responded to a report of an intoxicated driver travelling in a vehicle on a rural highway, suspected of carrying amphetamines. Upon passing the location where the vehicle had been sighted, police officers initially observed a man standing in front of the vehicle by the side of the highway. When police officers made a U-turn and returned to the vehicle, the man had left the scene. On viewing the vehicle, it appeared to have swerved off the road and into a tree, sustaining significant damage. The vehicle was towed away and a search of the thick bushland nearby was unsuccessful in finding the man. Police then left the scene.

The following morning a female driver travelling on the highway near the scene of the previous night's incident observed a man lying on the side of a railway line running parallel to the highway. The female driver went with a local farmer to the location and found the man to be deceased. The man was identified as the driver from the previous night's incident and it was later established that he had died from head injuries sustained after being struck by a freight train.

Following the discovery of the body a critical incident was declared by the region commander and an SCII, CIIT and review officer were appointed.

Of the 83 strikeforces under review this was the only one to comply with the 2007 Guidelines in completing and scanning a review officer running sheet to e@gle.i. The running sheet was typed, thorough and detailed, logging the time of important actions, events, conversations and decisions made by the review officer during the course of the investigation, including the following:

[268] The 2007 Guidelines stated that 'all critical incident investigations must be recorded appropriately on e@gle.i' (NSWPF 2007a, p. 30).

- time of notification of critical incident and appointment as review officer
- discussion with SCII regarding critical incident guidelines and decision not to undertake drug and alcohol testing of involved officers
- details of briefing of review officer by SCII
- discussion with SCII concerning interviews with involved officers
- attendance and observations at incident scene.

12.6 CONTENTS OF REVIEW OFFICER REPORT

12.6.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that at the conclusion of the critical incident investigation the review officer should submit a final report to the commander of the region where the critical incident took place. The 2007 Guidelines stated:

> The report should provide an overview of the investigation including comments on the quality, timeliness and probity of the investigation conducted by the CIIT. It should identify and report on any deficiencies of a systemic nature that must be addressed by NSW Police (NSWPF 2007a, p. 26).

Whereas the 2007 Guidelines stated that the review officer should prepare a report to the commander of the region where the critical incident took place, the 2012 Guidelines and the 2016 Guidelines add that the review officer 'should prepare a separate report for the NSW Police Force Executive' (NSWPF 2012a p. 35; NSWPF 2016a, p. 36).

In addition to the above, the 2016 Guidelines, Appendix 10, include a review officer report template that states: 'The Review Report is to be completed only after the Critical Incident Investigation Report has been completed and reviewed by the Reviewing Officer' (NSWPF 2016a, pp. 47-49). The review officer report template includes detailed explanations as to the type of information to be included in a review officer report:

- Time/date of incident
- Location of incident
- Name of the SCII/Senior Investigator
- Name of the Reviewing Officer
- e@gle.i Operation name
- COPS Event Number
- A brief overview of the circumstances of the incident
- A summary of the investigation of the critical incident
- Supporting Documentation/Evidence (appropriately referenced with attachments and exhibits)
- General issues identified
- Issues for the NSW Police Force (comments or recommendations in relation to any corporate issues such as policy, procedure, guidelines and legislation)
- Review officers General Comment (including but not limited to matters such as):
    - Appropriate notifications were made at the time of the incident.
    - Appropriate control of the incident scene (log taking; delegation of tasks; welfare of officers; adequate hand-over to the CIIT).
    - Appropriate crime scene management.
    - Drug and alcohol testing conducted in accordance with guidelines.

- Adequate resources were assigned to the investigation and review of the incident.
- No conflict of interest was identified in the critical incident investigation or any conflicts identified were appropriately managed.
- The investigation was conducted in a timely manner.
- The quality and probity of the investigation was appropriate. The response by the local area commander and region was appropriate.
- Adherence to the Critical Incident Guidelines (NSWPF 2016a, pp. 48-49).

The 2007 Guidelines mentioned that all critical incident investigations '**must** be recorded appropriately on e@gle.i' (NSWPF 2007a, p. 30). The 2012 Guidelines and the 2016 Guidelines add: 'The review officer should use e@gle.i to monitor the investigation' (NSWPF 2012a, p. 35; NSWPF 2016a, p. 26).

12.6.2 WHAT IS THE RISK TO THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

The review officer performs the function of risk manager for the investigation of critical incidents and is required to report on the probity of the critical incident investigation. In strikeforces where the review officer has not documented his/her review of the critical incident investigation it is not possible to determine if the review officer has performed the role of risk manager.

12.6.3 WHAT DID THE COMMISSION FIND?

The Commission's review of 83 strikeforces identified 68 strikeforces with completed CIIRs recorded on e@gle.i, and anticipated the existence of an equivalent number of review officer reports recorded on e@gle.i.

Of the 68 strikeforces where a CIIR has been completed and recorded on e@gle.i the Commission:

- located 54 (79%) review officer reports on e@gle.i
- was unable to locate review officer reports on e@gle.i for 14 strikeforces.

The Commission located an additional two review officer reports on e@gle.i even though it was unable to locate on this system the two corresponding CIIRs to which they related.

The circumstances of the two strikeforces where a review officer report was located on e@gle.i but no CIIR was located on e@gle.i are described below. In the first of these strikeforces, the review officer referred to information from the SCII's statement. A copy of the SCII statement was located on e@gle.i.

One evening in 2009 police commenced a pursuit of a vehicle containing two armed robbers. The vehicle with the two armed robbers collided with another vehicle causing the death of a young child.

The SCII in this matter provided a statement but no CIIR.

The review officer provided a comprehensive 18-page review officer report in relation to the critical incident investigation, covering crime scene examination, mechanical examination of the armed robber's vehicle, examination of the video footage of the pursuit and collision, summary of interviewing of police involved in the pursuit with reference to relevant paragraphs contained in the SCII's statement, interviews with the armed robbers, etc. The review officer report refers frequently to paragraphs in the SCII statement. The review officer report stated that 'in my opinion the investigation conducted into this Critical Incident was thorough and complete'.

In the second case study, the review officer once again referred to the SCII statement. On this occasion the SCII statement was not located on e@gle.i and hence was not available for review to the Commission.

The second strikeforce concerned a man who died at hospital in December 2010. The man had been arrested by police a few days prior to his death and conveyed to hospital where a hospital guard was placed and a bedside Court Hearing was held. After the bedside hearing the man was taken for a shower. On returning to his bed within the intensive care unit, the man collapsed and despite attempts to resuscitate him he died of either a 'clot' or 'heart attack'.

The review officer report stated that:

> During the course of this investigation all statements and products have been made available to me. All statements have been downloaded to e@gle.i and I have recorded comments in the investigation log.

The review officer report further stated:

> I have reviewed the statement of [the SCII] and the brief items. I find that [the SCII] has followed protocol and investigated the matter thoroughly. I agree with his findings and support his comments. The investigation was diligent and professional providing a sound investigation into the death of XX…

The Commission was unable to locate a CIIR on e@gle.i nor did it locate the statement of the SCII to which the review officer report referred. The Commission did locate a two-page statement by the SCII on e@gle.i, however, this statement did not provide an account of the critical incident investigation, nor did it make any findings or comments pertaining to the critical incident investigation.

The Commission requested information from the NSWPF regarding whether a statement by the SCII can ever replace a CIIR. The NSWPF advised the Commission that 'a statement by the senior critical incident investigator does not replace a critical incident investigation report (CIIR)'. According to the NSWPF whereas the CIIR is an 'internal administrative document which is used to inform the NSW Police Force Executive of the circumstances of the incident and the outcome of the investigation', the statement by the SCII is used in a 'Tribunal of Fact', that is it informs the court in both coronial matters and

matters that result in criminal charges. A statement does not include discussion on systemic or procedural issues or comment on the conduct of officers involved in the critical incident whereas a CIIR includes both these things. The NSWPF stated that it is a 'requirement for the SCII to complete a CIIR at the completion of all critical incident investigations', and in instances where the matter is to be heard before a court 'both a statement and a CIIR report would be required'. The NSWPF stated that:

> There should never be a statement without a CIIR once all associated proceedings are finalised.[269]

The Commission's examination of 56 review officer reports identified that the information contained in review officer reports varied greatly. Some were very comprehensive reports while some review officer reports provided scant information or agreed with the findings of the CIIR without offering any comments or observations as to the appropriateness of the actions of the involved officers.

As mentioned previously, the three sets of guidelines outline that the review officer report should provide an overview of the investigation including comments on the quality, timeliness and probity of the investigation conducted by the CIIT and should also 'identify and report on any deficiencies of a systemic nature that must be addressed by the NSW Police Force' (NSWPF 2007a, p. 26; NSWPF 2012a, p. 35; NSWPF 2016a, p. 26). The results of the Commission's audit in connection with these procedural requirements are presented below.

Overview of the investigation

The Commission reviewed whether or not the 56 review officer reports located on e@gle.i provided an overview of the investigation and found that:

- 43 (77%) review officer reports provided some overview of the investigation; 31 of these reports outlined specific details of the individual investigation while the other 12 reports provided very limited details (e.g. 'A C was established and a critical incident investigation was conducted')
- 13 review officer reports did not provide an overview of the investigation. In other words, these review officer reports **did not comply** with 2007 Guidelines.

Quality of the investigation

Of the 56 review officer reports located on e@gle.i:

- 43 (77%) review officer reports commented on the quality of the investigation conducted by the CIIT; seven of these reports outlined specific details about the quality of the individual investigation while the other 36 reports provided very limited details (e.g. 'The quality of this investigation was of a high standard'). These 36 review officer reports did not provide any additional discussion of what it was about the investigation that led the review officer to form this conclusion

[269] Letter from the Assistant Commissioner NSWPF Professional Standards Command to the Commission, dated 21 April 2016.

- 13 review officer reports did not comment on the quality of the investigation conducted by the CIIT. In other words, they **did not comply** with the 2007 Guidelines.

An example of a strikeforce where the review officer report commented on the quality of the investigation conducted by the CIIT is outlined below.

One evening in 2009 a fully-marked NSWPF vehicle observed a vehicle overtaking other vehicles at an excessive speed. The officers in the NSWPF vehicle decided to catch up to the vehicle to speak to the driver about their manner of driving. The lights and sirens of the NSWPF vehicle were activated and the driver of the civilian vehicle accelerated away. When the NSWPF vehicle lost sight of the vehicle its lights and sirens were turned off. The driver of the vehicle continued to drive at speed, clipped a gutter, lost control of the vehicle and collided with an oncoming vehicle. The passenger in the offending vehicle died in hospital later that night.

The review officer, in their report, explained that they had reviewed the CIIR and the attached transcripts and statements and found that the CIIT had '… undertaken competent and thorough inquiries appropriate to the circumstances of the incident'. The review officer report justified this statement by explaining that the CIIT had pursued numerous avenues of inquiry and that the findings of the CIIR were consistent with the evidence that had been gathered.

In another example, the coroner was critical of the review officer in not identifying the serious flaws in the investigation.

On the morning of 18th November 2009 NSW Police Force and Ambulance Service of NSW were called to the home of Mr Adrian Salter in Lakemba. Mr Salter' son, Adam Salter, had stabbed himself several times.[270]

Ambulance officers arrived first at the scene and commenced to treat Adam Salter who was conscious and compliant. Four police officers arrived a short time later. A sergeant was the most senior officer to arrive at the house of Adam and Adrian Salter. A short time after police arrived Adam Salter died after being shot by the sergeant using their police service revolver. Immediately prior to the sergeant shooting Adrian Salter the sergeant had shouted 'taser, taser, taser'.[271]

Following the death of Adam Salter a critical incident investigation, led by the Homicide Squad, began.

State coroner's criticism of review officer report

The state coroner was critical of the review officer report and stated that the review officer gave his colleague's report 'a clean bill of health'. The state coroner's report further stated:

> For the reasons I have outlined, my opinion in contrast is that the investigation was seriously flawed, provided the Commissioner with a very unreliable view of the

270 Report by the NSW State Coroner into death in custody/police operations 2011, Inquest into the death of Adam Salter on the 18th November 2009 at Campsie. Finding handed down by Deputy State Coroner Mitchell at Glebe on the 14th October 2011, pp. 133-134. (Public report)

271 Report by the NSW State Coroner into death in custody/police operations 2011, Inquest into the death of Adam Salter on the 18th November 2009 at Campsie. Finding handed down by Deputy State Coroner Mitchell at Glebe on the 14th October 2011, pp. 134 – 138.

> circumstances of Adam Salter's death and will have failed to persuade the community that the circumstances surrounding Adam Salter's death were investigated scrupulously and fairly.[272]
>
> The state coroner further rejected the review officer's recommendation that 'at the appropriate time/juncture all four involved officers receive formal recognition for their actions of the performance of their duties' and stated that the [NSW Police] Commissioner should:
>
> > most definitely not accept this recommendation which he might well see as likely to contribute to community unease regarding Adam Salter's fate and to the family's suspicion of what Mr Rushton described as 'a cover up and a whitewash'.[273]

Timeliness of the investigation

Of the 56 review officer reports located on e@gle.i:

- 27 (48%) review officer reports commented on the timeliness of the investigation conducted by the CIIT; 12 of these reports outlined specific details about the timeliness of the individual investigation while the other 15 reports provided very limited details (e.g. 'I am satisfied that this investigation was completed in a timely fashion'). These 15 review officer reports did not provide any additional discussion of what led the review officer to reach this conclusion
- 29 review officer reports did not comment on the timeliness of the investigation conducted by the CIIT, that is, they **did not comply** with the 2007 Guidelines.

A good example of a strikeforce where the review officer report commented on the timeliness of an investigation is outlined below.

> Police attached to a regional local area command were called to a farm in 2009 where an indigenous man, who appeared to be unconscious, had been found. The two involved officers placed the man in the rear of a NSWPF four-wheel drive vehicle and conveyed him to the local hospital. Upon arrival at the hospital the man was found to be in a critical condition and was transferred to a larger hospital where he was subsequently diagnosed with pneumonia.
>
> The review officer report explained that while the critical incident investigation was conducted in a timely manner, there had been some delay in obtaining medical records and doctor's statements.

272 Report by the NSW State Coroner into death in custody/police operations 2011, Inquest into the death of Adam Salter on the 18th November 2009 at Campsie. Finding handed down by Deputy State Coroner Mitchell at Glebe on the 14th October 2011, p. 153.

273 Report by the NSW State Coroner into death in custody/police operations 2011, Inquest into the death of Adam Salter on the 18th November 2009 at Campsie. Finding handed down by Deputy State Coroner Mitchell at Glebe on the 14th October 2011, p. 153.

Probity of the investigation

Of the 56 review officer reports located on e@gle.i:

- 23 (41%) review officer reports commented on the probity of the investigation conducted by the CIIT; three of these reports outlined specific details about the probity of the individual investigation while the other 20 reports provided very limited details (e.g. 'There were no probity issues identified'). These 20 review officer reports did not provide any additional discussion of what led the review officer to reach this conclusion
- 33 review officer reports did not comment on the probity of the investigation conducted by the CIIT. In other words, they **did not comply** with the 2007 Guidelines.

An example of a strikeforce where the review officer report commented on the probity of an investigation is described below.

Shortly after midnight one evening in 2011 two police officers were called out to a suburban family home where a break in had occurred and an assault was in progress. Upon arriving at the location the two officers were mistakenly identified by the male resident as the offenders. The male resident proceeded to run towards the two police officers, armed with a makeshift weapon. One of the police officers shot and injured the man.

The review officer report commented on the probity of the critical incident investigation related to this incident, stating that: 'There were no concerns identified with respect to the integrity of the investigation'. The review officer report further explained that he drew this conclusion based on a number of factors, including that drug and alcohol testing was conducted in accordance with the guidelines; that the directly involved officers were not known to any of the investigating officers; and that key investigative activities were observed by him, the review officer.

The circumstances of one strikeforce where the review officer report referred to a number of documents that were allegedly reviewed by the SCII and the review officer but that are not located on e@gle.i is described below.

In the early hours of a morning in 2010 officers from a metropolitan command engaged in a pursuit of a stolen vehicle. The stolen vehicle collided with a telegraph pole and the driver sustained serious injuries as a result of the collision.

The CIIR referred to a number of records that were reviewed or obtained as part of the critical incident investigation, including:

- VKG radio tape that indicated that the police pursuit lasted a mere 20 seconds
- expert statement from the NSWPF Crash Investigation Unit
- conversations with the duty officer
- one witness statement
- results of mandatory alcohol and drug testing of involved officers.

None of the above documents were located on e@gle.i.

The review officer report referred to a review of the VKG audio tape and the results of the mandatory testing. The review officer report concluded that, based on the attached documents, there was nothing adverse to be raised against the involved officers.

However, the review officer report made no mention that none of the above documents were located on e@gle.i and it is unclear how and if the review officer personally reviewed these documents or whether the review officer relied on the information provided in the CIIR. It is unclear why in this particular strikeforce there was no mention that none of the documents referred to in the CIIR were located on e@gle.i.

Identification of and report on any deficiencies of a systemic nature

The Commission's examination of 56 review officer reports found that:

- 17 review officer reports considered specific broader lessons and improvements to systems, policies, processes, practices and training
- ten review officer reports specifically mentioned that no improvements to systems, policies, processes, practices and training were needed
- ten review officer reports agreed with recommendations made within CIIRs without providing any additional discussion or comments to broader lessons and improvements to systems, policies, processes, practices and training
- three review officer reports considered recommendations made by the coroner for improvements to systems, policies, processes, practices and training without mentioning any broader lessons to be learned from the incident or proposing improvements to systems, policies, processes, practices and training other than the recommendations made by the coroner
- 14 review officer reports did not document broader lessons and improvements to systems, policies, processes, practices and training (the Commission was not in a position to assess whether or not the review officer report should have considered broader lessons and improvements in these areas)
- in two review officer reports the consideration of broader lessons and improvements to systems, policies, processes, practices and training was not relevant. One incident related to a civilian who died as a result of a lethal range of drugs; the other incident related to a civilian who was accidentally hit by a police car.

The following case study is an example of an investigation where the coroner identified problems with the NSWPF Safe Driving Policy (SDP) which had not been identified in the NSWPF critical incident investigation. In contrast to the review officer report, which focussed on the behaviour of individual officers, the coroner identified systemic flaws in the SDP rather than finding fault with the behaviour of individual officers.

In 2011 police began a pursuit of a motorcycle. During the pursuit the motorcycle swerved to the right of another vehicle which caused the motorcycle to become airborne and cross to the other side of the road. In doing so, the motorcycle rider had a head-on collision with another vehicle and was ejected from the motorcycle. The motorcycle rider was taken to hospital and died a short time later.

Critical incident investigation report (CIIR)

The SCII, while commenting that the involved officer had breached one aspect of the NSWPF SDP that related to 'precautions to be taken at a controlled intersection' concluded that this breach 'did not in any way have an impact on the riding behaviour of XX or the ultimate outcome of the pursuit'. The SCII made one recommendation that the breach of the SDP in relation to 'precautions to be taken at a controlled intersection' be referred to the involved officer's Local Area Command Safe Driver Panel to be 'reviewed, assessed and actioned in line with NSW Police Force Policy'. The SCII made no comments or recommendations in relation to broader lessons and improvements to systems and policies resulting from this investigations.

Review officer report

The review officer, in his report, mentioned that he was 'at odds' with the SCII's acceptance of explanations by the involved officers in relation to some aspects of compliance with the SDP and recommended that education and training regarding the SDP be reiterated to the involved officers in the police pursuit. The review officer did, however, conclude that he had found 'no systemic deficiencies within the SDP or other standard operational procedures' during his role as reviewing officer.

Coroner's inquest findings

The coroner did identify systemic issues in the NSWPF SDP and made recommendations to the Minister for Police that the NSWPF Police SDP in respect of police pursuits be reviewed by a panel of independent experts appointed by the Minister in light of Australian and international experience and research with a view to establishing best practice for the NSW Police Force.

Pending any review the coroner further recommended to address ambiguities in the SDP; consider the vulnerability of motorcyclists when engaging in a pursuit; SDP to make specific reference to the high rate of casualties resulting from high-speed pursuits; restricting high-speed pursuits to cases in which a serious offence is reasonably suspected of having been committed etc.

The coroner further stated that there were flaws in the SDP and NSWPF practice and that the SDP is 'in certain respects ambiguous and appears self-contradictory'. The coroner concluded that the issues in relation to the SDP were 'systemic not personal' and that none of the officers involved in the pursuit of XX did anything other than what they perceived to be their duty on that night.[274]

12.7 OBSERVATIONS

The 2016 Guidelines provide a comprehensive template for review officers to use as a basis to complete review officer reports. The Commission is satisfied that the review officer report template does not require any amendments or improvements. One of the issues identified by the Commission when reviewing the most recent version of the guidelines, i.e. the 2016 Guidelines, is that they state:

274 Coroner's inquest into the death of Hamish Raj, Date of findings: 7 April 2014, p. 40.

> These guidelines have been developed to assist officers by providing an outline of the actions to be considered when managing, investigating and reviewing critical incidents. These guidelines are not an exhaustive instruction for investigators and have been developed to assist through the provision of suggested investigative processes that may be employed in the investigation of these matters (NSWPF 2016a, p. 6).

The Commission is concerned that the 2016 Guidelines only state that officers shall 'consider' these actions and that some of the suggested investigative processes 'may' be employed.

Running sheets: content and documentation

While the 2007 Guidelines specified that the review officer 'should maintain a running sheet (separate to the investigation running sheet) documenting all action taken, advice given and create file notes of all relevant conversations' (NSWPF 2007a, p. 27) they provided no guidance as to how and where this information should be stored so that it can be easily located if required. Of the 83 critical incidents audited the Commission located one strikeforce that had attached a review officer running sheet to e@gle.i. Given the stated importance of transparency and accountability in critical incident investigations, the inability to access review officer running sheets is of concern as it significantly impedes the ability to assess whether appropriate investigative actions and decisions have taken place. In strikeforces where the review officer has not documented his or her review of the critical incident investigation it is not possible to determine if the review officer has effectively performed the role of risk manager.

Since the 2007 Guidelines there have been no improvements made to address this issue. The 2012 Guidelines provided identical guidance to that of the 2007 Guidelines regarding running sheets. Of even greater concern is that the 2016 Guidelines remove all mention of running sheets. The 2016 Guidelines only directly refer to the recording of relevant decisions and actions by the review officer, in the checklists attached to the 2016 Guidelines (and not in the main body of the text). The following action is required to be taken by the review officer as outlined in the 'Review Officer Checklist' attached at Appendix 6:

> Document all action taken, advice given and create file notes of all relevant conversations (NSWPF 2016a, p. 41).

In addition no running sheet template has been provided in the 2016 Guidelines. Without specific direction and assistance regarding how and where the review officer is to record important actions taken and decisions made during the critical incident investigation, it will be difficult to locate and access evidence with which to assess the critical incident investigation itself.

Briefing of review officer

Whereas the 2007 Guidelines specified that the duty officer will 'Brief the SCII and the review officer on arrival' (NSWPF 2007a, p. 19), the 2016 Guidelines state that the duty officer will 'be responsible for managing and coordinating the scene until the SCII arrives' (NSWPF 2016a, p. 19). Both the 2007 Guidelines and the 2016 Guidelines state that the review officer is required to 'attend the scene of the critical incident and advise the DOI

on arrival' (NSWPF 2007a, p 27; NSWPF 2016a, p. 41). Given the role of the review officer to perform the function of risk manager for the critical incident investigation it is important that the duty officer brief the review officer with a first-hand account of the management of the critical incident scene.

Review officer report

The Commission's audit of 56 review officer reports identified that the information contained in review officer reports varied greatly, ranging from very comprehensive review officer reports, to review officer reports with scant information. The 2016 Guidelines include Appendix 10 which is a comprehensive three-page review officer report template that provides detailed information as to what is to be included in the review officer report. There is no specific requirement in the 2016 Guidelines that review officers are required to use the review officer report template. Given the importance of review officers in monitoring and reviewing the probity and transparency of critical incident investigations the Commission's view is that review officers should use the review officer report template as basis for completing their review.

13. FOCUS AND FINDINGS OF CRITICAL INCIDENT INVESTIGATIONS

13.1 OVERVIEW

A primary function of the critical incident investigation is to ensure that the circumstances of a critical incident have been thoroughly examined and independently reviewed at a senior level, so that the community can have confidence in an investigation's outcome and findings (NSWPF 2007a, p. 1).

The NSWPF acknowledges in each of its 2007, 2012 and 2016 Guidelines that to retain public confidence and credibility, critical incident investigations need to fully address the circumstances that led to the death or serious injury of a person, the appropriateness of officer conduct, and whether there are any lessons that can be learnt from these incidents to minimise their future occurrence (NSWPF 2007a, p. 1; NSWPF 2012a, p. 6; NSWPF 2016a, p. 6). More specifically, the 2007 Guidelines highlighted that:

> Managing an incident as a 'critical' one should remove any doubts that might otherwise endure about the integrity of involved officers and provide reassurance that:
>
> - any wrongful conduct on the part of any members of NSW Police is identified and dealt with
> - welfare implications associated with the incident have been considered and addressed
> - consideration is given to improvements in NSW Police policy or procedure to avoid recurrences in the future (NSWPF 2007a, p. 1)[275].

This chapter describes what the Commission was able to establish from available NSWPF investigative reports regarding the extent to which the 83 investigations under review:

- examined and dealt with any wrongful conduct on the part of NSWPF officers
- considered improvements to NSWPF policies, procedures, guidelines or training based on lessons learnt from the critical incidents.

Summary of findings

The Commission based its findings in this chapter solely on its analysis of the content of the critical incident investigation reports (CIIRs), review officer reports and region commander reports located on e@gle.i.

275 While the Commission strongly supports the importance of considering the welfare of those involved in a critical incident, welfare implications are not discussed in this chapter. Consistent with the focus of Project Harlequin this chapter specifically addresses whether the NSWPF appropriately identified and managed officer misconduct as well as whether it considered broader lessons and improvements to systems and policies.

As at March 2016, 68 CIIRs, 56 review officer reports and 27 region commander reports from the 83 critical incident investigations included in the audit were located on e@gle.i. That is to say, 15 CIIRs, 27 review officer reports and 56 region commander reports from the audit sample were not located on e@gle.i. Consequently, the Commission had no information from which to assess whether or not the 15 investigations (or 18% of the audit sample where the CIIR was not located on e@gle.i) had examined and dealt with any wrongful conduct on the part of NSWPF officers or had considered improvements to NSWPF policy, procedures, guidelines or training.

In its audit of the 68 CIIRs located on e@gle.i, the Commission identified evidence that the critical incident investigation teams (CIIT) had:

- considered and examined the lawfulness of police action in 26 (47%) of the 55 CIIRs where the requirement was applicable
- considered and examined involved officers' compliance with relevant guidelines, policies and procedures in 59 (94%) of the 63 CIIRs where the requirement was applicable
- considered prosecution for involved officers in 2 (4%) of the 55 CIIRs where the requirement was applicable (the Commission was not in a position to assess whether or not the prosecution of involved officers needed to be considered in the investigation of any other critical incidents)
- considered management action for involved officers in 15 (24%) of the 63 CIIRs where the requirement was applicable (the Commission was not in a position to assess whether or not management action for involved officers needed to be considered in the investigation of any other critical incidents)
- considered specific broader lessons and improvements to systems, policies, and procedures in 23 (42%) of the 55 CIIRs where the requirement was applicable and specifically mentioned that no improvements to systems, policies and training were required in a further 7 (13%) of the 55 applicable CIIRs.

The Commission also examined the contents of the available review officer reports and region commander reports in relation to considerations given to any improvements in NSWPF policies, procedures and training since the 2007 Guidelines required that the review officer report should identify and report on any deficiencies of a systemic nature and further required that the region commander's report should highlight broader lessons to be learnt from the incident and any proposed improvements to systems.

In its audit of the 56 review officer reports located on e@gle.i, the Commission identified evidence that review officers:

- had considered specific broader lessons and improvements to systems, policies, processes and training in 17 (31%) and specifically mentioned that no improvements were required in a further 10 (19%) of the 54 review officer reports where the requirement was applicable
- considered recommendations that had been made by the coroner in three of the 54 applicable review officer reports

- agreed with recommendations made in CIIRs without providing any additional discussion or comments about proposed broader lessons and improvements in 10 of the 54 applicable review officer reports.

In its audit of the 27 region commander reports located on e@gle.i, the Commission identified evidence that:

- none of the region commanders proposed any improvements to systems beyond the improvements identified in either the CIIR or the review officer report
- one region commander stated, in one of the 27 applicable region commander reports, that he did not support a specific recommendation for improvements in policies and procedures that had been made in a CIIR and proposed that there be no further action in relation to this particular recommendation
- region commanders 'agreed' with recommendations made in CIIRs without providing any additional discussion or comments about proposed broader lessons and recommendations in 17 of the 27 applicable region commander reports and in one region commander report commented that the recommendations in another CIIR had already been appropriately actioned
- one region commander referred to broader issues identified in the review officer report stating, in the region commander report, that no further action in relation to this issue was necessary.

13.2 WHAT IS THE RISK IF THE INVESTIGATION DOES NOT FOCUS ON THESE ELEMENTS?

If the NSWPF does not examine and, if required, respond to any wrongful conduct by its officers, there is a risk that public confidence in the NSWPF's ability to conduct critical incident investigations may be undermined. There may be a perception by the public that NSWPF investigators are unable to objectively investigate and assess the actions of their fellow officers or, conversely, that the NSWPF is more concerned with protecting its reputation (and those of the involved officers) than in conducting an impartial, evidence-based investigation.

If a critical incident investigation does not examine the lawfulness of police action and compliance with internal policies and procedures, there is a risk that officers might incorrectly believe that the NSWPF does not consider their actions leading up to and during a critical incident to be important.

Also, if the investigation does not identify the broader lessons to be learnt from a critical incident there is a risk that the NSWPF will lose opportunities to make improvements to NSWPF policies, guidelines and procedures that may prevent similar incidents occurring in the future.

13.3 WHAT INFORMATION DID THE COMMISSION CONSIDER?

The Commission did not seek to re-investigate the 83 critical incidents in its audit sample.

Rather, the Commission relied solely on the content within the CIIRs, review officer reports and region commander reports located on e@gle.i to determine whether an investigation had considered:

a) the lawfulness of police action

b) involved officers' compliance with NSWPF guidelines, policies and procedures

c) management action for any involved officer(s)

d) prosecution of any involved officer(s)

e) broader lessons to be learnt from the incident and proposed improvements to NSWPF systems, policies, processes, practices and training.

The CIIR is the primary document in which the SCII records the investigative findings in relation to relevant events and activities leading to the incident, the appropriateness of officer conduct, any recommendations for management action and/or prosecution, as well as any problems that were identified. It is for this reason that the available CIIRs were the principal source of information for this chapter.

For the 83 strikeforces in the audit sample the Commission found that 73 NSWPF officers performed the role of SCII. The Commission notes that the variability in the style and approach of CIIRs may be due to the number of different individuals undertaking the SCII role and their varying level of experience in investigating critical incidents.

The Commission's audit further established that 62 NSWPF officers performed the role of review officer and 13 NSWPF officers[276] authored the region commander reports.

It is difficult to determine how many of the 83 possible CIIRs, review officer reports and region commander reports it would have been reasonable to expect to have been located on e@gle.i in March 2016. A check of the 'investigation status' recorded on e@gle.i at that time revealed that 75 of the 83 investigations had the status of either 'finalised' or 'complete'. Based on this, one view would be that it would be reasonable to assume that at least 75 CIIRs, 75 review officer reports and 75 region commander reports would have been located on e@gle.i. However, only 27 of these 75 investigations had all three reports located on e@gle.i and 10 of these completed or finalised investigations had none of the three reports located on e@gle.i.[277]

During its audit of the 83 critical incident investigations, the Commission found that as at 3 March 2016, a significant number of CIIRs, review officer reports and region commander

[276] Five of these NSWPF officers were region commanders, the remaining eight NSWPF officers were professional standards managers and the region commander signed off on their reports.

[277] On the other hand, three of the six investigations with a 'current' status, had CIIRs and two of these three investigations had a review officer report located on e@gle.i.

reports were not located on e@gle.i. As a result, the Commission was able to review the information contained within the following reports which were located on e@gle.i:

- 68 CIIRs
- 56 review officer reports[278]
- 27 region commander reports.[279]

That is to say, 15 CIIRs, 27 review officer reports and 56 region commander reports were not located on e@gle.i almost four years after the last and more than seven years after the first of the critical incidents in the audit sample occurred.

Where a report was not available, the Commission was not able to assess whether or not the investigation examined and dealt with any wrongful conduct on the part of NSWPF officers. Nor was the Commission able to assess whether or not the investigation considered improvements to NSWPF policies, procedures, processes, guidelines or training based on lessons learnt from the critical incidents.

In cases where a report was located, but where the report did not comment on these key issues, the Commission was unable to determine whether the investigation had neglected to document their consideration of these issues in the CIIR or whether the investigation had not considered them at all.

13.4 EXAMINATION OF CONDUCT OF NSWPF OFFICERS

One component of critical incident investigations is identifying if any of the involved officers engaged in wrongful conduct, that is, either acted unlawfully or failed to comply with relevant NSWPF guidelines, policies and procedures.

This section describes the guidance provided in the 2007, 2012 and 2016 Guidelines and what was found in the Commission's audit of available reports for 83 critical incident investigations in relation to the consideration of:

- the lawfulness of police action
- compliance with relevant guidelines, policies and procedures.

13.4.1 WHAT DO THE GUIDELINES SAY?

In relation to the lawfulness of police action and compliance with guidelines, policies and procedures, the 2007 Guidelines stated that the critical incident investigation team (CIIT) 'should examine the lawfulness of police action, the extent of police compliance with relevant guidelines, legislation and internal policy and procedures' (NSWPF 2007a, pp. 20, 29).[280] The

278 In two of the 56 strikeforces which had a review officer report located on e@gle.i, the relevant CIIR was not located on e@gle.i.

279 In 20 out of 27 region commander reports, the region commanders did not produce a separate report. Instead the region commander signed off on either the PSM report (15) or the review officer report (5). In these instances, apart from a signature by the region commander there were comments such as 'noted', 'agree' and 'I support the findings in the PSM report'. The remaining seven region commander reports were 'standalone' reports - that is they appeared to have been prepared and signed solely by the region commander.

280 The 2012 and 2016 Guideline include the same requirement (NSWPF 2012a, pp. 11, 28; NSWPF 2016a, pp. 8-9, 21).

2007 Guidelines also stated that 'the investigation report [CIIR] should include relevant events and activities leading to the incident and comment on the lawfulness of police action' (NSWPF 2007a, p. 24).[281]

While there was no specific requirement in the 2007 Guidelines for either the review officer or the region commander[282] to specifically comment on the conduct of the involved officers in their reports, it was open for them to do so if they chose to comment. For example, as the 'risk manager' for the investigation, the review officer could comment on how well the investigation had considered the conduct of the involved officers when commenting on the quality of the investigation in the review officer report. Similarly the region commander, who was accountable for the overall management of the investigation, was also open to comment on how well the investigation had considered the conduct of the involved officers in the region commander report.

13.4.2 WHAT DID THE COMMISSION FIND?

Lawfulness of police action

In relation to whether or not any of the 68 CIIRs located on e@gle.i considered the lawfulness of police action, the Commission's audit found that:

- in 26 CIIRs there was sufficient evidence that the CIIT considered and examined the lawfulness of police action (the Commission made this assessment in investigations where the CIIR mentioned specific legislation and examined officers' actions in relation to compliance with this legislation)
- in 24 CIIRs there was no mention of the lawfulness of police action nor was there a reference to any legislation that may have been breached
- in five CIIRs, which mentioned that the actions of involved officers were 'lawful' or mentioned particular legislation without any further discussion or examination as to the lawfulness of the officers' actions, the Commission was unable to assess the extent to which lawfulness of police action had been considered
- in 13 CIIRs the requirement to consider the lawfulness of police action was not applicable. These incidents related predominantly to suicides (either by police or civilians) and were not related to any police action or police operation (e.g. a civilian died as a result of a lethal range of drugs; a civilian was accidentally hit by a police car).

An example of one of the 26 investigations where there was evidence that the SCII considered and examined the lawfulness of police action is described below.

281 The 2012 and 2016 Guidelines include the same requirement (NSWPF 2012a, p. 33; NSWPF 2016a, pp. 8-9, 21). In addition the 2016 Guidelines state that: 'The SCII is responsible for gathering the necessary evidence and for determining the degree of an officer's involvement in an incident' (NSWPF 2016a, p. 21).

282 By contrast the 2012 and the 2016 Guidelines state that the region commander report should highlight and comment on any conduct issues identified in the critical incident investigation (NSWPF 2012a, p.17; NSWPF 2016a, p. 15).

Early one evening in 2009 two officers escorted a man, who had been attacked and robbed, back to his unit. The man spoke little English and appeared to be intoxicated. Upon arriving at the unit, the officers discovered that the man's girlfriend was there and left him with her.

After leaving, the officers were informed that the man was a suspected illegal immigrant and the officers returned to the unit to detain him. When the officers knocked on the door, there was no answer. A neighbour informed the officers that the man had jumped off the balcony and was lying in the gardens below. Concerned about the welfare of the man's girlfriend, the officers forced entry into the unit where she was found safe. The man suffered spinal fractures and broke a number of ribs as a result of his fall.

The SCII, in his report, considered the involved officers' compliance with legislation relevant to the incident. The SCII mentioned that the officers could have, but did not invoke, the provision of s206 of the *Law Enforcement (Powers and Responsibilities) Act 2002*, which relates to the detention of intoxicated persons. Instead, the SCII noted that the officers had met their obligation under s6.1 of the *Victims Rights Act 1996* to treat the man, who had been a victim of crime, with courtesy, compassion and respect by escorting him home.

The SCII also considered s189.1 of the *Migration Act 1958* and found that the officers had the power to detain the man after they were informed that he was a suspected illegal immigrant. The SCII further referred to s9(b) of the *Law Enforcement (Powers and Responsibilities) Act 2002* and stated that the officers were authorised to force entry into the unit as they had reasonable grounds to believe that the man's girlfriend was in there and they had concerns for her welfare.

Compliance with relevant guidelines, policies and procedures

In relation to whether or not any of the 68 CIIRs located on e@gle.i considered the involved officers' compliance with relevant guidelines, policies and procedures, the Commission found that:

- in 59 CIIRs there was sufficient evidence that the CIIT considered and examined involved officers' compliance with relevant guidelines, policies and procedures. The Commission made this assessment in investigations where the CIIR mentioned specific guidelines, policies and procedures and examined officers' actions in relation to compliance with these documents
- two CIIRs did not make any mention of any guidelines, policies or procedures and there was no examination in the CIIRs of whether involved officer(s) acted within any policies or procedures (the Commission was not in a position to assess if police compliance with relevant guidelines, policies and procedures needed to be considered in these two incidents)
- two CIIRs mentioned that involved officers acted within 'police guidelines', however, the CIIRs did not provide any reference to specific guidelines nor did they discuss or examine the involved officers' compliance with any specific internal policies or procedures. Hence the Commission was unable to assess the extent to which compliance with relevant guidelines, policies and procedures had been considered in these investigations

- in five CIIRs the requirement to consider involved officer(s) compliance with relevant guidelines, policies and procedures was not applicable.[283] These incidents related to either suicides (three incidents) or incidents (two incidents) that were not related to any police action or police operation (i.e. where a civilian died as a result of a lethal range of drugs; a civilian was accidentally hit by a police car).

An example of one of the 59 investigations where there was evidence that the SCII examined involved officers' compliance with relevant guidelines, policies and procedures is provided below.

> In 2010 two officers attended a hotel room at a regional location where the occupant, a man, was suspected of having consumed a large quantity of the drug ice and was threatening violence. Upon arrival, the officers attempted to deescalate the situation by talking calmly to the man. When the man lunged at the officers with a broken glass stem the officers used OC spray, tasered him in the chest and then attempted to physically restrain him. Despite this, the man managed to leave the hotel room and subsequently fell down a stairwell suffering serious head injuries as a result.
>
> The SCII stated that the officers had complied with the NSWPF Guidelines for the Management of People affected by Methylamphetamine and other Stimulant Drugs. In particular, the SCII noted that these guidelines stipulated that police should 'where possible, make additional efforts to establish a rapport with the person, to calm them down and reassure them. This may reduce the chance of the situation from escalating' (NSWPF 2014, p. 9). The SCII then explained that the officers had engaged the man in conversation for a period of ten to 15 minutes and had reassured him that he was being cared for and that an ambulance was on its way. For these reasons the SCII deemed that the officers had complied with the NSWPF Guidelines for the Management of People affected by Methylamphetamine and other Stimulant Drugs.
>
> The SCII, however, noted that one of the officers had momentarily removed the taser from the holster of the other officer and had not activated it. The SCII highlighted that this was a breach of the NSWPF Standard Operating Procedures for use of Electronic Control (Taser) Devices, in that it was deemed a 'hazardous practice' to not activate the device immediately after removing it from the holster. The SCII recommended that this officer undertake retraining in the use of the taser.

An example of one of the two investigations where the CIIR mentioned that involved officers acted within 'police guidelines' but did not refer to any specific guidelines nor examine involved officers' compliance with any specific internal policies or procedures is described below.

283 While there were 13 investigations that were classified as 'not applicable, in terms of assessing if the CIIT examined the 'lawfulness' of police action, there were only five strikeforces that were classified as 'not applicable' in assessing if the CIIT examined involved officers compliance with internal policies in procedures. This occurred in circumstances where examination of legislation was not applicable, but where the CIIT examined internal police policies and procedures, thus the difference of eight strikeforces.

One evening in 2011 a NSWPF officer was patrolling a regional location looking for a car. The driver of this car was reported to be drunk and to have recently been involved in a domestic incident. Upon seeing the car the officer indicated for it to pull to the side of the road. The driver pulled to the side of the road. As the officer got out of his car, however, the driver accelerated away. The officer ran back to his car and commenced a pursuit. During the pursuit, the car collided with a telegraph pole and the driver sustained serious injuries.

While the SCII commented in the CIIR that the officer had 'followed police procedures at all times' he did not specify what 'procedures' the officer had complied with and did not explain how the officer had complied with these procedures.

13.5 RESPONDING TO ANY WRONGFUL CONDUCT BY NSWPF OFFICERS

As outlined at the beginning of this chapter, one aspect of critical incident investigations is to ensure that any wrongful conduct by NSWPF officers is identified and managed (NSWPF 2007a, p. 1). This section outlines what was found in the Commission's audit of available reports located on e@gle.i in relation to the consideration of management action and/or prosecution for any of the involved officer(s).

13.5.1 WHAT DO THE GUIDELINES SAY?

The 2007 Guidelines provided the following guidance, which was not directed at any specific officer or at any specific role in the CIIT:

> Managing an incident as a 'critical' one should remove any doubts that might otherwise endure about the integrity of involved officers and provide reassurance that:
>
> - any wrongful conduct on the part of any members of NSW Police is identified and dealt with (NSWPF 2007a, p. 1).

In relation to considering prosecution or management action for any involved officer(s), the 2007 Guidelines stated that the SCII was:

> responsible for ensuring that appropriate action is taken concerning the prosecution of any person for any identified offence arising from the investigation. The SCII is also responsible for reporting any management issues that need to be addressed concerning any police officer (NSWPF 2007a, p. 20).[284]

The 2007 Guidelines also stated that:

> The CIIT's responsibility is solely to investigate those matters that constitute the critical incident and to examine the circumstances surrounding the critical incident itself. This includes the prosecution of any person for any offence found to have

[284] The 2012 Guidelines and the 2016 Guidelines include the same requirement (NSWPF 2012a, p. 33; NSWPF 2016a, p. 21).

> been committed or the presentation of a brief of evidence to the on duty State/Deputy State Coroner (NSWPF 2007a, p. 31).[285]

As mentioned previously, while the three sets of guidelines state that the review officer report should provide an overview of the investigation and the review officer should perform the function of a 'risk manager', the guidelines do not specifically mention that the review officer is responsible for considering any wrongful conduct by officers involved in a critical incident.

In relation to the content of the region commander report, the 2007 Guidelines did not mention that the report should include information pertaining to the prosecution of involved officers or the consideration of management action for any of the involved officers. By contrast the 2012 and the 2016 Guidelines state that the region commander report should highlight and comment on any conduct issues identified in the critical incident investigation (NSWPF 2012a, p. 17; NSWPF 2016a, p. 15).

As the 2007 Guidelines did not specifically require either the review officer report or the region commander report to examine or comment on any wrongful conduct by officers involved in a critical incident, the Commission's results focus on whether or not the CIIR reported on any management issues or prosecution of involved officers.

13.5.2 WHAT DID THE COMMISSION FIND?

Consideration of management action for any involved officers

Consideration of management action for any involved officers would not be applicable in all CIIRs. It would only be applicable where an investigation had found that an officer had breached some NSWPF policy or procedure or had acted unlawfully.

In relation to whether any of the 68 CIIRs located on e@gle.i considered management action, the Commission found that:

- 15 CIIRs considered management action for one or more of the involved officer(s). None of these investigations considered reviewable action[286], instead suggesting that non-reviewable action[287] be implemented
- in 48 CIIRs no breaches of internal guidelines, policies and procedures were mentioned and no management action was taken against any of the involved officers. The Commission was not in a position to assess whether or not management action needed to be considered

---

285 This requirement remained the same in the 2012 Guidelines (NSWPF 2012a, p. 26), however, it is not included in the 2016 Guidelines.

286 Reviewable action refers to management action that is reviewable, upon application, to the NSW Industrial Relations Commission. Types of reviewable action are outlined in s173(2) of the Police Act 1990 and include: a) a reduction of the police officer's rank or grade; b) a reduction of the police officer's seniority; c) a deferral of the police officer's salary increment; or d) any other action (other than dismissal or the imposition of a fine) that the Commissioner considers appropriate. The Commissioner of the NSWPF also 'has the legislative authority under s181D (1) [of the Police Act 1990] to remove an officer in whom he has lost confidence having regard to the officer's conduct, integrity, competence or performance' (NSWPF 2016a, p. 17).

287 Types of non-reviewable management action are listed in Schedule 1 of the Police Act 1990 and include the following: coaching; mentoring; training and development; increased professional, administrative or educational supervision; counselling; reprimand; warning; retraining; personal development; performance enhancement agreements; non-disciplinary transfer; change of shift; restricted duties; and recording of adverse findings.

- in five CIIRs, as noted in the previous section, the requirement to consider officer compliance with relevant guidelines, policies and procedures was not applicable because of the nature of the critical incidents (suicides and incidents that were not directly related to police action), consequently the requirement to consider management action for any involved officers was also not applicable.

An example of one of the 15 investigations where management action was considered by the SCII is outlined below.

> Early one morning in 2010 two police officers spotted a suspected stolen car at a regional location. They approached the car, with one officer standing in front of the car and the other to the side. The driver of the car drove forward. Fearing for the safety of his colleague, the officer standing to the side of the car shot the driver. The bullet struck the driver's right hip and he subsequently required surgery.
>
> The SCII recommended that the involved officers be reminded that when approaching motor cars in high risk situations that it is best to do so out of the path of the car and preferably from the side. The SCII also recommended that the two involved officers each undertake a scenario-based remediation program with either an accredited officer within the command or a senior operational safety instructor attached to the Operation Safety and Skills Command.

Consideration of prosecution for any involved officers

Consideration of prosecution of any involved officers would not be applicable in all CIIRs. It would only be applicable where an investigation had found that an officer had acted unlawfully.

In regard to whether or not the 68 CIIRs located on e@gle.i considered the prosecution of any involved officer(s), the Commission found that:

- two CIIRs considered the prosecution of an involved officer
- in 24 CIIRs there was sufficient evidence that the CIIT had considered and examined the lawfulness of police action. The CIIR did not recommend prosecution of involved officers
- in 29 CIIRs (24 CIIRs where there was no mention of the lawfulness of police action and five CIIRs that mentioned that the actions were lawful with no further discussion or examination of how the investigation reached that conclusion) the Commission was not in a position to assess if the prosecution of any involved officers needed to be considered
- in 13 CIIRs the requirement to consider the lawfulness of police action was not applicable and hence considering the prosecution of any involved officers was also not applicable.

The circumstances of an investigation which included evidence that the prosecution of an officer was considered, but subsequently rejected by the Office of the Director of Public Prosecutions (ODPP), is described below.

One afternoon in 2011 two officers located a stolen car parked on the front lawn of a house in a metropolitan area. Both officers approached the car. One of the officers removed the passenger from the car and arrested him without incident. The other officer attempted to remove the driver from the car and in the process shot the driver in the neck. The officer then threw away his firearm.

The SCII, in the CIIR, used excerpts from a report by an expert from the NSWPF Weapons and Tactics Policy and Review to identify non-compliance with the 'Discharging firearms' section of the NSWPF Handbook:

> The decision to use your firearm rests with you. You are accountable for your actions. If you kill or injure a person when such action is not reasonable you could face serious criminal charges and civil action.
>
> You are only justified in discharging your firearm when there is an immediate risk to your life, or the life of someone else, or there is an immediate risk of serious injury to you or someone else and there is no other way of preventing the risk.
>
> Do not draw your firearm, point, or aim it unless you consider you are likely to be justified in using it. The discharge of your firearm is to be regarded only as a last resort.
>
> Do not fire warning shots.
>
> Whenever possible, announce your office and call on the offender to surrender.
>
> Only discharge your firearm when there is no other reasonable course of action available.

The SCII then noted that the expert had identified the following breaches with this section of the NSWPF Handbook:

- at no stage were the lives of the involved officers or any other person(s) at immediate risk
- at no stage were the involved officers or any other person(s) at immediate risk of serious injury
- there were other reasonable courses of action available.

The CIIR also listed the following recommendations made by the expert from the Weapons and Tactics Policy and Review:

- that the involved officer undertake a complete psychological evaluation and assessment to ensure organisational suitability
- that the involved officer undertake remedial training in the following:
    - defensive tactics
    - routine and armed and dangerous traffic stops.

There was no indication in the CIIR, review officer report or region commander report as to whether or not this management action was implemented.

The SCII considered the lawfulness of the involved officer's actions by stating that the evidence gathered in the course of the critical incident investigation had been forwarded to the NSWPF Operational Legal Advice Unit (OLAU) for consideration of charging the officer with 'recklessness' in regard to the handling and security of his firearm. The SCII explained that the OLAU had advised that it considered the officer's actions to be a training or disciplinary issue, and that the matter had been referred to the ODPP for additional advice. The ODPP subsequently advised that there was insufficient evidence to commence criminal proceedings against the officer.

The circumstances of an investigation where the involved officer was prosecuted and pleaded guilty to an offence is described below.

One morning in 2011 a NSWPF van responded to a broadcasted message regarding a domestic violence incident. The NSWPF van travelled through a 'give way' road sign and collided with a car, killing its driver.

The CIIR was completed two-and-a-half years after the critical incident occurred. The SCII, in his CIIR, considered the lawfulness of the involved officer's actions in that he noted that the officer driving the NSWPF van had pleaded guilty to the offence of Driving Occasioning Death and was convicted and sentenced to a term of imprisonment for one year and ten months. This was suspended under s12 of the *Crimes Act (Sentencing Procedure) Act 1999* (NSW) and the driver was placed on a good behaviour bond and disqualified from driving for two years.

The SCII also noted that the following breaches of the NSWPF Safe Driving Policy had occurred:

- the officer driving the NSWPF van was not authorised to engage in urgent duty driving under any circumstances
- the officer driving the NSWPF van stated that he was responding under 'code blue' conditions, which meant that he was required to obey the road rules and not turn on the van's lights or sirens. He, however, admitted to speeding and on one occasion turning on the van's lights and sirens
- an inappropriate car was used for urgent duty response.

These breaches of policy were confirmed in a departmental investigation that commenced at the end of the criminal proceedings. The departmental investigation found the following issues to be sustained:

- culpable / negligent / dangerous driving
- failure to comply with operational procedures.

The officer was transferred to a different command, placed on restricted duties and instructed that he was not to drive for two years. His appointments were also removed. In addition the officer was served a Deputy Commissioner's Warning Notice that stipulated that any further unsatisfactory conduct may result in further management action and possible removal from the NSWPF under s181D of the *Police Act 1990*.

13.6 CONSIDERATIONS GIVEN TO IMPROVEMENTS IN NSWPF POLICY OR PROCEDURE TO AVOID RECURRENCES IN THE FUTURE

One facet of critical incident investigations is considering 'improvements in NSW Police policy or procedure to avoid recurrences in the future' (NSWPF 2007a, p. 1). This section outlines the findings of the Commission's audit of the available investigative reports located on e@gle.i in relation to whether consideration was given to improvements in NSWPF policies, procedures or guidelines to avoid recurrences in the future.

13.6.1 WHAT DO THE GUIDELINES SAY?

According to the 2007 Guidelines, at the conclusion of an investigation the SCII was required to prepare an investigation report that included 'any problems that have been identified' (NSWPF 2007a, p. 24). No explanation was provided as to what was meant by the term

'problems', however, it may have been interpreted that 'problems' with systems, policies, processes, practices and training could have been included here.[288]

The 2012 and the 2016 Guidelines refer to identifying 'systemic issues'. The 2012 and the 2016 Guidelines[289] state that: 'During the investigation, if any systemic issues are identified, immediately report the issue/s by way of manuscript report via the chain of command so that appropriate timely action can be taken to address the issues' (NSWPF 2012a, p. 31; NSWPF 2016a, p. 22).[290]

In relation to the responsibilities of the review officer, the 2007 Guidelines stated that review officer reports 'should identify and report on any deficiencies of a systemic nature that must be addressed by NSW Police' (NSWPF 2007a, p. 26). This message is repeated in the 2012 and the 2016 Guidelines (NSWPF 2012a, p. 35; NSWPF 2016a, p. 26).[291]

The 2007 Guidelines also stated that: 'the Region Commander's report should highlight broader lessons to be learned from the incident and any proposed improvements to systems, policies, processes, practices and training' (NSWPF 2007a, pp. 10, 28).[292]

The 2007 Guidelines, which were the focus of the Commission's audit, specifically required that the review officer and the region commander should report on any deficiencies of a systemic nature that must be addressed by the NSWPF and to highlight broader lessons to be learned from these deficiencies and how to improve NSWPF systems, policies and practices. As such, Section 13.6.2 presents the results in relation to each of the three reports that the Commission was able to locate on e@gle.i, i.e. 68 CIIRs, 56 review officer reports and 27 region commander reports.

13.6.2 WHAT DID THE COMMISSION FIND?

Critical incident investigation reports

The Commission's audit of the 68 CIIRs located on e@gle.i found that:

- 23 CIIRs considered **specific** broader lessons and improvements to systems, policies, processes, practices and training. The Commission made this assessment in investigations where the CIIR mentioned specific broader lessons learnt and/or discussed improvements in these areas

288 The same requirement is included in the 2012 and 2016 Guidelines (NSWPF 2012a, p. 33; NSWPF 2016a, p. 39).

289 In the 2016 Guidelines this information was placed under the heading 'Workplace Health and Safety Issues', suggesting that such systemic issues might only include those that pertain to workplace health and safety issues.

290 Further guidance is provided in a template for the Critical incident – investigation report that is appended to the 2012 Guidelines: 'This section will cover numerous issues dependant on the incident. Some examples would be: to identify policy and procedure which may not be appropriate / adequate'. This information is repeated in the template appended to the 2016 Guidelines, however, the wording changes from 'will cover' to 'may cover' (NSWPF 2016a, p. 46). The template appended to the 2016 Guidelines also states that: 'The Executive Summary should include information concerning any systemic issues identified and the action taken in response to those matters' (NSWPF 2016a, p. 45).

291 Appended to the 2012 and 2016 Guidelines is a template for the Critical incident - review report which instructs review officers to: 'Clearly comment upon and make recommendations in relation to any corporate issues such as policy, procedure, guideline and legislation. This may incorporate positive comments or comments relating to inadequacies or the need for amendment' (NSWPF 2016a, p. 48).

292 The 2012 and the 2016 Guidelines include the same requirement (NSWPF 2012a, p. 17; NSWPF 2016a, p. 15).

- seven CIIRs specifically mentioned that no improvements to systems, policies processes, practices and training were needed
- 20 CIIRs did not document any broader lessons or improvements to systems, policies, processes, practices and training (the Commission was not in a position to assess whether or not the CIIT should have considered broader lessons and improvements in these areas in the investigations of these particular critical incidents)
- five CIIRs considered recommendations made by the coroner for improvements to systems, policies, processes, practices and training. An investigation was placed into this category if the CIIR did not mention any broader lessons to be learnt from the incident or propose improvements to systems, policies, practices and training other than the recommendations made by the coroner
- in 13 CIIRs the consideration of broader lessons and improvements to systems, policies, processes, practices and training was not applicable. These incidents related predominantly to suicides (either by police or civilians) or were not related to any direct police action or police operation (a civilian died as a result of a lethal range of drugs; a civilian was accidentally hit by a police car).

An example of one of the 23 investigations where the SCII considered broader lessons in the CIIR and made recommendations for improvements to training is outlined below.

In 2011 an abandoned motor car was found on a highway in a rural location. A day later the wife of the owner of the abandoned car reported to police that her husband was missing. Subsequent searches of the nearby forest and townships failed to locate the missing man. Three days later a thorough ground and air search involving the local area command, POLAIR, Police Rescue and State Emergency Services located the man, who was deceased, in a nearby forest.

The SCII found in this instance that there was a lack of knowledge amongst staff regarding the requirement to request the attendance of a qualified land search coordinator to undertake search operation planning and coordination. The CIIR also identified that there was a general absence of training for officers in coordinating searches. The CIIR recommended that NSWPF Education Services formulate training for officers in land search coordination.

Review officer reports

The Commission found that of the 56 review officer reports located:

- 17 review officer reports considered specific broader lessons and improvements to systems, policies, processes, practices and training
- ten review officer reports specifically mentioned that no improvements to systems, policies, processes, practices and training were needed
- ten review officer reports agreed with recommendations made within CIIRs without providing any additional discussion or comments to broader lessons and improvements to systems, policies, processes, practices and training
- three review officer reports considered recommendations made by the coroner for improvements to systems, policies, processes, practices and training without mentioning any broader lessons to be learnt from the incident or proposing

improvements to systems, policies, processes, practices and training other than the recommendations made by the coroner

- 14 review officer reports did not document broader lessons and improvements to systems, policies, processes, practices and training (the Commission was not in a position to assess whether or not the review officer report should have considered broader lessons and improvements in these areas)
- in two review officer reports the consideration of broader lessons and improvements to systems, policies, processes, practices and training was not applicable. One incident related to a civilian who died as a result of a lethal range of drugs; the other incident related to a civilian who was accidentally hit by a police car.

An example of one of the 17 investigations where the review officer considered broader lessons and improvements and made recommendations, is outlined below.

One rainy evening in 2011 two officers were called to attend an accident that involved a car and a prime mover truck in a metropolitan location. A short time later, police requested that the truck driver move his car off the road. As he did so the truck came into contact with one of the officers, who was then run over and dragged along by the truck. The officer sustained serious leg injuries as a result and was admitted to hospital.

The review officer report identified a number of deficiencies of a systemic nature. One of the issues identified was that the hood of the NSWPF issued raincoat did not allow for peripheral vision. The review officer report suggested that consideration be given to inserting a clear panel at either side of the hood. It also recommended that a copy of their report be provided to the NSW Police Academy to inform future training in the safe management of motor car scenes, spatial awareness, and taking a safe location when conducting radio communications.

Region commander reports

The Commission found that of the 27 region commander reports located:

- none considered any improvements to systems beyond the improvements identified in either the CIIR or the review officer report
- one region commander report referred to recommendations made in the CIIR and stated they had been appropriately actioned. There is no further comment or examination of these recommendations in the region commander report
- one region commander report stated that the CIIT did not identify any issues of concern and that no recommendations had been made. The region commander report further agreed with the findings in the CIIR that there were no issues for the NSWPF but provided no additional comment or examination regarding this matter
- one region commander report did not support a specific recommendation for improvements to policies and procedures that had been made in the CIIR and proposed no further action in relation to this particular recommendation

- one region commander report referred to broader issues identified in the review officer report, but not the CIIR, and stated that no further action in relation to this issue was necessary

- 17 region commander reports agreed[293] with recommendations made within CIIRs without any additional discussion or comments about proposed broader lessons or improvements to systems, policies, processes, practices and training

- six region commander reports did not mention any broader lessons or improvements to systems, policies, processes, practices and training (the Commission was not in a position to assess whether or not the region commander report should have considered broader lessons and improvements in these areas).

A summary of the investigation where the region commander disagreed with recommendations made in the CIIR in relation to improvements to policies and procedures is described below.

One night in 2011 two NSWPF officers were called out to a metropolitan family home where a break-in had occurred and an assault was in progress. Upon arriving at the location the two officers were mistakenly identified by the male resident as the offenders. The man proceeded to run towards the two police officers, armed with a makeshift weapon. One of the police officers shot and injured the man. This police officer did not have the option of using his taser, due to a restriction under the standard operating procedures (SOPs) that stipulated that only one officer was permitted to be armed with a taser in a working pair.

The CIIR recommended that the SOPs in relation to tasers be reviewed to allow for more than one officer to be armed with a taser. This would increase the choice of appointments that could be used in circumstances such as this. The review officer report supported the CIIR's recommendation.

The region commander, however, in his report stated that he considered taser SOPs to be a corporate issue and that he did not support the recommendation made in the CIIR.

The following case study provides an example where while broader lessons and improvements were not considered in the CIIR, they were considered in the review officer report and were also mentioned in the region commander report.

Late one evening in 2009 a NSWPF officer was driving a fully marked NSWPF car and noticed a stolen car pass him without its headlights on. The officer commenced pursuing the car, however, he terminated the pursuit a minute later due to excessive speed – he was travelling at 200 km per hour.

The driver of the stolen car continued driving at speed, before colliding with another car which then crashed into a tree. The driver of the stolen car drove another 300 metres before abandoning the stolen car and running from the scene. The driver of the car that collided into the tree was admitted to hospital and placed in a medically induced coma.

The SCII did not identify any policy, practice or training weakness in the CIIR.

293 This relates to strikeforces where the CIIR and/or review officer report considered broader lessons and improvements to systems, policies, processes, practices and training but the region commander report makes only a broad comment concerning these broader issues and improvements (e.g. 'noted', 'agree', etc.).

The review officer, however, noted that the constable who conducted the breath testing of the officer who drove the NSWPF car was not authorised to conduct breath testing under s211A (2a) of the *Police Act 1990*. The review officer recommended that senior police who take command of critical incidents be reminded of their roles and responsibilities in relation to drug and alcohol testing procedures.

The region commander noted in his report that the issue of authorised breath testing had been the subject of a state-wide memorandum.

13.7 OBSERVATIONS

As mentioned previously, one of the objectives of critical incident investigations conducted by NSWPF officers is that these investigations provide assurance to the public that any wrongful conduct by involved officers is identified and dealt with in a transparent, unbiased and efficient manner. This chapter considered:

- whether NSWPF critical incident investigations examined the conduct of police officers and, in instances where wrongful conduct was identified, appropriately dealt with it either by management action or, in cases where the law was breached, prosecution
- whether the NSWPF identified any broader issues and improvements to its own internal systems and processes to avoid recurrences in the future.

One of the key audit findings discussed in this chapter was the significant number of CIIRs, review officer reports and region commander reports that could not be located on e@gle.i almost four years after the last of the critical incidents and more than seven years after the first of the critical incidents in the audit sample occurred. These reports provide important accountability mechanisms for the way the investigations are conducted, reviewed, oversighted and managed. While it was difficult to establish how many reports should have been located on e@gle.i at the time of the Commission's audit, this lack of available reports reduces the effectiveness of the NSWPF supervision and accountability mechanisms in relation to critical incident investigations.

That these reports cannot be located e@gle.i is contrary to the 2007 Guidelines which stated that the SCII is to ensure the investigation is recorded on e@gle.i (NSWPF 2007a, p. 20) and to ensure that all investigative material is cross-referenced to e@gle.i (NSWPF 2007a, p. 24). The 2012 and 2016 Guidelines include the same requirement but expand on this and mention that e@gle.i will be the primary storage facility for documents relating to the critical incident investigation (NSWPF 2012a, p. 28; NSWPF 2016a, p. 21).

One of the safeguards that the NSWPF has built into its critical incident investigations is a three-tiered process of supervision, comprising the SCII, the review officer and the region commander:

- the SCII heads the CIIT which conducts the investigation
- the review officer is appointed to perform the function of 'risk manager' and to produce a report which provides an overview of the investigation and comments on the quality, timeliness and probity of the investigation conducted by the CIIT

- the region commander is accountable for the overall management of the critical incident investigation and for providing a comprehensive report to the NSWPF Executive which should highlight any broader lessons to be learnt from the incident and any proposed improvements to systems, policies, processes, practices and training.

The Commission acknowledges that the 2016 Guidelines already include requirements for:

- the CIIT to examine the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation and internal policy and procedures
- the CIIR to include relevant events and activities leading to the incident and comment on the lawfulness of police action as well as any problems that have been identified
- the review officer report to identify and report on any deficiencies of a systemic nature that must be addressed by the NSWPF
- the region commander report to highlight and comment on any conduct issues identified in the critical incident investigation[294] and to highlight broader lessons to be learnt from the incident and any improvements to systems, policies, processes, practices and training.

However, despite these requirements being included within the various iterations of the guidelines, the Commission's audit identified that the contents of a number of the CIIRs would not be sufficient to provide reassurance that any wrongful conduct on the part of NSWPF officers involved in critical incidents had been adequately considered or that opportunities to avoid the recurrence of similar incidents in the future had been addressed.

In circumstances where the CIIR did not refer to any specific legislation and/or internal NSWPF policies and procedures the Commission was not in a position to assess whether or not the CIIT had specifically examined the conduct of involved officers in its investigation. All the Commission, or any other external reviewing process, would be able to conclude is that:

- these strikeforces did not comply with the requirement that the CIIR should include comments on the lawfulness of police action
- the CIIR did not provide evidence that the investigation had thoroughly examined:
    - the lawfulness of police action[295] and the extent of police compliance with relevant guidelines, legislation and internal policies and procedures[296] to identify and deal with any wrongful conduct on the part of any involved officers

294 While not specified in the 2007 Guidelines, this is specified in the 2012 Guidelines (NSWPF 2012a, p. 17) and in the 2016 Guidelines (NSWPF 2016a, p. 15).

295 This was the case in 29 of the 55 available CIIRs where the requirement to consider and examine the lawfulness of police action was applicable.

296 This was the case in four of the 63 available CIIRs where the requirement to consider and examine involved officer compliance with relevant guidelines, policies and procedures was applicable.

- the circumstances of the incident and considered improvements to NSWPF policies or procedures to avoid recurrences in the future.[297]

These findings illustrate that including a requirement within a set of guidelines is not, by itself, sufficient to ensure compliance. Supervision, including holding officers undertaking specific roles accountable for particular actions, can assist in achieving the standards sought by the NSWPF in its critical incident investigations.

The Commission suggests that the NSWPF uses its three-tiered process of supervision to ensure that critical incident investigations thoroughly examine the conduct of officers so that any wrongful conduct of involved officers is identified and dealt with in a transparent, unbiased and efficient method.

The Commission's review found that 73 different NSWPF officers performed the role of SCII within the 83 critical incident investigations and 62 different NSWPF officers performed the role of review officers. These findings indicate that NSWPF officers do not conduct critical incident investigations, and their mandatory subsequent reviews, on a regular basis and may not be entirely experienced with all the procedural requirements necessary for this type of internal police investigation. It is therefore crucial that the supervisory regime, consisting of the review officer and ultimately the region commander, is able to identify and address any deficiencies in these investigations to demonstrate the merits of different layers of supervision pertaining to critical incident investigations. Robust, transparent and accountable NSWPF supervision into police-related serious injuries and deaths reassures the community, bereaved family members and other interested groups that the NSWPF is committed to examining the appropriateness of the conduct of the involved officers as well as the probity of the subsequent critical incident investigation.

One important requirement pertaining to critical incident investigations is the consideration and examination by the SCII, review officer and region commander, of systemic issues pertaining to critical incidents and, where appropriate, to formulate improvements in these areas. The aim of examining broader issues, which goes beyond the actual investigation of actions of officers that led to the incident, is to improve existing systems, policies, processes, practices and training so as to avoid recurrences of similar incidents. The Commission’s audit identified five CIIRs that did not mention any broader lessons and improvements to systems, policies, processes, practices and training other than the recommendations made by the coroner. Similarly three review officer reports did not mention any broader lessons and improvements to systems, policies, processes, practices and training other than the recommendations made by the coroner.

Guidance concerning timing of the preparation of the CIIR has changed since the time the critical incidents that were subject of the Commission’s audit occurred. In the 2007 Guidelines the SCII was required to prepare a CIIR at the completion of the critical incident investigation (NSWPF 2007a, p. 24). In contrast, under the 2016 Guidelines, the SCII is required to await the outcome of the coronial inquest and to include any comments and recommendations made by the coroner, before completing their own, independent investigation report (NSWPF 2016a, p. 25).

The Commission is concerned that these changes may result in even fewer SCIIs, review officers or region commanders seeking to identify opportunities for improvements to their

[297] This was the case in 25 of the 55 available CIIRs where the requirement to consider broader lessons and improvements was applicable and in 27 of the 54 available review officer reports and in 23 of the 27 available region commander reports where this requirement was applicable.

internal systems and processes. The risk exists that the SCII, and subsequently the review officer and region commander, may rely on the findings of the coronial inquest rather than reaching their own independent findings and conclusions in relation to the critical incident, the actions of the involved officers and any potential review of existing NSWPF systems, policies and procedures.

14. ACCOUNTABILITY AT SENIOR LEVEL: ROLE AND RESPONSIBILITIES OF REGION COMMANDER

14.1 OVERVIEW

Each of the sets of guidelines 'impose accountability for the investigations of critical incidents at senior levels' (NSWPF 2007a, p. 1; NSWPF 2012a, p. 6; NSWPF 2016a, p. 6). The three sets of guidelines continue to say that by imposing accountability at senior levels 'the community, members of NSW Police and their families can be assured that all critical incidents are handled professionally, with integrity and that the decisions made and processes used are appropriate and reasonable' (NSWPF 2007a, p. 1; NSWPF 2012a, p. 6; NSWPF 2016a, p.6).

One of the major implications of an incident being classified as 'critical' includes the early involvement of the region commander (NSWPF 2007a, p. 2; NSWPF 2012a, p. 15; NSWPF 2016a, p. 16). The region commander has the ultimate responsibility for the 'management, investigation and review of all critical incidents that have occurred within the geographical boundaries of their region' (NSWPF 2007a, p. 7; NSWPF 2012a, p. 15; NSWPF 2016a, p. 11). At the conclusion of the critical incident investigation, the region commander should provide a comprehensive report to the Commissioner's Executive Team (NSWPF 2007a, p. 10; NSWPF 2012a, p. 17; NSWPF 2016a, p. 15).

After describing the role of the region commander, this chapter focusses on what can be learnt from an audit of documents located on the NSWPF e@gle.i system regarding how the region commander's role is undertaken in practice. More specifically it provides information relating to the:

- monitoring of the critical incident investigation
- contents of the region commander report.

Summary of findings

Processes to monitor the progress of critical incident investigations under the guidelines

One aspect of the role of the region commander in relation to the investigation of critical incidents is to implement processes to monitor the progress of investigations under the critical incident guidelines.

The Commission located no documents and/or records on e@gle.i that indicated how or if region commanders implemented processes to monitor the progress of critical incident investigations and subsequent reviews of investigations.

Region commander reports

The Commission's audit of 83 critical incident strikeforces located 27 region commander reports that are located on e@gle.i. This is just less than half of the 56 region commander reports the Commission would have anticipated based on the 56 review officer reports located by the Commission.

Of these 27 region commander reports:

- 20 comprised the region commander signing off on either the professional standards manager (PSM) report (15) or the review officer report (five). In addition to the region commander's signature, in these cases the region commander's comments were limited to remarks such as: 'noted'; 'agree'; and 'I support the findings in the PSM report' etc.
- seven were separate 'standalone' reports which varied in the detail of their content
- none highlighted any broader lessons to be learnt from the incident or proposed improvements to police systems, policies, practices and/or training as required by the guidelines
- none included comments to the effect that, having considered the circumstances of the incident, that the region commander did not believe that any changes to policy were required
- in instances where the senior critical incident investigator (SCII) identified systemic issues in the critical incident investigation report (CIIR), the majority of region commanders signed off on either the PSM or review officer report and 'agreed' with the findings and recommendations included in the CIIR or review officer report without providing any additional opinions or observations.

14.2 WHAT INFORMATION DID THE COMMISSION CONSIDER?

The Commission's audit of 83 critical incident strikeforces located 27 region commander reports on e@gle.i. The Commission classified a 'region commander report' as any report that included the signature of the region commander. For example, the Commission's review located 15 professional standard manager reports and five review officer reports that were signed off by the region commander.

In addition the Commission reviewed e@gle.i to locate any documents that provided information how region commanders implemented processes to monitor the progress of critical incident investigations and their subsequent reviews.

14.3 ROLE OF REGION COMMANDER

14.3.1 WHAT DID THE GUIDELINES SAY?

In relation to critical incidents it is the responsibility of the region commander to:

- declare an incident as critical[298] (NSWPF 2007a, p. 7; NSWPF 2012a, p. 15; NSWPF 2016a, p. 12)
- form a critical incident investigation team (CIIT) and select the CIIT members according to an established protocol[299] (NSWPF 2007a, pp. 8, 20, 29; NSWPF 2012a, p. 15; NSWPF 2016a, p. 12)
- appoint a senior officer to act as the review officer[300] (NSWPF 2007a, p. 8; NSWPF 2012a, p. 16; NSWPF 2016a, p. 14)
- ensure that terms of reference and an investigation agreement for the critical incident investigation are drawn up and agreed as soon as practicable after the commencement of the investigation[301] (NSWPF 2012a, p. 16; NSWPF 2016a, p.13)
- implement processes to monitor the progress of investigations under the critical incident guidelines (NSWPF 2007a, p. 9; NSWPF 2012a, p. 16; NSWPF 2016a, p. 13)
- report the outcome of a critical incident investigation to the NSW Police Executive so that matters arising can be dealt with at a senior level (NSWPF 2007a, pp. 8, 10, 28; NSWPF 2012a, p. 17; NSWPF 2016a, p. 15)
- highlight broader lessons to be learnt from the incident and any proposed improvements to systems, policies, processes, practices and training in the region commander report (NSWPF 2007a, pp. 10, 28; NSWPF 2012a, p. 17; NSWPF 2016a, pp. 15-16).

14.4 MONITORING OF THE CRITICAL INCIDENT INVESTIGATION

14.4.1 WHAT DID THE GUIDELINES SAY?

The 2007, 2012 and 2016 Guidelines state that the region commander should:

> Implement processes to monitor the progress of investigations under these guidelines (NSWPF 2007a, p. 9; NSWPF 2012a, p. 16; NSWPF 2016a, p. 13).

298 The region commander's decision making in relation to declaring an event to be a 'critical incident' and the documentation of that decision making is discussed in Chapter 5.

299 The selection of the senior critical incident investigator and other CIIT members is discussed in Chapter 6.

300 The appointment of an independent officer to act as the review officer is discussed in Chapter 12.

301 No mention of this requirement was included in the 2007 Guidelines and this requirement was not examined during the Commission audit.

There is no further explanation of how this monitoring is to be conducted or how it is to be documented in any of the three sets of guidelines reviewed by the Commission.

14.4.2 WHAT IS THE RISK TO THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

The guidelines state the purpose of imposing accountability at a senior level is to provide assurance to the community, members of the NSWPF and their families that all investigations of critical incidents are handled professionally, with integrity and the decisions made are appropriate and reasonable.

When accountability is not demonstrated at a senior level, such an assurance to the community, members of the NSWPF and their families is diminished.

14.4.3 WHAT DID THE COMMISSION FIND?

The Commission located no records on e@gle.i that indicated how, or if, region commanders' implemented processes to monitor the progress of critical incident investigations, and subsequent reviews of these investigations.

14.5 CONTENTS OF REGION COMMANDER REPORT

14.5.1 WHAT DID THE GUIDELINES SAY?

The 2007 Guidelines stated that the region commander should:

> Provide a comprehensive report to the Commissioner's Inspectorate at the end of the matter for forwarding to Commissioner's Executive Team. The documentation should include the reports from the senior critical incident investigator and review officer. Among other matters, the Region Commander's report should highlight broader lessons to be learned from the incident and any proposed improvements to systems, policies processes, practices and training (NSWPF 2007a, p. 10).

The 2016 Guidelines include the same requirement, but in addition require that in matters involving a coronial inquest:

> After the conclusion of the inquest the region commander **must** ensure a comprehensive manuscript report is provided to the Deputy Commissioner, Field Operations, to enable the coronial findings and any recommendations to be considered. The report should be endorsed by the region commander and include the reports from the SCII and the review officer (NSWPF 2016a, p. 15).[302]

The 2016 Guidelines also state that the region commander's report 'should highlight and comment on any conduct issues identified …' (NSWPF 2016a, p. 15).

302 The 2012 Guidelines included a similar requirement (NSWPF 2012a, p. 17).

Interestingly, the 2016 Guidelines, unlike the 2012 Guidelines, mention the provision of an interim report prior to the completion of any coronial inquest. More specifically:

> 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 (NSWPF 2016a, p. 15).

It is not clear whether 'any matters arising' refers to officer misconduct matters or policy, procedure and training matters, or both.

The 2016 Guidelines do not provide a template for the region commander report or a list of what the region commander report might include.

The 2012 Guidelines emphasised the 'pivotal role' of the region commander in communicating the outcomes of critical incident investigations to the NSWPF Executive:

> Region commanders also play a pivotal role in ensuring the outcomes of a critical incident investigation are reported to the NSW Police Executive so matters arising can be dealt with at senior level. For this reason, region commanders are required to brief the deputy commissioners on each critical incident investigation that has occurred in their region (NSWPF 2012a, p. 17).

Also the 2016 Guidelines elaborate that the region commander report 'provides assurances that the region commander is fully briefed on the outcome of the investigation and will ensure that any recommendations stemming from the investigation are addressed' (NSWPF 2016a, p. 15).

When the Commission's preliminary audit of e@gle.i records located very few region commander reports, the Commission contacted the NSWPF to seek its opinion of what constituted a region commander report. The NSWPF responded:

> It is recognised that Region Commanders may not necessarily complete a formal review report, this seems to be completed by the Region PSM. The outcome of the investigation (sic) any identified issues are formally considered by the Region Commanders as a result of the PSM's report. There are informal briefings conducted with the Region Commander during the course of the investigation and in the event that an issue is identified (including matters relating to systemic, procedural or conduct concerns) these matters are discussed with the Region Commander at the time they are identified.[303]

While the 2007 Guidelines stated that 'The region Professional Standards Manager (PSM) may play a coordinating role in representing the Region Commander in implementing the protocols for the region' (NSWPF 2007a, p. 9) they did not specifically outline the need for a PSM report or that the PSM could prepare the region commander report. In its audit of 83 critical incident investigations the Commission located some PSM reports which were not signed by the region commander. In these instances, the Commission did not count PSM reports as region commander reports.

[303] Correspondence from the NSWPF to the Commission, 6 June 2014.

The 2012 Guidelines and the 2016 Guidelines both mention that at the conclusion of an investigation the region commander 'should provide a comprehensive report to the Deputy Commissioner, Field Operations' including 'comment on any conduct issues identified, any broader lessons to be learned from the incident and any proposed or implemented improvements to systems, policies, processes, practices and training' (NSWPF 2012a, p. 17; NSWPF 2016a, p. 15). There is no mention in either the 2012 Guidelines or the 2016 Guidelines of the PSM preparing the region commander report or playing any part in its preparation.

14.5.2 WHAT IS THE RISK TO THE INVESTIGATION IF THE GUIDELINES ARE NOT FOLLOWED?

One of the key responsibilities of the region commander in relation to critical incident investigations is to consider if there are any potential systemic issues related to police systems, policies, processes, practices and training that may have led to the critical incident occurring.

The intent of this requirement appears to be that the focus of the investigation is not just on the actions of individual officers but also on broader NSWPF systems and policies.

In the absence of any consideration of the implications of individual critical incident investigations for systemic issues with NSWPF policies, procedures and systems, there is the risk that the NSWPF does not address systemic issues which may, in turn, lead to further critical incidents in the future.

14.5.3 WHAT DID THE COMMISSION FIND?

The Commission located 27 documents which included the region commander's signature on e@gle.i. The Commission classified these documents as 'region commander reports'. This is just less than half of the number of region commander reports the Commission would have anticipated should have been attached to this system. The Commission anticipated that there would be 56 region commander reports based on the Commission's audit having located 56 review officer reports.

In 20 out of 27 region commander reports, the region commanders did not produce a separate report. Instead the region commander signed off on either the PSM report (15) or the review officer report (five). In these instances, apart from a signature by the region commander there were sometimes comments such as: 'noted'; 'agree'; and 'I support the findings in the PSM report' etc. Such comments do not necessarily provide assurance that the region commander has examined the investigation and considered any broader lessons to be learned from the critical incident.

Seven of the 27 region commander reports were 'standalone' reports. The Commission categorised a standalone report as any report that appeared to have been prepared by the region commander as they were signed solely by the region commander. There were four 'standalone' region commander reports from one particular region commander. These four reports followed the same structure and each provided:

- the reason why an incident was declared 'critical'
- background information as to actions of police that led to the critical incident

- the region commander's comments in relation to the outcome of the critical incident investigation and whether the region commander accepted the findings outlined in the CIIR
- the region commander's recommendation to disseminate a copy of the CIIR to the Deputy Commissioner of Police, Field Operations, as per the Critical Incident Guidelines.

In none of these four reports did the region commander make reference to the review officer report.

Two standalone region commander reports, which were signed by another region commander, simply mentioned that a review of the CIIR, PSM report and review officer report had been completed and that the region commander agreed with the SCII that there are 'no issues for the NSWPF' and 'no further action is required regarding this matter'. Of interest is that in one of these two strikeforces, no review officer report could be located on e@gle.i, yet the region commander did not comment on this fact. These two standalone region commander reports comprised seven lines and eight lines respectively.

The seventh standalone region commander report provided some discussion as to the appropriateness of actions of involved officers in the incident and whether or not they had breached the NSWPF Safe Driving Policy (SDP). The region commander concluded that in their view the involved officers had acted appropriately in all the circumstances. This report consisted of five paragraphs and was half a page in length.

A brief summary from the CIIR, the review officer report and the region commander report for each of the seven standalone region commander reports is presented below:

1. The CIIR pertaining to a police suicide discussed issues of mental health training in the NSWPF and recommended that the NSWPF consider protocols relating to the management of police on anti-depressant and other medication prescribed to treat psychological illness. The CIIR also mentioned that there were no formalised Standing Operating Procedures (SOPs) in relation to the process of an officer gaining access to their firearm at the commencement of each shift. The CIIR further stated that as a result the Deputy Commissioner had commissioned a project to develop recommendations to formalise these procedures.

   The review officer report agreed with the conclusions and recommendations made in the CIIR but offered no independent review of the critical incident investigation.

   The region commander report referred to the coronial report and the recommendations made in the CIIR. The region commander report supported recommendations included in the CIIR in regard to safe storage of firearms and in relation to health and well-being of officers, psychiatric assessment, medical matters and peer support.

2. A police pursuit of a vehicle resulted in shots being fired by police in an inner city Sydney suburb. No one was injured as a result of the shots being fired. The CIIR examined the actions of involved police officers in terms of their compliance with the NSWPF SDP and their discharge of a police firearm. The report concluded

that both involved officers were in breach of some aspects of the SDP but were justified in discharging their firearms. The SCII recommended that one of the involved officers be referred to an inner city Safe Driving Panel with consideration of a complaint being initiated in regard to the breach of the SDP. The review officer report supported the findings of the CIIR.

The region commander report provided a brief overview of the incident and supported the recommendations made in the CIIR.

3. A fatal motor vehicle collision near a regional centre resulted in a pedestrian being killed. The region commander declared a critical incident due to police involvement with the deceased shortly before the collision. The CIIR concluded that the deceased had died as a result of his own misadventure and that the involved officers were not under any legislative obligation to detain the deceased in relation to his intoxication. There was no review officer report located on e@gle.i. The region commander report mentioned that an examination of the review officer report and the CIIR has been completed and agreed with the PSM who commented in his/her report that there were no issues for the NSWPF.

   The region commander report did not provide any information as to why no review officer report was made available on e@gle.i.

4. In 2009 two police officers were involved in an operation trying to identify offenders responsible for Break, Enter and Steal offences in a regional area of New South Wales. Police engaged in a vehicle pursuit when they came across a vehicle that drove in a 'suspicious manner'. Police lost sight of the vehicle and stopped their pursuit which only lasted about ten seconds. Police continued to drive at the legal speed limit and located the vehicle which had collided with a large tree. One of the passengers in the car received serious injuries. The CIIR concluded that the actions of the two involved officers were lawful and justified and that they had complied with the SDP. The review officer report agreed with the findings of the CIIR and stated that the actions of all police involved in this matter had been found to be 'in line with police policy and standard operating procedures'.

   The region commander report referred to the CIIR and the PSM report and discussed some aspects of the SDP in relation to what constitutes a pursuit and stated and the SDP is 'open to interpretation'. The region commander report pointed out that 'my view is that no pursuit was initiated and the officers acted appropriately in all the circumstances'.

5. A police pursuit resulted in the rider of the pursued motor cycle colliding with two metal signs. As a result of the collision the rider of the motor cycle received serious leg injuries. The CIIR concluded that the involved officers complied with the pursuit guidelines of the SDP. The review officer signed off on the CIIR and stated: 'I accept the investigator's finding for each issue'.

   The region commander report, in relation to the critical incident investigation stated that he accepted the recommendation of the SCII that police involved in the critical incident acted appropriately, without making any further comment.

6. A critical incident was declared when a women climbed a tower in an inner city suburb and despite police negotiators and the Police Rescue Squad arriving at the site, the woman fell off the tower and was conveyed to hospital where she recovered. When spoken to by police approximately two weeks after the incident had occurred she did not blame police but stated: 'It's my own fault I reckon … I don't blame nobody else, only myself'. The CIIR discussed the lawfulness of police actions and their compliance with relevant NSWPF policies and procedures. The CIIR concluded that all police involved in this incident had acted lawfully and that all had performed their duties in accordance with relevant internal policies and procedures. The review officer signed off on the CIIR and agreed with the findings and recommendations of the CIIR.

   The region commander report provided a brief summary of the incident and commented that he accepted the findings of the critical incident investigation team that police involved in the critical incident had acted appropriately.

7. The seventh critical incident with a standalone region commander report related to a police pursuit of a motorcycle which resulted in the motorcycle colliding with an oncoming car. The rider and the pillion passenger were conveyed to hospital with head injuries. The CIIR concluded that the actions of the involved officers were in accordance with the NSWPF SDP. The review officer report supported the findings of the CIIR.

   The region commander report mentioned that the CIIR, review officer report and region PSM report had been reviewed and that the region commander agreed with the PSM report that there were no issues for the NSWPF.

In none of the 27 region commander reports reviewed by the Commission did region commanders highlight any broader lessons to be learnt from the incident or propose improvements to police systems, policies, processes, practices and training as required by the 2007 Guidelines. There were also no specific comments that region commanders had considered the investigations and did not believe any changes to policy were required. In instances where the SCII identified systemic issues in CIIRs, the majority of region commander reports comprised the region commander signing off on either the PSM or review officer report and 'agree' with the findings and recommendations included in CIIRs or review officer reports without providing any additional opinions or observations.

14.6 OBSERVATIONS

The three iterations of the guidelines state that the region commander has ultimate responsibility for the management, investigation and review of all critical incidents that have occurred within the geographical boundaries of their region. Furthermore, the three sets of guidelines require the region commander to provide a comprehensive report.

The Commission considers that the region commander report provides an appropriate mechanisms by which region commanders can demonstrate that they have taken responsibility for the investigation of a critical incident and have fulfilled each of their responsibilities in relation to the management and investigation of the critical incident, as described in the different iterations of the critical incident guidelines.

However, the number and nature of the documents that the Commission was able to locate on e@gle.i and classify as a 'region commander report' during its audit of 83 strikeforces was not sufficient to provide assurance that the region commanders associated with the investigation of these 83 strikeforces had:

- implemented processes to monitor:
    - the progress of the investigations
    - that the decisions made and processes used were appropriate and reasonable in each case
    - that the investigations had taken appropriate steps to identify any conduct by involved officers that was unlawful or that did not comply with NSWPF policies and procedures
- provided a comprehensive report to the NSWPF Executive
- had considered whether there were any broader lessons to be learnt from the incident and whether any improvements to NSWPF systems, policies, processes, practices and training should be imposed.

The Commission is aware that the NSWPF has prepared templates to assist the SCII and the review officer to prepare their CIIRs and review officer reports. The Commission suggests that the NSWPF similarly prepare a template as a guide to region commanders to reduce the chance of important information being inadvertently omitted from region commander reports.

In its examination of region commander reports the Commission became aware of two other types of reports: 'PSM reports' and 'interim reports'. The Commission considers that those involved with the critical incident investigation and with the documentation of the investigation could benefit with further clarification of these reports.

While the guidelines do not require a PSM report or make mention of any specific role for the PSM in preparing the region commander report, the Commission identified that 15 of the 27 documents that it classified as 'region commander reports' were PSM reports that had been signed by both the PSM and the region commander. The Commission's view is that if the PSM is intended to have a role in drafting the region commander report, the nature and extent of this role should be clearly specified in current and future critical incident guidelines.

The need for the region commander to ensure the provision of an 'interim report' prior to the completion of the coronial inquest was first mentioned in the 2016 Guidelines. The 2016 Guidelines, however, do not clarify who is responsible for preparing the interim report or when any conduct issues identified in the interim report would be managed or otherwise dealt with. It is the Commission's view that additional guidance in relation to the role and purpose of the interim report should be included in current and future critical incident guidelines.

15. ASSESSMENT AND RECOMMENDATIONS

15.1 OVERVIEW

The Commission initiated Project Harlequin in 2012 to identify the misconduct and other risks associated with critical incident investigations, and to assess how well the processes used by the NSWPF to investigate critical incidents managed those risks.

This chapter:

- discusses what the Commission has learnt about the three mechanisms relied upon by the NSWPF to identify and investigate critical incidents
- discusses what the results of the Commission's audit suggests about NSWPF's capacity to prevent or minimise misconduct and other risks associated with critical incident investigations
- identifies areas for change in the application by the NSWPF of its own processes to improve the management of misconduct and other risks associated with critical incident investigations.

15.2 MECHANISMS IN PLACE TO MANAGE NSWPF CRITICAL INCIDENT INVESTIGATIONS

The framework within which the NSWPF identifies and investigates critical incidents is provided by the following three mechanisms:

- written guidelines to be followed by involved officers
- an electronic management system (e@gle.i) to be used by investigating and reviewing officers
- a three-tiered process of supervision.

15.2.1 NSWPF CRITICAL INCIDENT GUIDELINES

The Commission reviewed three iterations of the NSWPF critical incident guidelines: the 2007, 2012 and 2016 versions. The 2007 Guidelines were the applicable guidelines for the 83 critical incident investigations audited by the Commission.

15.2.2 NSWPF INVESTIGATIONS MANAGEMENT SYSTEM (E@GLE.I)

Since 2001, the NSWPF has used a web-based investigations management system, named e@gle.i as the principal storage facility for all documents and records relating to a critical incident investigation. E@gle.i stores and manages documents, photographs, images, audio and video recording on a central database.[304]

[304] E@gle.i was rolled out to local area commands in 2001. Police Service Weekly, Vol 12 No 48, 4 December 2000, p.8.

15.2.3 NSWPF THREE-TIERED PROCESS OF SUPERVISION OF CRITICAL INCIDENT INVESTIGATIONS

When an incident is declared 'critical' by the region commander a three-tiered process of supervision is triggered. This process, which is set out in the guidelines requires:

- the appointment of a senior critical incident investigator (SCII) whose role it is to supervise and manage the critical incident investigation team (CIIT) (NSWPF 2007a, p. 29; NSWPF 2012a, p. 26; NSWPF 2016a, p. 19)
- the appointment of a review officer who performs the function of 'risk manager' and who is required to produce a report providing an overview of the investigation and comment on the quality, timeliness and probity of the investigation conducted by the CIIT[305] (NSWPF 2007a, p. 26; NSWPF 2012a, p. 35; NSWPF 2016a, pp. 25-26)
- the provision by the region commander of a comprehensive report to the NSWPF Executive highlighting any broader lessons to be learnt from the incident and any proposed improvements to systems, policies, processes, practices and training[306] (NSWPF 2007a, pp. 7,10).

15.3 COMPLIANCE WITH THE NSWPF CRITICAL INCIDENT GUIDELINES

The following section of the report presents the Commission's assessment of the guidelines and audit results relating to the level of compliance with particular requirements of the guidelines in the 83 strikeforces examined.

15.3.1 PRINCIPLES, PURPOSE AND FUNCTION OF THE NSWPF CRITICAL INCIDENT GUIDELINES

The 2007, 2012 and 2016 Guidelines contain the following statement of principles underpinning how critical incident investigations should be conducted by NSWPF officers:

> NSW Police is committed to demonstrating its professionalism by investigating all such incidents in an effective, accountable and transparent manner. If public credibility is to be maintained, [investigation of] such incidents are most appropriately conducted independently (NSWPF 2007a, p. 1; NSWPF 2012a, p. 6; NSWPF 2016a, p. 6).

It is not clear to whom the investigation is accountable and transparent given that critical incident investigation reports are not made public by the NSWPF.

---

305 The three sets of guidelines state that the review officer should, as a minimum, be of the same rank as the SCII.

306 The 2012 and 2016 Guidelines add that the region commander is also responsible for the 'review of all critical incidents that have occurred within the geographical boundaries of their region'. The requirement to provide a comprehensive report remains the same as in the 2007 Guidelines (NSWPF 2012a, pp.15, 17; NSWPF 2016a, pp. 11, 15-16). More detailed information pertaining to the role and functions of the region commander are provided in Chapter 14 of this report.

Indeed a redacted version of the NSWPF critical incident guidelines was only made publicly available in July 2016, and accordingly public credibility in individual investigations is probably not something that can be delivered under the current arrangements.

The Commission's review of the three sets of guidelines further noted that they all contained assurances as to the thoroughness of a critical incident investigation, as follows:

> 'Managing an incident as a 'critical' one should remove any doubts that might otherwise endure about the integrity of involved officers and provide reassurance that:
>
> - any wrongful conduct on the part of any members of NSW Police is identified and dealt with
> - welfare implications associated with the incident have been considered and addressed
> - consideration is given to improvements in NSW Police policy or procedure to avoid recurrences in the future.
>
> These guidelines are a statement by NSW Police that the community can have full confidence that the facts and circumstances of these incidents will be thoroughly examined and reviewed by NSW Police.' (NSWPF 2007a, p. 1; NSWPF 2012a, p. 6; NSWPF 2016a, p. 6)

To assess how well the NSWPF delivered on these assurances the Commission assessed NSWPF compliance with selected procedural requirements outlined in the 2007 Guidelines for 83 critical incident investigations. The Commission also undertook a comparison of information contained within the 2007 and 2016 Guidelines to assess if there were any changes that may impact on the stated function and purpose of NSWPF critical incident investigations.

15.3.2 WHAT DID THE COMMISSION FIND REGARDING NSWPF COMPLIANCE WITH SELECTED PROCEDURAL REQUIREMENTS OF NSWPF CRITICAL INCIDENT GUIDELINES?

The procedural requirements which the Commission audited were:

- the timely declaration of a critical incident by the region commander and the recording of reasons why/why not such a declaration was made (this ensures that the consequential procedures for critical incident investigations are activated at an early stage)
- the appointment of investigators of a suitable rank from a command other than the command where the incident occurred or where the involved officers were from (to avoid inferior investigations and conflicts of interest likely to affect the impartiality of the investigating officers)
- the taking control of the scene by a duty officer at the earliest opportunity and commencement of a running sheet for handover to the critical incident investigator (to ensure a written record is available of the earliest police actions and continuity is assured)

- the preservation of the incident scene (to avoid destruction of evidence, planting of evidence or tampering)
- the separation of involved officers (to remove the opportunity for collusion or fabrication of evidence)
- the correct handling of exhibits (to prevent the opportunity for loss of evidence or tampering)
- the administration of drug and alcohol testing of involved officers (to remove any doubts about the whether or not the judgement of the involved officers was impaired by drugs or alcohol)
- the undertaking of a thorough and impartial review of the investigation (to ensure that senior officers are also involved and take responsibility for the investigation outcome)
- the consideration of the lawfulness of police actions and consideration of improvements to policies and procedures (to prevent a recurrence of what occurred).

A key finding from the Commission's research was a lack of documentation located on e@gle.i for the 83 critical incident investigations audited by the Commission. This finding had significant implications for the Commission's capacity to adequately assess compliance of the NSWPF with the investigative and procedural requirements set out in the 2007 Guidelines, as well as the NSWPF's implementation of the three-tiered process of supervision.

The Commission acknowledges that where information and records have not been located on e@gle.i, it is not possible to conclude that a procedural requirement did not occur. All that can be concluded is that there is no evidence of the procedural requirement occurring.

Where sufficient documentation was located on e@gle.i that enabled the Commission to make a finding regarding NSWPF compliance or non-compliance with a specific procedural requirement contained in the 2007 Guidelines, a rating has been applied using the following scale:

- high level of compliance
- very low level of compliance
- high level of non-compliance.

The following section highlights some of the Commission's key findings according to these levels of compliance.

High level of compliance with procedural requirements

From its audit, the Commission found a high level of compliance with the following procedural requirements amongst the 83 critical incident investigations reviewed:

- identifying involved officers to a critical incident (100%)
- conducting interviews or obtaining statements from involved officers (93%)
- identifying witnesses and taking of witness statements (97%)
- securing involved officers police issue appointments for later examination (93%)
- undertaking drug testing of involved officers (100%)
- undertaking drug testing within the desired timeframe of 24 hours from the time of the incident (96%)
- appointing an appropriately independent and senior officer as SCII (96%)
- region commander appointing a review officer (100%).

Very low level of compliance with procedural requirements

From its audit, the Commission found a very low level of compliance with the following procedural requirements amongst the 83 critical incident investigations reviewed:

- evidence of handover of duty officer running sheet to SCII (5%)
- evidence mandatory alcohol testing conducted within desired timeframe of two hours (14%)
- evidence of running sheet maintained by review officer (1%).

High level of non-compliance with procedural requirements

From its audit, the Commission found a very high level of non-compliance with the following procedural requirements amongst the 83 critical incident investigations reviewed:

- identifying who the nominated exhibit officer was (84%)
- appointing an appropriately independent and senior officer as review officer (25%).

Whilst it is the Commission's view that NSWPF critical incident guidelines can be improved by adding further clarity regarding certain procedural requirements, the guidelines in and of themselves do not ensure compliance. For example, given the infrequency with which individual NSWPF officers are likely to respond to a critical incident and undertake the role of SCII and review officer, it is unlikely all SCIIs and review officers attending a critical incident scene will be aware of all the procedural requirements, investigative processes and practices required by the guidelines.

15.3.3 PROCESSES AND PROCEDURES THAT ARE WELL-DOCUMENTED WITHIN THE 2016 GUIDELINES

The Commission's comparison of the 2007 and 2016 Guidelines found a number of improvements in the 2016 Guidelines. These improvements include:

- expanded advice to the SCII and review officer concerning the identification and management of conflicts of interest
- attaching the template for the P1103, Conflicts of interest declaration form to the 2016 Guidelines
- the requirement for all members of the CIIT, the SCII and review officer to complete a P1103 Conflicts of interest declaration form
- attaching a detailed review officer report template to the 2016 Guidelines.

15.3.4 PROCESSES AND PROCEDURES THAT NEED CLARIFICATION IN THE 2016 GUIDELINES

In addition to the above improvements, the Commission also identified instances where some practices within the 2016 Guidelines need further clarification, or where guidance is not provided for key procedural requirements that might reasonably be expected to be included.

Outlined below is a list of requirements mentioned in the 2016 Guidelines that the Commission views as requiring additional guidance or explanation within the document:

- according to the 2016 Guidelines it is 'essential that reasons for commencing, continuing or ceasing a critical incident investigation are documented and retained for future reporting purposes' by the region commander (NSWPF 2016a, p. 12). However, no additional guidance is included as to where this information should be recorded and stored
- the 2016 Guidelines state that the region commander is responsible for determining 'whether an incident is a Critical Incident, and if so, making a declaration that a critical incident investigation will commence' (NSWPF 2016a, p. 11). However, no additional guidance is included as to where this information should be recorded and stored
- the 2016 Guidelines state that the SCII must ensure 'an exhibits officer is appointed to assist the forensic investigators and other FSG[307] personnel in the collection, security, continuity and integrity of all exhibits' (NSWPF 2016a, pp. 36-37). However, the guidelines do not specify where the exhibits, or name of the exhibit officer, should be recorded and stored
- the 2016 Guidelines do not provide specific timeframes in which mandatory drug testing should occur. In relation to the requirement to conduct mandatory drug and alcohol testing of officers involved in a critical incident, the 2016 Guidelines state 'in the event that an authorised Drug and Alcohol Testing officer will be delayed in attending, a local, independent authorised officer may complete the required alcohol tests' (NSWPF 2016a, p. 11).

307 Forensic Services Group

However, the guidelines do not provide any explanation as to who a 'local, independent authorised officer' is

- the 2016 Guidelines direct the SCII and the review officer to resolve any conflicts of interest through the use of 'treatment strategies' (NSWPF 2016a, p. 20). However, the guidelines do not define or otherwise describe the possible 'treatment strategies' available to the SCII and review officer in managing conflicts of interest
- the 2016 Guidelines provide a review officer report template, however there is no requirement for review officers to use this template.

The Commission acknowledges that critical incidents can occur in a variety of settings, usually under very difficult circumstances and that it is not always possible, or relevant, to carry out each of the procedural requirements for every critical incident investigation. It may be reasonable not to conduct some procedural requirements under some conditions. However, compliance with the requirements listed above would contribute to the prevention or minimization of the misconduct and other risks identified in this report and involved police officers should be left in no doubt as to how compliance is achieved. When a decision is made by the NSWPF not to undertake a specific procedural requirement, the reason why the requirement was not undertaken should documented and made available to senior NSWPF officers (or any other external review body) involved in the monitoring or reviewing of the critical incident investigation. As mentioned in Chapter 5, the timely declaration of a critical incident by the region commander and the recording of the reasons why such a declaration was made ensures that critical incident protocols are implemented immediately. The Commission located no documentation concerning the reason why a region commander declared an incident to be a critical incident for 52 (63%) of the 83 strikeforces audited. For 30 (36%) of the 83 strikeforces the Commission was not able to locate any information or records as to the time or date a region commander declared an incident to be critical.

Delays in declaring critical incidents can have a significant impact on the integrity and effectiveness of the investigation. Amongst other things, protocols for preserving the incident scene, collecting evidence, separating involved officers and witnesses, conducting mandatory drug and alcohol testing of involved officers may not be activated in a timely way. The risk being that the integrity of the investigation may be compromised, evidence lost, and opportunities for evidence tampering created. As discussed in Chapter 5, for the 52 strikeforces where information was available, half (50%) of these incidents were declared as critical within an hour of the event occurring with the remaining incidents being declared within five hours of the event occurring.

The absence of drug and alcohol testing for officers involved in critical incidents could potentially lead to questions about whether or not the judgement of involved officers involved was impaired at the time the incident took place. This is particularly relevant in circumstances where a death or serious injury has occurred following interaction with police.[308] As discussed in Chapter 11, the Commission found that drug testing was undertaken in all 49 (100%) mandatory testing strikeforces, forty-seven (96%) of these strikeforces complied within the desired timeframe for drug testing of involved officers to be undertaken within 24 hours of the incident. With regard to alcohol testing, the

[308] The Commission views that any death of, or serious injury to, a person(s) arising from contact with NSWPF officer(s) warrants automatic mandatory drug and alcohol testing of the involved officers. This would remove the potential risk whereby an incident may be not classified as a 'police operation' to circumvent the need for the mandatory drug and alcohol testing of involved officers.

Commission was able to identify that alcohol testing was carried out in 43 (88%) of the 49 mandatory testing strikeforces. Six (14%) strikeforces complied within the desired timeframe for alcohol testing to be undertaken within two hours of the incident.

Recommendation 1

It is recommended that NSWPF critical incident guidelines reinforce the responsibility of the region commander to:

a. document the decision-making processes in declaring an incident as 'critical' in the region commander report;

b. document the date and the time when an incident is declared 'critical' in the region commander report;

c. document the time the critical incident investigation team was formed in the region commander report;

d. document the time the critical incident investigation team arrived at the local area command where the critical incident occurred in the region commander report;

e. ensure that documents outlining the decision making-processes in relation to critical incidents are located on e@gle.i

f. ensure that information outlining the decision-making processes in relation to why an incident was not declared to be 'critical' are recorded on the relevant COPS event report.

Recommendation 2

It is recommended that nominated members of the critical incident investigation team attach a record of all exhibits seized to e@gle.i.

Recommendation 3

It is recommended that NSWPF critical incident guidelines:

a. replicate information which appears within the mandatory testing incident section of the NSWPF Drug and Alcohol Policy;

b. include the following information:

- specific timeframes within which mandatory drug and alcohol testing should occur;
- reference to the *Road Transport (Safety and Traffic Management) Act 1999* (NSW);
- directions about where results of mandatory drug and alcohol testing are to be recorded;

- advice as to who is responsible for attaching the results of the mandatory drug and alcohol testing of involved officers to e@gle.i;
- advice as to who an 'authorised officer' is;
- advice as to who a 'local independent authorised officer' is.

Recommendation 4

It is recommended that NSWPF critical incident guidelines clearly outline the possible "treatment strategies" to be used by the senior critical incident investigator and/or review officer once a conflict of interest has been identified.

Given the importance of review officers in monitoring and reviewing the critical incident investigation the Commission proposes that NSWPF critical incident guidelines require that review officers are to use the review officer report template when completing their review.

Recommendation 5

It is recommended that NSWPF critical incident guidelines stipulate that review officers use the review officer template as a basis for completing their review of a critical incident investigation.

15.3.5 PROCESSES AND PROCEDURES NOT INCLUDED IN THE 2016 GUIDELINES

The Commission identified a number of processes and procedures for which no guidance was provided in the 2016 Guidelines. Based on the audit findings, there is room for improvement where the 2016 Guidelines:

- provide no detailed guidance as to how, and where, the actions of the duty officer are to be recorded and communicated to the SCII except to note, 'document all action taken, advice given and create file notes of all relevant conversations' (NSWPF 2016a, p. 32). Additionally, the guidelines no longer require the duty officer to complete a running sheet, or to record the handover of the incident scene to the SCII
- do not provide guidance as to how the duty officer is to record confirmation that involved officers and witnesses have been separated
- do not specify how, and where, actions taken to preserve an incident scene are to be documented, except to direct the incident scene guard to record details of people entering the incident scene in a police notebook
- no longer require the notebook records of involved officers' observations to be obtained following a critical incident

- provide no detailed guidance as to how, and where, key decisions and investigative actions taken by the SCII and CIIT are to be recorded, nor do the guidelines require the SCII to maintain an investigation running sheet
- no longer require the review officer to complete a running sheet. No detailed guidance is provided as to how, and where, key decisions and investigative actions taken by the review officer are to be recorded
- removed the requirement for the duty officer to brief the review officer upon arrival at the incident scene
- do not provide a region commander report template nor detail how, what, or where the region commander is to document his/her monitoring of the critical incident investigation.

The Commission's audit found that for 54 (68%) critical incident investigations no duty officer running sheets were located on e@gle.i, which is contrary to the 2007 Guidelines. The duty officer running sheet is essential for recording key information pertaining to the initial stages of a critical incident. In the absence of a duty officer running sheet, it is difficult for the SCII and review officer to determine which investigative actions which would prevent potential misconduct have been completed by the duty officer, such as separation of involved officers and other witnesses to prevent the risk of possible collusion, the preservation of the crime scene to prevent the risk of contamination of that scene etc.

Recommendation 6

It is recommended that NSWPF critical incident guidelines include:

a. a duty officer running sheet template;

b. a mandatory requirement for the duty officer to maintain a running sheet by using the running sheet template;

c. a requirement that the duty officer record the following information on the duty officer running sheet:
   - name and registration number of the duty officer
   - date and time the critical incident occurred
   - date and time the incident was declared critical by the region commander
   - brief description of events leading up to the critical incident
   - actions taken at the incident scene by the duty officer
   - persons spoken to by the duty officer
   - names of all incident scene guards
   - names and details of all witnesses to the critical incident
   - names of all officers involved in the critical incident
   - if and when involved officers were separated and, if not all involved officers were separated, the reason for deciding not to separate these officers

- if and when involved officers provided immediate and independent notebook records and, if not all involved officers provided immediate and independent notebook records, the reason for this
- how the duty officer ensured that the evidence of witnesses was not cross-contaminated, or any reason for why the duty officer did not take steps to ensure that the evidence of witnesses was not cross-contaminated
- if and when the duty officer recorded a version of events from independent witnesses prior to speaking to involved officers, or any reason the duty officer decided not to record a version of events from independent witnesses prior to speaking to involved officers
- what actions did the duty officer take to preserve evidence
- date and time the duty officer briefed the senior critical incident investigator
- the name of the senior critical incident investigator.

d. a requirement for the duty officer to note the completion of the following actions taken to secure and preserve the incident scene(s) on the duty officer running sheet:

- the presence of both inner and outer perimeters
- the placing of incident guards at the incident scene perimeters
- the maintenance of an incident scene log or logs
- the presence or absence of an original command post and if applicable its preservation for forensic examination
- the establishment of a critical incident investigation team command post independent of any original command post, if applicable;

e. a requirement for the completed duty officer running sheet to be physically handed to the senior critical incident investigator at the incident scene or during the briefing;

f. a requirement for the senior critical incident investigator to:

- acknowledge receipt of the duty officer running sheet at the critical incident scene by signing the last duty officer entry of the running sheet
- ensure that the duty officer running sheet is located on e@gle.i.

NSWPF critical incident guidelines stipulate that the first officer at the scene of a critical incident is required to place incident guards at the scene. Incident scene guards are required to secure the incident scene and preserve the integrity of the incident scene. This role is important in preventing or minimising the risk that the crime scene is contaminated or that evidence is destroyed, planted or tampered with. It is concerning that for 37 (46%) strikeforces the Commission was unable to locate sufficient information or documents that an incident scene guard had been placed at the scene. For 30 strikeforces (38%) there was not enough information to assess if incident guards had secured the scene; for 29 strikeforces (35%) there was no evidence that incident scene logs had been maintained.

Recommendation 7

It is recommended that:

a. NSWPF critical incident guidelines require the senior critical incident investigator to obtain statements from all incident scene guards present at the incident scene and to ensure these statements are located on e@gle.i. These statements should note the duties performed by each incident scene guard to secure the incident scene and outline any interactions with the duty officer, senior critical incident investigator, involved officers, other attending officers and members of the public

b. the NSWPF adopts the incident scene log template used by the State Crime Command, attaches it as an appendix to NSWPF critical incident guidelines and recommends its use at the incident scene by the incident scene guards

c. NSWPF critical incident guidelines require all incident scene logs maintained at the incident scene to be located on e@gle.i.

d. NSWPF critical incident guidelines require all incident scene logs maintained at the incident scene to record the following information:

- the time and identity of persons entering the incident scene
- the incident scene guard responsible for the log and the location of the incident scene
- the time when responsibility for the log is handed over to a relieving incident scene guard and their details.

The SCII running sheet provides a record of decisions made and investigative actions taken by the SCII and the critical incident investigation team. When SCII running sheets are not available, police are at greater risk of the suggestions of a cover-up or of deliberately 'running dead' on the investigation. This can undermine the credibility and integrity of the critical incident investigation. The Commission's audit of 83 strikeforces located 22 (27%) SCII running sheets.

Recommendation 8

It is recommended that NSWPF critical incident guidelines require:

a. the senior critical incident investigator to complete a separate running sheet using the running sheet template and attach it to e@gle.i

b. the senior critical incident investigator running sheet to record the following information:

- date and time the critical incident is declared by the region commander
- identification of the senior critical incident investigator, critical incident investigation team members, the review officer, all involved officers the exhibit officer and independent witnesses

- date and time of arrival of the senior critical incident investigator and critical incident investigation team members at the critical incident scene
- date and time of briefing by the duty officer with the senior critical incident investigator and critical incident investigation team
- outline of briefing from the duty officer regarding actions already taken at the incident scene, especially the security of the incident scene, appropriate notifications and the separation of involved officers
- steps taken to ensure the evidence of witnesses has not been cross-contaminated
- date and time of attendance by specialist police officers such as crash investigation officers and the Forensic Services Group
- date and time when a version of events has been taken from independent witnesses prior to speaking with involved officers
- date and time when notebook records of involved officers have been obtained
- date and time and location of mandatory drug and alcohol testing of involved officers
- a chronological outline of actions taken by the senior critical incident investigator and the critical incident investigation team to obtain evidence (for example: charge records, custody records, police rosters, ICV, CCTV, ballistics evidence, inspection of vehicles in situ etc.)
- advice as to what welfare has been officered/ provided to involved officers
- observations of the incident scene
- any contact with media outlets
- date and time of interviews conducted with involved officers and independent witnesses
- any discussions with the review officer and region commander concerning the critical incident investigation.

The 2007 Guidelines stated that the review officer should maintain a running sheet that documented all action taken and advice given. The Commission's audit of 83 strikeforces located one review officer running sheet on e@gle.i. As with duty officer and SCII running sheets, review officer running sheets provide assurance that the review officer has performed his/her designated role in critical incident investigations. A lack of review officer running sheets considerably inhibits the capacity to assess if the review officer has successfully performed the role of risk manager.

The Commission's review also identified that whereas the 2007 Guidelines stipulated that the duty officer is required to brief the SCII and the review officer on arrival at the incident scene this requirement in relation to the review officer is no longer included in the 2016 Guidelines. The Commission proposes that the duty officer continues to brief the review officer. This will allow the review officer to assess any potential risks that may have occurred prior to his/her arrival.

Recommendation 9

It is recommended that NSWPF critical incident guidelines:

a. stipulate that the review officer must maintain a review officer running sheet documenting all actions taken, advice given, including all files notes of all relevant conversations

b. provide additional guidance to review officers on the type of actions and information to be recorded on the review officer running sheet

c. specify that the review officer must ensure the review officer running sheet is located on e@gle.i.

Recommendation 10

It is recommended that NSWPF critical incident guidelines stipulate that the duty officer brief the review officer on arrival to allow the review officer to obtain a first-hand account of the management of the critical incident scene.

NSWPF critical incident guidelines require the region commander, who carries ultimate accountability for a critical incident investigation, to provide a comprehensive report to the NSWPF Executive after the completion of a critical incident investigation. NSWPF protocols require region commanders to look beyond individual officer conduct and to also examine organisational or systemic issues that may have led to the critical incident. Failure to do so runs the risk that systemic or organisational issues that have contributed to the incident are overlooked or lost and can result in a repeat of similar incidents in the future.

The Commission's audit of 83 critical incident investigations located 27 region commander reports. In the majority of these reports (20) the region commander signed off on either the professional standards manager report or the review officer report. None of the region commander reports highlighted any broader lessons to be learnt from the incident or included any additional comments or observations by the region commander.

Recommendation 11

It is recommended that NSWPF critical incident guidelines include a region commander report template that clearly outlines what information needs to be included in the region commander report, such as:

- background information as to the actions of police that led to the critical incident
- date and time the critical incident occurred
- date and time when the region commander declared the incident as 'critical
- reason why the region commander declared the incident as 'critical'
- in cases where the incident is subsequently de-escalated, reasons for ceasing or de-escalating a critical incident investigation are clearly documented

- date and time the region commander appointed the senior critical incident investigator, the review officer and the critical incident investigation team
- processes the region commander implemented to monitor the progress of a critical incident investigation
- comments in relation to the outcome of the critical incident investigation and whether the region commander accepted the findings outlined in the critical incident investigation report and the review officer report
- comments on any conduct issues identified
- consideration of any broader lessons to be learnt from the incident and any proposed or implemented improvements to systems, policies, practices, processes and training
- confirmation that key documents for each investigation, such as the critical incident investigation report, review officer report, duty officer statement, running sheets/logs etc. are located on e@gle.i
- date that a copy of the critical incident investigation report, review officer report and region commander report was disseminated to the Deputy Commissioner of Police, Field Operations.

15.4 DISCUSSION OF THE NSWPF INVESTIGATIONS MANAGEMENT SYSTEM (E@GLE.I)

The 2007 Guidelines clearly stated that 'all critical incident investigations must be recorded appropriately on e@gle.i' (NSWPF 2007a, p. 30) and that it is the responsibility of the SCII to 'ensure that the investigation is recorded on e@gle.i' (NSWPF 2007a, p. 20). Furthermore the 2007 Guidelines specified that at the conclusion of the investigation, the SCII should ensure that 'all investigative material is cross-referenced to relevant COPS, e@gle.i and, where appropriate, c@ts.i files' (NSWPF 2007a, p. 24).[309]

The 2012 and 2016 Guidelines expand on the responsibilities of the SCII and state that the SCII is to 'ensure when an e@gle.i investigation is set up, the reviewing officer and appropriate region staff have relevant access' (NSWPF 2012a, p. 28; NSWPF 2016a, p. 21).

In summary while all three sets of guidelines state that all critical incident investigations should be recorded on e@gle.i it is not clear from the guidelines whether that means attaching all records created as part of the investigation to e@gle.i or only some records. None of the three sets of guidelines provide any direction as to who is responsible for attaching which particular documents to e@gle.i. The Commission's audit of 83 strikeforces identified critical incident investigations that had thousands of records attached to e@gle.i and critical incident investigations that had only a small number of documents attached to e@gle.i. For example for one strikeforce less than ten documents pertaining to the investigation were located on e@gle.i.

[309] A similar requirement is included in the 2012 and 2016 Guidelines, which state that 'the primary record management system to be used is e@gle.i' (NSWPF 2012a, p. 28; NSWPF 2016a, p. 29).

The Commission's research indicated that of the 125 critical incidents that had occurred in the time period reviewed by the Commission, only 83 were recorded on e@gle.i. That is to say a further 42 critical incident investigations were not recorded or managed on e@gle.i.[310] When the Commission requested advice from the NSWPF why these 42 critical incident investigations were not recorded on e@gle.i the NSWPF advised the Commission that recording documents pertaining to critical incident investigations was not always NSWPF practice and that the investigator decided whether or not the incident was managed on e@gle.i.[311] This is clearly inconsistent with the requirements contained in the guidelines.

When the Commission commenced its audit of the 83 strikeforces that were located on e@gle.i it noticed that certain information or records pertaining to critical incidents investigations could not be located on e@gle.i. In early 2013 the Commission provided the NSWPF with an opportunity to upload relevant information and documents to e@gle.i prior to commencing its audit.[312]

The Commission's audit results, as at March 2016, identified that there continued to be a noticeable lack of documentation located on e@gle.i. More specifically, the Commission's audit identified:

- for 52 of the 83 strikeforces the Commission was unable to locate documents or records concerning the reason why an incident was declared critical
- for 30 of the 83 strikeforces the Commission was unable to locate documents or records as to the time or date the region commander declared an incident to be critical
- for 61 of the 83 strikeforces the Commission was unable to locate documents or records to calculate the time it took between the incident being declared critical and the formation of the CIIT
- for 54 of the 83 strikeforces the Commission was unable to locate duty officer running sheets
- for 25 of the 65 applicable strikeforces the Commission was unable to locate documents or records that included information as to whether or not involved officers had been separated by the duty officer
- for 41 of the 76 applicable strikeforces the Commission was unable to locate any notebook records of any of the involved officers
- for 49 of the 55 strikeforces where witnesses were mentioned in either the CIIR, duty officer statements or other documents, the Commission was unable to locate documents or records that demonstrated that the requirement to record a version of events from independent witnesses prior to speaking to involved officers had been complied with
- for 13 of the 38 strikeforces where vehicles were involved the Commission was unable to locate documents or records that vehicles involved in critical incidents had been secured for later examination

310 The timeframe of the audit sample was 1 January 2009 – 30 June 2012.

311 Advice provided by the NSWPF Professional Standards Command in an email dated 28 May 2012.

312 More detailed information relating to the consultation between the Commission and the NSWPF in relation to providing the NSWPF with an opportunity to update its records on e@gle.i is included in Chapter 2 of this report.

- for 82 of the 83 applicable strikeforces the Commission was unable to locate a review officer running sheet
- for 15 of the 83 strikeforces the Commission was unable to locate a CIIR
- for 27 of the 83 strikeforces the Commission was unable to locate a review officer report
- for 56 of the 83 strikeforces the Commission was unable to locate a region commander report.

The lack of critical incident investigation records located on e@gle.i stymied the Commission's ability to assess compliance with a number of procedural requirements of NSWPF critical incident guidelines for the 83 strikeforces under 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 NSWPF, 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.

The Commission's audit further identified that there was a lack of guidance in NSWPF critical incident guidelines as to whose responsibility it is for attaching records pertaining to a critical incident investigation to e@gle.i. While the guidelines state that it is the responsibility of the SCII to ensure that the investigation is recorded on e@gle.i they do not specifically mention that the SCII is responsible for attaching all documents relating to a critical incident onto e@gle.i.

Recommendation 12

It is recommended that the NSWPF enforces the requirement with officers involved in critical incident investigations that all records pertaining to critical incidents and any subsequent investigations must be located on e@gle.i.

Recommendation 13

a. It is recommended that NSWPF critical incident guidelines specify who is responsible for attaching documents relating to a critical incident and the subsequent investigation to e@gle.i.

b. It is recommended that NSWPF critical incident guidelines specify who is responsible for attaching documents that were created by those officers that first arrived at the scene (such as duty officer, incident scene guard etc., but who are not part of the CIIT) to e@gle.i.

c. It is recommended that the NSWPF conducts regular compliance audits of critical incident investigations to find out if all records pertaining to these investigations are located on e@gle.i.

15.5 DISCUSSION OF THE NSWPF THREE-TIERED PROCESS OF SUPERVISION OF CRITICAL INCIDENT INVESTIGATIONS

One feature of a critical incident investigation that distinguishes it from other NSWPF investigations is a three-tiered process of supervision, comprising of the SCII, the review officer and the region commander.

15.5.1 SENIOR CRITICAL INCIDENT INVESTIGATOR

The SCII is appointed by the region commander and is the officer in charge of the critical incident investigation and of the CIIT. The CIIT is responsible for a number of tasks, outlined in the 2007 Guidelines which have been developed to 'ensure' the probity of the critical incident investigation (NSWPF 2007a, p. 20). According to the 2007 Guidelines, the key responsibilities of the SCII were:

- considering how any conflicts of interest within the team will be identified and managed
- examining the lawfulness of police action
- examining police compliance with relevant guidelines, legislation, internal policy and procedures
- ensuring that appropriate action is taken concerning the prosecution of any person for any identified offence arising from the investigation
- reporting any management issues that need to be addressed concerning any police officer
- preparing an investigation report when the investigation has been concluded; the report should include any problems that have been identified during the investigation
- ensuring that the investigation is recorded on e@gle.i (NSWPF 2007a, pp. 20, 24).[313]

While the above is not a complete list of the responsibilities of the SCII pertaining to the critical incident investigation, the Commission's audit of 83 strikeforces focussed on these procedural requirements because of their relevance to preventing or minimising misconduct and other risks associated with critical incident investigations.

To show that conflicts of interest within a team of police investigators has been properly managed, a SCII must show that consideration of conflicts of interest between critical incident investigation team (CIIT) members has been considered prior to commencing an investigation.

The Commission's audit identified that in only eight out of 83 strikeforces had the SCII documented that they had considered conflicts of interest.

313 These responsibilities remain the same in the 2012 and 2016 Guidelines, except that in the 2016 Guidelines the SCII is required to include the comments and recommendations of a coronial inquest, where applicable, in the CIIR.

Recommendation 14

It is recommended that NSWPF critical incident guidelines stipulate that the identification, management and recording of conflicts of interest in critical incident investigations is a mandatory requirement and must be documented and located on e@gle.i.

The CIIT is also responsible for considering and examining the lawfulness of police action. In investigations where the SCII identifies that legislation has been breached by involved officers the SCII is responsible for 'ensuring that appropriate action is taken concerning the prosecution of any person for any identified offence' (NSWPF 2007a, p. 20; NSWPF 2012a, p. 20; NSWPF 2016a, p. 21). A death or serious injury following an interaction with police, particularly if occurring in circumstances which were physically isolated and where the only other witnesses were police themselves, can give rise to a natural suspicion amongst the family of the deceased or injured party, as well as the broader community, that excessive force may have caused or contributed to the injury or death. A failure by a police agency to recognise this risk and effectively manage it may lead to a perception that the investigation was not conducted rigorously and/or acts of wrongdoing by police officers and failures of the police agency were covered up or minimised by investigating officers.

The Commission's audit identified that in 29 of the 55 applicable strikeforces the CIIR either made no mention of the lawfulness of police action (24) or simply stated that the actions of involved officers were 'lawful' (5) without any further discussion of how such a conclusion was reached.

It was also difficult for the Commission to determine how many CIIRs should have been recorded on e@gle.i. The investigation status of 75 strikeforces was listed as either 'finalised' or 'complete' on e@gle.i. The Commission located 68 CIIRs on e@gle.i. This lack of documentation on decision-making processes pertaining to critical incident investigations was a recurring theme during the Commission's audit of 83 strikeforces and will be discussed in more detail at the end of this chapter.

15.5.2 REVIEW OFFICER

According to the 2007 Guidelines, the review officer performed the function of risk manager and had to be independent of the critical incident investigation. To ensure the independence of the review officer the 2007 Guidelines stipulated that the review officer should come from a command different to that of members of the CIIT, different to that where the incident occurred and different to that where the involved officers were from. In addition the 2007 Guidelines specified that the review officer should, 'as a minimum', be of the same rank as the SCII (NSWPF 2007a, p. 26). According to the 2007 Guidelines the review officer was required to ensure that work submitted by the CIIT had met the expected standard of quality, timeliness and probity. In addition to this, the review officer was required to identify any deficiencies of a systemic nature that needed to be addressed by the NSWPF (NSWPF 2007a, p. 26). The purpose of this latter requirement is that the NSWPF looks beyond the actions of individual officers and tries to identify if there are any broader systemic weaknesses in internal NSWPF processes and systems that can be strengthened to avoid similar incidents recurring in the future. The 2007 Guidelines further required the review officer to maintain a review officer running sheet

'documenting all action taken, advice given and create file notes of all relevant conversations' (NSWPF 2007a, p. 27).

The Commission located 56 review officer reports on e@gle.i. Like the findings pertaining to CIIRs the Commission found it difficult to determine how many review officer reports should have been located on e@gle.i. The Commission's audit of 56 review officer reports identified that the information contained in review officer reports varied greatly, ranging from very comprehensive to scant. More than half of the review officer reports did not comment on the probity of the critical incident investigation (59%) nor comment on the timeliness of the investigation (52%). A further 42% of review officer reports did not provide an overview of the investigation.

As stated previously the Commission located only one review officer running sheet on e@gle.i out of a possible 83. Given the stated importance of transparency, accountability and senior level supervision in critical incident investigations, the lack of information contained in review officer reports, where available, and the inability to access review officer running sheets must be addressed.

The Commission's audit of 83 strikeforces identified a lack of documentation in relation to key actions taken and decisions made by police first arriving at the incident scene and subsequently by members of the CIIT. The Commission anticipated, at a minimum, that one of the responsibilities of the review officer would be to ensure that all applicable critical incident documents are located on e@gle.i. Lack of records attached to the primary investigations management system for critical incident constitutes, in the Commission's opinion, an area of deficiency that should have been picked up and addressed in review officer reports. However, this was not the case. Furthermore, the Commission's audit located a mere 56 review officer reports out of 83 strikeforces and only one review officer running sheet. It is unsatisfactory that review officers, who were performing the role of 'risk manager' in critical incident investigations were not creating and/or uploading information to e@gle.i and neither were they providing commentary on, or addressing, the lack of documentation provided by the CIIT.

Recommendation 15

It is recommended that review officers be required to:

a. examine the quality of the investigation in terms of whether the investigation has thoroughly examined:
   - the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation and internal policy and procedures to identify and deal with any wrongful conduct on the part of any officer
   - the circumstances of the incident and considered improvements to NSWPF policy or procedures to avoid recurrences in the future

b. examine the quality and content of the critical incident investigation report in terms of how well it provides an account of the aspects of its investigation listed under point a) above

c. ensure that review officer reports are located on e@gle.i.

15.5.3 REGION COMMANDER

As outlined in Chapter 14 of this report, imposing accountability at the region commander level is aimed at providing assurance to the community and members of the NSWPF that critical incidents are 'handled professionally, with integrity and that the decisions made and processes used are appropriate and reasonable' (NSWPF 2007a, p. 1; NSWPF 2012a, p. 1; NSWPF 2016a, p. 6). NSWPF critical incident guidelines stipulate that the region commander is required to 'implement processes to monitor the progress of investigations under the critical incident guidelines (NSWPF 2007a, p. 9; NSWPF 2012a, p. 9; NSWPF 2016a, p. 13), and therefore has ultimate responsibility for the way a critical incident investigation is conducted.

The Commission's audit of 83 strikeforces established that as at March 2016, 75 of the 83 strikeforces bore the investigation status on e@gle.i of either 'finalised' or 'complete'. Based on this information, it is the Commission's view that it would be reasonable to expect at least 75 region commander reports to be on e@gle.i. However, the Commission's audit located only 27 region commander reports on e@gle.i. For 15 of the 27 region commander reports that were located on e@gle.i the region commander signed off on the professional standards manager report. For five of the region commander reports the region commander signed off on the review officer report. Neither the 2007 Guidelines nor the 2016 Guidelines prescribe any specific role for the professional standards manager in preparing the region commander report.

> Recommendation 16
>
> It is recommended that if the region professional standards manager is intended to have a role in the preparation of the region commander report, the nature and extent of this role should be clearly specified in NSWPF critical incident guidelines.

The region commander reports located by the Commission did not contain any specific opinions, comments or discussions regarding how a critical incident investigation had been monitored. Recommendation 11 outlines the type of information that should be included in a region commander report.

15.6 CONCLUSION

The NSWPF expresses its commitment in its corporate guidelines to investigating all critical incidents in an '*effective, accountable and transparent manner'*. The Commission's audit, which sought to examine the effectiveness of the guidelines, management system and the three-tiered process of supervision in managing the investigations revealed that, while some of the requirements contained in the guidelines had a high rate of compliance, in many other respects the practices of the investigating police did not match the corporate rhetoric. Many of the basic requirements in the guidelines, which are also fundamental to managing or minimising risk in the investigation of critical incidents, did not enjoy a high rate of compliance.

The Commission's audit of the 83 critical incident investigations indicated that some investigating officers appeared to view the corporate guidelines as a form of non-mandatory guidance rather than procedures that needed to be followed. This was evident particularly in the lack of records located on the primary investigations management system, e@gle.i.

In particular, the Commission could not be comfortably satisfied in most cases that review officers and region commanders had effectively monitored and commented on the quality, transparency and probity of critical incident investigations when key documents outlining actions taken by officers involved in these investigations were not located on the primary management system. The number, and at times, quality, of review officer reports and region commander reports was not sufficient to provide assurance that review officers and region commanders had met the NSWPF corporate expectations outlined in its guidelines.

The Commission acknowledges that its audit was confined to a sample of investigations of critical incidents occurring between 1 January 2009 and 30 June 2012 and that there may have been improvements in compliance with the guidelines in later NSWPF investigations. It is hoped that the findings and recommendations published in this report provide assistance as to those areas which require attention.

In late 2016 the *Law Enforcement Conduct Commission Act 2016* was passed by the NSW Parliament and is awaiting proclamation to commence in full. Part 8 of that Act provides that NSWPF critical incident investigations can be subject to real time monitoring or oversight by the Law Enforcement Conduct Commission. Such oversight will enable more timely scrutiny of individual critical incident investigations and will hopefully provide a new layer of assurance to the community that the investigations are being conducted in a manner that is '*effective, accountable and transparent'*.

GLOSSARY

2007 Guidelines	*NSW Police Force Guidelines for the management and investigation of critical incidents,* February 2007.
2012 Guidelines	*NSW Police Force Critical Incident Guidelines,* August 2012.
2016 Guidelines	*NSW Police Force Critical Incident Guidelines*, January 2016.
Appointment	See 'Police appointments' below.
Authorised person	Division four of both the Police Regulation 2000 and the Police Regulation 2008 provides for the appointment of authorised persons. Clause 60 (1) of the Police Regulation 2000 and Clause 89 (1) of the Police Regulation 2008 each provide that 'The Commissioner may, by instrument in writing, appoint any person to be an authorised person for section 211A or 211AA of the Act and this Part. For those purposes, the Commissioner may appoint a police officer or any other person.
Computer Aided Dispatch (CAD)	Computer Aided Dispatch (CAD) is a NSW Police Force resource deployment and incident management system. CAD manages and supports deployment of police resources in response to incidents generated by the community and other NSW response agencies (NSWPF intranet, accessed 18/2/2016).
Command post	A command post is a 'single agency term which refers to the location at or near the site from which a Commander from that particular agency controls, directs and coordinates the activities and resources of his/her own agency only' (NSWPF 2012, p. 12).
Commissioned officer	A commissioned officer means a police officer of or above the rank of inspector.
Commission	Police Integrity Commission
COPS reports	The NSW Police Force stores operational and intelligence information on an electronic data system called Computerised Operational Policing System ('COPS'). COPS is the main repository for any information on persons, organisations, locations, objects, events and vehicles that come to the attention of NSW police officers during the performance of their duties. Officers of all ranks and positions use COPS to record and enquire on the details of any entities as part of their policing duties.
Coroner's inquest	An inquest is 'an inquiry by a public official into the circumstances of a particular death. Coroners are concerned not only with how the deceased died but also with why' (NSW Office of the State Coroner 2014, p. 7).

Corruption	See 'Police misconduct' below.
Crash Investigation Unit	A unit in the NSW Police Force that has the primary responsibility to investigate serious motor vehicle collisions.
Critical incident	A critical incident is an incident which by its nature or circumstances requires an independent investigation and review (NSWPF 2007a, p. 4).
Critical incident investigation report (CIIR)	A critical incident investigation report (CIIR) is an 'internal administrative document which is used to inform the NSW Police Force Executive of the circumstances of the incident and the outcome of the investigation' (Letter from the Assistant Commissioner NSWPF Professional Standards Command dated 21/4/16).
Critical incident investigation team (CIIT)	Critical incidents are investigated by a critical incident investigation team (CIIT). The CIIT is responsible for conducting 'a full investigation of the incident including relevant events and activities leading to the incident' (NSWPF 2007a, pp. 20, 29).
Duty Operations Inspector	The Duty Operations Inspector (DOI) facilitates the effective running of the Radio Operations Centre providing operational advice, major incident management and coordination for the delivery of police communications services. The DOI is accountable for the effective organisation of activities in the coordination of responses to critical occurrences (including emergency situations, terrorism and public order) requiring communication assistance. The DOI is a state wide resource, and provides a 24 hour seven day a week response to high level general enquiries. The DOI reports to the Commander, Sydney Radio Operations. (Downloaded from the NSWPF Intranet website: http://intranet.police.nsw.gov.au/ on 24/1/2017)
e@gle.i	E@gle.i is a NSWPF intranet based investigations management system.
Employee Assistance Program (EAP)	The NSW Police Force provides personal counselling services for all staff and their immediate families via an external counselling organisation. EAP employs registered psychologists who are located throughout the State and provides emergency help for all employees. Crisis telephone counselling can be accessed 24 hours a day, 7 days a week.
Exhibit officer	An exhibit officer is 'Any police officer appointed to collect, record and manage the gathered exhibits'. An investigator attached to the investigation usually performs the role of the exhibit officer (Letter from the NSWPF Assistant Commissioner Professional Standards Command dated 29/4/16).
Forensic Services Group (FSG)	A command of the NSW Police Force that provides specialist forensic services to assist investigations, including the collection and examination of evidence and the identification of

	individuals through the gathering of biometric data such as fingerprints and DNA.
Imminent death	An injury that is 'likely to result in the death of a person, and that advice has been provided by a qualified medical practitioner to that effect' (2016 Guidelines, p.10).
Independent witness	Any person other than an involved officer who had any knowledge of the critical incident.
In car video (ICV)	In-car video (ICV). In 2004 the NSW government introduced the *Law Enforcement (Powers and Responsibilities) Amendment (in-car Video Systems) Bill 2004* (Part 8A) which allows police to record motorists' conversations without their consent.
Inquest	See 'Coroner's inquest' above.
Local area command	One of the 76 subdivisions of the NSW Police Force. The NSW Police Force is subdivided into 76 local area commands on the basis of their geographical location. Local area commands include both metropolitan and rural commands.
Mandatory testing incident	A mandatory testing incident is one where the death or serious injury of a person occurs under specific circumstances. These incidents are defined within Section 211A (7) of the *Police Act 1990 NSW* as: An incident where a person is killed or seriously injured: (a) as a result of the discharge of a firearm by a police officer, or (b) as a result of the application of physical force by a police officer, or (c) while detained by a police officer, or while in police custody, or (d) in circumstances involving a police aircraft, motor vehicle or vessel.
Misconduct	See 'Police misconduct'.
Operations Support Group (OSG)	Operations Support Group (OSG) is a specialist group within the NSW Police Force that provides operational support on a 24 hour basis to all police to resolve public order incidents.
P79A Form	A P79A form is used by the NSW Police Force to report a death to the coroner. The P79A report 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 may inform the coroner whether a medical practitioner had been treating the deceased person in recent times and whether it is likely or not that a death certificate will be issued by the doctor. It will also outline, for the benefit of the coroner, the preliminary views of the police as to whether the circumstances of the death are suspicious. (Judicial Commission of New South Wales, 2010).

Police appointments	Police appointments include handcuffs, batons, ballistic vests, OC spray and tasers.
Police Association of NSW (PANSW)	The Police Association of New South Wales (PANSW) is an organisation that 'represents the professional and industrial interests' of sworn police officers in NSW' (PANSW website, accessed 6/7/2016).
Police misconduct	The term 'police misconduct', as it is used in the *Police Integrity Commission Act 1996*, includes but is not restricted to police corruption. Section 5 (2) of the Act provides the following examples of police misconduct: Police misconduct can involve (but is not limited to) any of the following: (e) police corruption (f) the commission of a criminal offence by a police officer (b1) misconduct in respect of which the Commissioner of Police may take action under Part 9 of the *Police Act 1990* (g) corrupt conduct within the meaning of the *Independent Commission Against Corruption Act 1988* involving a police officer (h) any other matters about which a complaint can be made under the *Police Act 1990*.
Professional Standards Command (PSC)	The Professional Standards Command (PSC) is the NSW Police Force command responsible for: investigating police misconduct; assisting NSW Police Force commands to meet their responsibility to manage complaints and employee management issues; and developing and promoting professional standards products and services.
Region commander	'The Region Commander has ultimate responsibility for declaring an incident as critical … [and] is accountable for the overall management and investigation of all critical incidents that have occurred within the geographical boundaries of their region' (2007 Guidelines, p. 7).
Region commander report	The region commander '… should highlight broader lessons to be learned from the incident and any proposed improvements to systems, policies, processes, practices and training' (2007 Guidelines, p. 10).
Review officer	'The review officer's role is to ensure that a high quality comprehensive investigation is conducted and to ensure that the investigation process has integrity and can withstand independent scrutiny' (2007 Guidelines, p. 8).
Review officer report	'The report should provide an overview of the investigation including comments on the quality, timeliness and probity of the investigation conducted by the CIIT [critical incident

	investigation team]. It should identify and report on any deficiencies of a systemic nature that must be addressed by NSW Police' (2007 Guidelines, p. 26). The review officer report is to be submitted to the region commander (2007 Guidelines, p. 26).
Risk	The chance of something happening that will have an impact on objectives. A risk is often specified in terms of an event or circumstance and the consequences that may flow from it. Risk is measured in terms of a combination of the consequences of an event and their likelihood. Risk may have a positive or negative impact (Standards Australia & Standards New Zealand 2004a, p. 4). In consideration of fraud and corruption risk, this will generally by a negative impact (Standards Australia 2008, p. 16). Risk is a function of the threat of an activity occurring and the harmful consequences of that activity. Risk is commonly given a probability rating that is expressed in qualitative terms from low to very high (Crime and Misconduct Commission 2007, p. 29).
Senior critical incident investigator	The senior critical incident investigator leads a team in the investigation of all critical incidents. 'The primary role of the senior critical incident investigator is to ensure that critical incidents are rigorously and thoroughly investigated' (2007 Guidelines, p. 20).
Senior critical incident investigator statement	A senior critical incident investigator statement informs the court both in coronial matters and matters that result in criminal charges. A statement by the senior critical incident investigator does not replace a critical incident investigation report (Letter from the Assistant Commissioner NSWPF Professional Standards Command dated 21/4/16).
Serious injury	According to the 2007 Guidelines (p. 5) serious injuries included life threatening injuries; an injury that would normally require emergency admission to hospital and significant medical treatment; an injury likely to result in permanent impairment or long term rehabilitation; or an injury that would constitute grievous bodily harm.
Situation Report (SITREP)	Situation Report (SITREP), is an internal NSW Police Force document that provides an overview of an event and any proposed further action by the NSW Police Force.
Strikeforce	Refers to the NSW Police Force investigation of an individual critical incident.

REFERENCES

Barnes, M. A. (2015) Submission of the State Coroner to the Review of Police Oversight, NSW State Coroner, Sydney NSW, July 2015. Downloaded from: http://www.justice.nsw.gov.au/justicepolicy/Documents/review-police-oversight/State-Coroner.pdf on 24 February 2016.

Braidwood, T.R. (2010) *Why? The Robert Dziekanski Tragedy, Braidwood Commission on the Death of Robert Dziekanski*, Vancouver, British Columbia, May 2010. Downloaded from:

http://bccla.org/wp-content/uploads/2012/03/2009-BCCLA-Argument-Braidwood-Final-Report.pdf.

Clements, C. (2006) Finding of Inquest - Inquest into the death of Mulrunji, Queensland Courts, Office of the State Coroner, 27 September 2006. Downloaded from: http://www.courts.qld.gov.au/__data/assets/pdf_file/0008/86642/cif-doomadgee-mulrunji-20060927.pdf.

Coate, J. (2011) *Finding - Inquest into the Death of Tyler Cassidy*, Coroners Court of Victoria, delivered on 23 November 2011. Downloaded from: http://www.coronerscourt.vic.gov.au/resources/bafb5271-929b-4254-aea9-67191ca77162/tylercassidypart3_554208.pdf.

Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission (2012) *Report on the 13th General Meeting with the Police Integrity Commission*, Parliament of NSW, Sydney NSW, December 2012.

Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission (2014) *Report 8/55: 2014 General Meetings*, Parliament of NSW, Sydney NSW, August 2014.

Coroner's Court (2015) *Inquest into the death of Skye Sassine*. Coroner's Court, Glebe NSW, 15 May 2015. Downloaded from: http://www.coroners.justice.nsw.gov.au/Documents/SASSINE,%20Skye%20-%20Redacted%20Findings.pdf on 12 July 2016.

Commissioner for Human Rights (2009) *Opinion of the Commissioner for Human Rights concerning Independent and Effective Determination of Complaints against the Police*, Council for Europe, Commissioner for Human Rights, France, March 2009. Downloaded from: https://wcd.coe.int/ViewDoc.jsp?p=&id=1417857&direct=true.

Davies, W.H. (2009) *Alone and Cold: The Davies Commission Inquiry into the Death of Frank Paul - Interim Report*, Vancouver, BC, February 2009. Downloaded from: http://www.bccla.org/wp-content/uploads/2012/03/2009-BCCLA-Report-Davies-Inquiry-Alone-Cold.pdf.

Eagleman, D. (2015) *The brain: The story of you*. Great Britain: Canongate Books Ltd, pp. 22-26.

Gorta, A. (2011) *Project Manta: Report 2*, Police Integrity Commission, Sydney NSW, April 2011.

Grant, T. (2015) *Media Release: New Law Enforcement Watchdog for NSW*, Minister for Justice and Police, NSW Government, Sydney NSW, November 2016. Downloaded from: http://www.justice.nsw.gov.au/Pages/media-news/media-releases/2015/New-law-enforcement-watchdog-for-NSW.aspx on 18 October 2016.

Hand, D.W. (1998) *Inquest into the Death of Roni Levi*, State Coroner's Court of New South Wales, delivered on 11 March 1998. Downloaded from: http://sharepoint.sharepointapp.picinternal.com.au/25/Forms/PIC%20Document%20Set/docsethomepage.aspx?ID=3142&List=cce9aaaf-770b-4ea1-9550-8901ae7e0913&RootFolder=%2F25%2F25258&DocumentIDFilter=25258%2f38-1.

Independent Police Complaints Commission (2007a) *Stockwell One: Investigation into the shooting of Jean Charles de Menezes, at Stockwell underground station on 22 July 2005*, Independent Police Complaints Commission, London, November 2007.

Independent Police Complaints Commission (2007b) *Stockwell Two: An investigation into complaints about the Metropolitan Police Service's handling of public statements following the shooting of Jean Charles de Menezes on 22 July 2005*, Independent Police Complaints Commission, London, July 2007.

International Committee of the Red Cross (2013) *Guidelines for Investigating Deaths in Custody*, International Committee of the Red Cross, Geneva, Switzerland, October 2013.

Jerram, M. (2012) Inquest into the death of Roberto Laudisio-Curti. State Coroner's Court of New South Wales, Sydney, NSW, November 2012.

Johnston, E. (1991) *Royal Commission into Aboriginal Deaths in Custody, National Report*, April 1991. Downloaded from:

http://www.austlii.edu.au/au/other/IndigLRes/rciadic/#national.

Judicial Commission of New South Wales (2010) Coronial Matters. In *Local Court Bench Book*. Judicial Commission of New South Wales, Sydney NSW. Downloaded from: https://www.judcom.nsw.gov.au/local/ on 15 March 2016.

Loftus, E. F. (1997) Creating false memories. *Scientific American, 277(3),* 70-75. Downloaded from: https://faculty.washington.edu/eloftus/Articles/sciam.htm on 4 May 2016.

Mitchell, S. (2011) Inquest into the death of Adam Quddus Salter, State Coroner's Court of New South Wales, Sydney, NSW October 2011.

McClelland, R. (2013) *Oversight of police critical incidents. Report to the Hon Barry O'Farrell Premier of New South Wales*, 29 November 2013. Downloaded from: https://www.nsw.gov.au/sites/default/files/oversight-of-police-critical-incidents.pdf on 27 February 2015.

NSW Government (2014) Unsolicited Proposals, Guide for Submission and Assessment, February 2014. Downloaded from https://www.nsw.gov.au/sites/default/files/miscellaneous/Updated-Unsolicited-Proposals-Guide-February-2014.pdf on 30 November 2016.

NSW Office of the State Coroner (2011) *Report by the NSW State Coroner into deaths in custody/ police operations 2010*. NSW Office of the State Coroner, March 2011. Downloaded from: http://www.coroners.justice.nsw.gov.au/Documents/dicreport2010part1.pdf on 4 May 2016.

NSW Office of the State Coroner (2012) *Report by the NSW State Coroner into deaths in custody/police operations for the year 2011*. NSW Attorney General's Department, NSW Office of the State Coroner, Sydney NSW, March 2011, pp. 128-155. Downloaded from:

http://www.coroners.justice.nsw.gov.au/Documents/dic%20report%202011%20-%20with%20updated%20graphs.pdf on 16 March 2016.

NSW Office of the State Coroner (2013) *Report by the NSW State Coroner into deaths in custody/police operations for the year 2012*. NSW Department of Attorney General and Justice, NSW Office of the State Coroner, Sydney NSW, March 2013. Downloaded from: http://www.coroners.justice.nsw.gov.au/Documents/dic%20dipo%202012%20report.pdf on 12 July 2016.

NSW Office of the State Coroner (2014) *Report by the NSW State Coroner into deaths in custody/police operations for the year 2013*. NSW Department of Attorney General and Justice, NSW Office of the State Coroner, Sydney NSW, March 2014. Downloaded from: http://www.coroners.justice.nsw.gov.au/Documents/2014%20Death%20in%20Custody%20and%20Police%20Operation%20Report%20Final%20Printing.pdf on 26 May 2016.

NSW Office of the State Coroner (2015) *Report by the NSW State Coroner into deaths in custody/police operations for the year 2014*. NSW Department of Attorney General and Justice, NSW Office of the State Coroner, May 2015. Downloaded from: http://www.coroners.justice.nsw.gov.au/Documents/2014%20Death%20in%20Custody%20and%20Police%20Operation%20Report%20Final%20Printing.pdf on 25 May 2016.

NSW Police Force (2007a) *Guidelines for the management and investigation of critical incidents*. NSW Police Force, Professional Standards Command, Sydney NSW, February 2007.

NSW Police Force (2007b) *Appendix – Critical incident guidelines*. NSW Police Force, Professional Standards Command, Sydney NSW, February 2007.

NSW Police Force (2007c) *Drug and Alcohol Policy.* NSW Police Force, Safety Command, July 2007. (Downloaded from the NSW Police Force Intranet on 14 June 2016).

NSW Police Force (2007d) *Guidelines for the Investigation of Major Crime.* NSW Police Force, State Crime Command, Sydney NSW, March 2007.

NSW Police Force (2009) *e@gle.i: The Managers Guide.* NSW Police Force, Sydney NSW, May 2009.

NSW Police Force (2012a) *Critical Incident Guidelines*. NSW Police Force, Professional Standards Command, Sydney NSW, August 2012. (Downloaded from the NSW Police Force Intranet on 5 September 2012).

NSW Police Force (2012b) *NSW Police Force Critical Incident Database: Business Rules & User Guide*. NSW Police Force, Professional Standards Command, Sydney NSW, August 2012. (Downloaded from the NSW Police Force Intranet on 23 January 2013).

NSW Police Force (2012c) *Standard Operating Procedures for Responding to Coronial Directions in Critical Incident Investigations*. NSW Police Force, Sydney NSW, September 2012. (Downloaded from the NSW Police Force Intranet on 7 March 2016).

NSW Police Force (2014) *The Management of People affected by Methylamphetamine and other Stimulant Drugs: NSW Police Force Guidelines.* NSW Police Force, Sydney NSW, February 2014. (Downloaded from the NSW Police Force Intranet on 26 July 2016).

NSW Police Force (2014) Operations Support Group (OSG), Management & Operational Guidelines, March 2014. (Downloaded from the NSW Police Force Intranet on).

NSW Police Force (2015) *NSW Police Force Handbook.* NSW Police Force, Sydney NSW, October 2015. (Downloaded from the NSW Police Force Intranet on 24 June 2016).

NSW Police Force (2016a) *NSW Police Force Critical Incident Guidelines*. NSW Police Force, Professional Standards Command, Sydney NSW, January 2016. (Downloaded from the NSW Police Force Intranet on 27 January 2016).

NSW Police Force (2016b) *NSW Police Force Critical Incident Guidelines approved for external publication*. NSW Police Force, Professional Standards Command, Sydney NSW, July 2016. (Downloaded from the NSW Police Force Intranet on 30 October 2016).

NSW Police Service (1999) *FSG Investigator's Guide to Physical Evidence (Scene Responsibilities)*. NSW Police Service, Forensic Services Group, Sydney NSW, March 1999. (Downloaded from the NSW Police Force Intranet on 23 June 2016).

O'Dea, D.J. (1991) *Royal Commission into Aboriginal Deaths in Custody: Regional Report of Inquiry into Individual Deaths in Custody in Western Australia, Volume 2*, Council for Aboriginal Reconciliation, March 1991. Downloaded from: http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/wa_volume2/.

Office of Police Integrity (2011) *Review of the investigative process following a death associated with police contact*, Office of Police Integrity, Melbourne Victoria, June 2011.

Ombudsman New South Wales (2013) *Ombudsman monitoring of the police investigation into the death of Roberto Laudisio-Curti: A Special Report to Parliament under s.161 of the Police Act 1990*, Ombudsman of New South Wales, Sydney NSW, February 2013.

Ombudsman New South Wales (2015) *Ombudsman submission to the Review of Police Oversight in New South Wales*. Ombudsman New South Wales, Sydney NSW, June 2015. (Downloaded from https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0013/25060/Ombudsman-submission-to-Review-of-Police-Oversight-in-NSW-June-2015.pdf on 17 February 2016).

Parliament of New South Wales, *Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission, Report 8/55 August 2014, 2014 General Meetings*, Sydney, 2014.

Police Association of NSW (2016) *About Us*, Police Association of NSW, Sydney NSW. Downloaded from: https://pansw.org.au/about on 6 July 2016.

Police Integrity Commission Act 1996 (NSW).

Police Integrity Commission (2001) *Operation Saigon*. Police Integrity Commission, Sydney NSW, June 2001.

Police Integrity Commission (2005a) *Operation Abelia*. Police Integrity Commission, Sydney NSW, September 2005.

Police Integrity Commission (2005b) *Operation Whistler*. Police Integrity Commission, Sydney NSW, December 2005.

Police Integrity Commission (2013) *Operation Calyx*. Police Integrity Commission, Sydney NSW, June 2013.

Queensland Courts (2014) 'Chapter 7: Investigations' in *State Coroner's Guidelines 2013*, Queensland Courts, September 2014, (Downloaded from: http://www.courts.qld.gov.au/__data/assets/pdf_file/0017/206126/osc-state-coroners-guidelines-chapter-7.pdf).

Police Integrity Commission (2015) *Annual Report 2014-2015*, Police Integrity Commission, Sydney NSW, October 2015.

State Coroner's Court of New South Wales (2015) *Inquest into the death of William Crews*. NSW State Coroner's Court, Sydney NSW, 21 September 2015. Downloaded from: http://www.coroners.justice.nsw.gov.au/Documents/William%20Crews%20Findings%20for%20upload.pdf on 16 March 2016.

Tink, A. (2015) *Review of Police Oversight; A report to the New South Wales Government on options for a single civilian oversight model for police.* NSW Department of Justice, Sydney NSW, 31 August 2015. Downloaded from: http://www.justice.nsw.gov.au/justicepolicy/Documents/review-police-oversight/review-police-oversight-final-report.pdf on 3 February 2016.

Wootten, J.H. (1991) *Royal Commission into Aboriginal Deaths in Custody Regional Report of Inquiry in New South Wales, Victoria and Tasmania*, March 1991. Downloaded from:

http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/nsw-vic-tas/.

Wootten, H. (2011) 'The Royal Commission into Aboriginal Deaths in Custody and the Role of the Coroner', paper presented at the *Asia Pacific Coroners Society Conference*, Noosa, Queensland, 7-10 November 2011. Downloaded from: http://www.courts.qld.gov.au/__data/assets/pdf_file/0009/163764/osc-asia-pacific-conference-01-wootton-h.pdf.

Wyvill, L.F. (1991) *Royal Commission into Aboriginal Deaths in Custody, Regional Report of Inquiry in Queensland*, March 1991. Downloaded from: http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/qld/.