Review of the investigation of deaths associated with police contact

Issues paper
Foreword

This paper identifies issues raised during the Office of Police Integrity’s (OPI) review of the investigation of deaths associated with police contact. It also provides an overview of the review process, including OPI's progress to date. A final report is expected to be tabled in the Victorian Parliament in 2011.

When a citizen dies following action or inaction by the State, it is imperative that such action be subject to rigorous scrutiny and public accountability. This is to ensure that the duties and responsibilities of the State have been properly discharged, and that any issues related to an incident resulting in death are addressed. Where the action or inaction has been found to be unjustified, those responsible must be held to account.

Investigations of deaths associated with police contact require the highest levels of scrutiny, accountability and transparency. They must also have regard to the obligations imposed by the Victorian Charter of Human Rights and Responsibilities Act 2006.

OPI's review of Victoria Police policy and processes for investigating police-related deaths is one of the ways OPI is working to ensure that the Victorian community can have confidence in the way police discharge their responsibilities on behalf of us all.

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In the exercise of their duties, police are provided with a range of powers not afforded to other members of the community. These include the authority to:

- use force including weapons (firearms, batons, OC spray) and compliance or restraint holds;
- use discretion in relation to traffic management controls such as speed limits, traffic lights and road signage when operational needs require it;
- deprive citizens of their liberty by physically restraining and detaining them; and
- seize and confiscate personal property.

In some cases, the action (or inaction) of police may lead to the death of an individual. Although only a very small number of police contacts will result in death, it is of particular concern if the authority granted by the State results in the death of a citizen.

When a member of the public dies following or during an interaction with police, questions are naturally asked about the conduct and behaviour of those involved. More often than not, police-related deaths are subject to intense scrutiny by the police service, the State Coroner, media and the wider community.

The authority of police to use force and exercise the powers granted by the State does not mean a death associated with police contact is necessarily a consequence of inappropriate or unlawful conduct by the police involved. Nor does it exclude the possibility. In each case, the incident must be investigated.

Ordinarily, when any person dies as a result of the action or inaction of another person, an investigation into the death is undertaken. The first objective of this investigation is to determine how a person died. Once this has been determined, the investigation will consider whether a crime has been committed and whether any charges against a person or persons should be laid.

The same purpose and process applies to investigations of deaths associated with police contact.1 Investigators will seek to determine the circumstances of the death, and what, if any, action should follow. For example, once investigators have established how a person died, they will examine if the conduct of police involved was lawful, justified and in accordance with organisational policy. This process will determine if any disciplinary

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1 This paper uses the terms ‘deaths associated with police contact’ and ‘police-related deaths’ interchangeably.
or criminal action should be taken against the officer or officers involved or, conversely, whether there should be an acknowledgment of ‘good policing’. In addition, investigations of deaths associated with police contact will consider what can be learned from these incidents in terms of prevention, training or improvements to organisational policy and procedures.

Despite the common investigative process applied to police-related deaths and other deaths, there are some important differences between the two. First, in police-related deaths, there is generally no ‘mystery’ surrounding how the death occurred and who was involved. Death may follow a police shooting, a high-speed police pursuit or detention in a police vehicle or police cells. The police officers involved in the incident are known, have reported the matter, and are at the scene and can provide an account of what occurred. Secondly, police-related deaths will nearly always occur in the workplace of police – in other words, in the course of police carrying out their duties. Thirdly, in Victoria and other Australian jurisdictions, the police officers involved will be investigated by the organisation that employs them, their respective oversight agency, and the State Coroner.

Within this context, OPI’s review is examining the most appropriate framework for investigating deaths associated with police contact in Victoria. This paper identifies many of the issues raised during the review.
Introduction

In Victoria – like other Australian States and Territories – Victoria Police is responsible for conducting investigations of deaths associated with police contact on behalf of the State Coroner. This means Victoria Police is responsible for managing the entire investigation, including securing the incident scene, interviewing all police, other witnesses and third parties involved, collecting forensic and specialist evidence, and preparing the written brief of evidence for the State Coroner’s consideration. Police consult with the State Coroner, or the State Coroner’s representatives, as required during the investigation.

Following the fatal police shooting of 15 year old Tyler Cassidy in December 2008, concerns were raised by his family and community legal groups about the involvement of Victoria Police in the coronial investigation. In particular, it was argued that the conduct of the investigation by Victoria Police – ‘police investigating police’ – involves a conflict of interest and breaches the right to life obligations of the State imposed by the Victorian Charter of Human Rights and Responsibilities Act 2006 (the Charter).

While the concerns expressed following the death of Tyler Cassidy are not unique, the incident did reignite debate about the involvement of police in the investigation of deaths associated with police contact.2

‘Police investigating police’ is a complex issue and continues to generate public interest especially when the death has resulted from the use of lethal force, a police pursuit or detention in police custody. There has been much debate in Australia and overseas about who should be responsible for investigating these matters.

While police services, and other interested parties, generally consider police best-placed to conduct these investigations because of their investigative experience and expertise, others have questioned the independence and impartiality of police services to conduct such investigations. Key arguments raised by those who have concerns are based on the fact that police services have a vested interest in the training and conduct of officers, the reputation of the organisation, and in safeguarding any legal or financial liability that may arise if a person is wronged by the actions of a member of the policing service. There is also concern about the culture of police services, which are generally characterised by a sense of loyalty and empathy to fellow police members.

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2 Media and public debate also centred on the use of force by police and the management and treatment of people with mental illness.
Scope of the review

OPI has a statutory obligation to ensure the highest ethical and professional standards are maintained in Victoria Police, and that members of Victoria Police have regard to the human rights set out in the Charter.3

In November 2009, the Director, Police Integrity initiated a review of Victoria Police policy and process to determine the appropriateness of Victoria Police investigating deaths associated with police contact. The rationale for the review was to address ongoing concerns about conflict of interest – perceived or real – that come with police investigating their own officers and to consider the impact of Victoria’s Charter on current Victoria Police policy and practice.

Specifically, the review considers:

• the sufficiency and appropriateness of current Victoria Police policies, procedures and legislative framework for conducting investigations into deaths associated with police contact; and

• options to existing law and practice regulating the conduct of such investigations.

At the outset, it is important to state that OPI’s review does not examine or comment on individual cases of death associated with police contact. Rather, the focus is on the current processes and overall model used in Victoria to investigate such deaths.

A copy of the Terms of Reference for the review is at Appendix One.

3 Section 8, Police Integrity Act 2008.
Structure of this paper

This paper is divided into six sections:

• The first section sets out OPI’s methodology including stakeholders and interested parties consulted and the type of data and information examined.

• The second section discusses some of the definitional issues related to deaths associated with police contact, and provides data on the number and type of deaths that have occurred in Victoria between 2000 and 2010.

• The third section describes the current process for investigating deaths associated with police contact in Victoria. In particular, it summarises what happens during an investigation, and the roles and responsibilities of Victoria Police, OPI and the State Coroner in these matters.

• The fourth section provides an overview of the main issues associated with police investigating police, including the key advantages and disadvantages of the current model. It also discusses the right to life provision contained in the Charter of Human Rights and Responsibilities Act 2006.

• The fifth section summarises the public submissions to the review, key outcomes of OPI’s forum on investigations of deaths associated with police contact, and research on investigative models used in overseas jurisdictions.

• The final section describes current work being undertaken by OPI and Victoria Police to enhance the investigative and oversight processes in this area and details the next steps in the review.
Review methodology

Information for OPI’s review has been drawn from a range of public, Coronial and Victoria Police sources. These include:

- Contemporary literature and media search;
- Consultations with Victoria Police;
- Victoria Police policies and guidelines;
- Coronial and Victoria Police data and investigation files;
- Public submissions and consultations; and
- OPI’s forum on investigations of deaths associated with police contact.

In addition, OPI’s own experience in oversight of police-related deaths will be referred to throughout the review.

Literature and media search

In August 2009, OPI commenced preliminary research on models used in Australian and international jurisdictions for conducting investigations and oversight of deaths associated with police contact. This preliminary research drew mainly on the 2009 report, *Police Investigating Police*, prepared by the Commission for Public Complaints Against the Royal Canadian Mounted Police. Information obtained from this report was supplemented with material obtained from agency websites and reports, and consultations with Australian police services and oversight agencies, and overseas investigative bodies.

Library, internet and media searches were also conducted to help identify the main issues associated with police investigating police and any contemporary literature in this field.

Consultations with Victoria Police

Ongoing consultation with Victoria Police is an important part of OPI’s review. The project team has met with a number of investigative and oversight units about the policies and procedures governing the management of investigations of deaths associated with police contact, and recently participated in a workshop convened by the Victoria Police Ethical Standards Department on the guiding principles for incident oversight. Areas within Victoria Police consulted to date include the Homicide Squad, Major Collision Investigation Group, Ethical Standards Department, and the Civil Litigation unit.
Victoria Police policy and guidelines

All written documentation – policies, procedures and guidelines – pertaining to the investigation and oversight of deaths associated with police contact were reviewed by the OPI project team.

This included:

• relevant sections of the Victoria Police Manual;
• the Ethical Standards Department Discipline Investigations Manual; and
• the Ethical Standards Department Guide for Investigators.

Similarly, Victoria Police has undertaken its own review of these documents. The product of this work is progressing and will be considered by the OPI project team in the final report.

Data and investigation files

Data from the State Coroner’s Office and Victoria Police was examined as part of this review. The State Coroner’s Office conducted a search of its National Coroner’s Information Service on behalf of the project team. The aim of the search was to identify a) all reported police-related deaths in Victoria between 2000 and 2010 and b) any police-related deaths in Australia where the presiding Coroner made any comments or recommendations about the police investigation in his or her findings. Following approval from State and Territory Coroners, transcripts of the cases identified in Part B of this request were also provided to the project team.

Victoria Police provided data on all deaths associated with police contact that occurred between 2000 and 2010. The dataset contains details of all Ethical Standards Department review files where the person involved in the incident was reported as ‘deceased’.4 All records were sorted to remove any cases that involved the death of a sworn or unsworn member, either on- or off-duty. A total of 167 deaths were available for analysis.

In addition to analysing data on police-related deaths, the project team will review a sample of investigation files. The purpose of this file review is to help identify any discrepancies between Victoria Police policy and practice, and to assess the integrity and efficiency of investigations conducted by Victoria Police.

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4 Victoria Police Ethical Standards Department review files are created for each death associated with police contact. Where multiple deaths occur in the one incident (for example, a police pursuit), separate files are created.
Public submissions

On 5 June 2010, OPI called for public submissions from interested parties willing to share their knowledge, experience or opinions regarding deaths associated with police contact. A total of 15 submissions was received from a range of individuals and organisations including family members of people involved in a police-related death, legal and community groups, and police and oversight practitioners. A list of individuals and organisations which made submissions to the review is at Appendix Two.

OPI forum

On 29 and 30 July 2010, OPI held a forum on investigations of deaths associated with police contact (OPI forum). The aim of the forum was to discuss a range of issues associated with police investigating police, and to learn more about the experiences and models used in national and international jurisdictions. The forum brought together representatives from police services, oversight agencies, Coroners’ offices, and community and legal groups within Australia and overseas. The outcomes of the OPI forum – which are discussed in section five of this paper – have provided an important and useful platform for continuing collaborative work in this area. A list of agencies represented at the forum can be found at Appendix Three.

Victoria Police response

A draft copy of this paper was provided to Chief Commissioner Simon Overland for comment. Amendments have been made to incorporate relevant feedback.
Defining deaths associated with police contact

There is no common or consistent definition of deaths associated with police contact in Victorian legislation. The Coroners Act 2008 and the Police Regulation Act 1958 use terms which include deaths that are described as ‘police-related’ or ‘associated with police contact’ or ‘deaths in custody’.

State Coroner definition

Under the Coroners Act 2008, deaths associated with police contact are types of reportable deaths.\(^5\) The State Coroner has a statutory obligation to investigate all reportable deaths, which include:

- a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or
- the death of a person who immediately before death was a person placed in custody or care; or
- the death of a person under the control, care or custody of the Secretary to the Department of Justice or a member of the police force.

In this Act, a person placed in custody or care\(^6\) means:

- a person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or
- a person in the custody of a member of the police force; or
- a person in the custody of a protective services officer appointed under Part VIA of the Police Regulation Act 1958; or
- a person who a member of the police force or prison officer is attempting to take into custody or who is dying from injuries sustained when a member of the police force or prison officer attempted to take the person into custody; or
- a person in Victoria who is dying from an injury incurred while in the custody of the State.

As can be seen from the above, the Coroners Act 2008 broadly captures a wide range of deaths that may be associated with police contact.

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\(^5\) Sections 4 and 15, Coroners Act 2008.

\(^6\) Section 3, Coroners Act 2008.
Victoria Police definition

Under the Police Regulation Act 1958 (and the Victoria Police Manual), deaths associated with police contact fall into the category of ‘critical incidents’. Section 85A of the Police Regulation Act 1958 defines a critical incident ‘as an incident involving a member of the force while that member was on duty which:

- resulted in the death of, or serious injury to, a person; and
- also involved any one or more of the following:
  - the discharge of a firearm by the member;
  - the use of force by the member;
  - the use of a motor vehicle by the member (including as a passenger) in the course of the member’s duties; or
  - the death of, or serious injury to, the person while the person was in the custody of the member.’

Unlike the Coroners Act 2008, the Police Regulation Act 1958 more narrowly captures police-related deaths.

The different classifications used in the Coroners Act 2008 and the Police Regulation Act 1958 reflect the specific operational or administrative requirements of the State Coroner and Victoria Police. For the Coroner’s Office, the term ‘reportable deaths’ is used to determine which deaths, not just police-related deaths, will be subject to a coronial investigation and in some cases a coronial inquest. For Victoria Police, the term ‘critical incident’ is used to determine those incidents where members may be directed to participate in drug or alcohol testing under the Police Regulation Act 1958. Victoria Police also uses ‘critical incidents’ to determine the operational and investigative response to an incident resulting in death.

OPI’s review of the current Victoria Police Manual has identified that Victoria Police does not have a prominent or consolidated policy for the management of investigations of deaths associated with police contact. Rather, the reporting, investigative and oversight requirements for these incidents are set out across various Victoria Police Manual policies depending on the nature and circumstances of the death. Victoria Police advise that this is because the Victoria Police Manual is designed to meet the needs of operational police at the time they respond to specific incidents or events. For example, the police protocols for a response to a critical incident such as a police shooting are markedly different to a response to a death involving natural causes or no physical contact with police. Victoria Police further advise that having a consolidated policy for all deaths would result in a lengthy and complex document, with many duplicate entries and extensive cross referencing.
Notwithstanding the design of the Victoria Police Manual, a key issue for this review is whether capturing deaths associated with police contact as ‘reportable deaths’ and ‘critical incidents’ ensures that a police-related death can be readily identified and managed accordingly. More specifically, the question to be asked is: do we need a specific definition of death associated with police contact?

A more specific definition?

The importance of accurately defining and identifying a death associated with police contact is threefold: 1) it determines the State’s response to these matters; 2) it ensures consistency across agencies involved in the investigation and oversight of police-related deaths; and 3) it strengthens data collection and public reporting of these incidents.

State’s response

Any death arising from the action or inaction of the State must be afforded the highest level of scrutiny, transparency and accountability. This is because the State’s authority to engage in action which might result in the loss of life is the most significant authority afforded to it. Therefore, any exercise of the State’s powers that results in death must be investigated to ensure that any action was justified in the circumstances or that any inaction was not the result of a failure to discharge the duties and responsibilities of the State.

This is not to say that investigations into other deaths shouldn’t be conducted with the same rigour or lack appropriate scrutiny and accountability. Rather, it highlights the importance of ensuring that any State-related death can be readily identified, and then subjected to the higher level of investigation and oversight it requires.

Consistency between agencies

Notwithstanding the different functions of the State Coroner and Victoria Police, it is reasonable to suggest that agencies involved in the investigation and oversight of deaths associated with police contact have a common terminology, so they can provide a consistent response to the same incident. While this may not necessitate legislative change, it may require the adoption of a consistent working or internal definition.

Currently, Victoria Police use of ‘critical incidents’ does not appear to capture those deaths that might occur outside physical interaction or custody of police – for example, a death after police conduct.7 This might include a death that involves the suicide of a person soon after being released from police care or a death that occurs while police are en route to a call-out or when police are in the presence of a person. Under the Coroners Act 2008, these deaths would be captured under ‘unexpected or unnatural’ deaths. The issue here, however, is whether these deaths are (or need to be) identified and managed by Victoria Police in the same way as other police-related deaths.

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7 The definition used by Victoria Police in the former Victoria Police Manual, ‘death resulting from contact between police and the public’ did appear to capture these deaths through their inclusion of ‘any action or inaction by a sworn employee’. See former Victoria Police Manual 104-2 Major scene and investigation protocols, Definitions, originally issued 11/7/03.
Data collection and reporting

Introducing a more specific definition of deaths associated with police contact would facilitate easier data collection and public reporting on these matters, which is consistent with good public accountability and transparency. At present, data retrieval by Victoria Police and the Coroner’s Office can be a protracted process that generally requires some manual interrogation of the different databases to ensure that relevant cases have been included. This is because without a specific category for deaths associated with police contact, searches of databases require like or related fields to be used to capture what would be considered a police-related death. The two risks here of course are 1) missing or excluding cases that may have been entered or recorded under other categories or do not include terms such as ‘death’, ‘deceased’, ‘died’ or ‘fatality’ etc, and 2) the collection of inconsistent data or the preparation of inconsistent reports relating to deaths associated with police contact.

Defining deaths associated with police contact would therefore enable agencies to identify which cases are police-related in the first instance, specifically enter or flag cases as such on respective databases, and then more easily retrieve the data for public reporting.

Victoria Police advised that they recently introduced new categories for classifying and recording deaths associated with police contact in its internal police system. Victoria Police is currently in the process of retrospectively applying these categories to all police-related death incidents to enable better data management and reporting on these matters.

What should be included in the definition?

Closely related to the issue of whether there should be a specific definition of death associated with police contact is: what should it include? Submissions to the review and OPI consultations have identified consensus regarding some deaths, and concerns or differences of opinion about the inclusion of others.

There is widespread agreement that deaths which are obviously related to police action or occur in police custody or care should be defined as police-related.

This includes any death following:

- A police shooting;
- Police pursuit;
- Police use of force; and
- Police custody (for example, police cells or vans).
Where there is disagreement or concern, however, is in those cases where police action or inaction is not so clear. Generally these are cases where there is no proximity of police – either in place or time – to the relevant event. For example, when the death occurs while police are not physically present or near a person (proximity in place) or when a death occurs before or after contact with police (proximity of time). Interestingly, it is these cases that currently account for nearly half of all deaths associated with police contact (see discussion in next section).

Some specific examples of these types of deaths include deaths that occurred:

- days or weeks after a person is released from police custody (for example, as a result of suicide, an accident or physical condition);
- after a police pursuit has clearly been terminated;
- in a situation where police are called out to a matter but are not able to respond or there is a delay in responding and the person dies;
- while police are en route to an incident or are approaching a person (for example, a person who commits suicide before police reach the person); and
- after police leave a scene or incident (for example, a person kills their partner after police attend a reported domestic violence situation).

The concerns raised as part of this review are:

- whether these types of deaths need to be subject to the same investigative and oversight response as deaths that are clearly associated with police contact; and
- whether, following investigation, these types of deaths should be counted and publically reported as deaths associated with police contact.

While these challenges will be explored further as part of this review, it is worth noting two points here.

The Coroner’s Office and Victoria Police explain that in some cases the first report of a death may not identify any police contact. This is because details of an incident may change over a period of time or there may be a lack of sufficient or consistent information when first reported. In these cases, it may be difficult to initially establish an association between police action or inaction and the death of a person.

In addition, the reason for, or the circumstances surrounding, a particular death may not be known or readily identifiable. For example, what might seem like an accident, death from natural causes or an unrelated suicide may in fact have some association with police involvement. Until there is an opportunity to investigate the incident, verify information and establish a police connection, it is possible these cases might be missed as police-related, which could result in an injustice to the deceased, family and the wider community.
The second point is that excluding deaths on the basis of a lack of proximity ignores the fact that a police officer’s duty of care is not confined by either place or time. In other words, the responsibilities of police do not cease once they stop interacting with a person or are out of sight of a person. Actions or inactions of police might set off a chain of events that result in a death well after police contact.

Discussions at OPI’s forum about defining deaths associated with police contact reached consensus on a number of points. Primarily, it was agreed that if any police involvement is raised in a death it must be treated as a police-related matter. Agreement was also reached on:

• avoiding a prescriptive definition of police-related deaths;
• casting the net widely and working inwards to establish that something might be police-related;
• determining a trigger for different investigative and oversight responses, if required;
• judging each potential police-related death on its merits; and
• determining the most appropriate categories of police-related deaths, if required.

These views will be considered with other suggestions put forward in relation to definitional issues. For example, it has been suggested that all near-deaths (that is, serious injuries) and alleged human rights abuses by police also be subject to the same investigative and internal and external oversight processes used for deaths associated with police contact. Furthermore, it has been suggested that the definition be expanded to include all deaths involving current and former police.
How many deaths are associated with police contact?

For the purpose of this paper, a death associated with police contact has been interpreted broadly. It refers to any death where a police connection, either through direct contact or otherwise, can be made with the deceased at any stage before or during the incident that resulted in death.\(^8\)

This includes deaths that occurred:

- following an interaction or physical contact with police;
- while a person was in police custody;
- while police were en route to an incident; or
- any time after police had recent or relevant contact with a person.

Between 2000 and February 2010, 167 deaths associated with police contact were recorded by Victoria Police. While most cases investigated by police involved one fatality, eight cases involved multiple fatalities. Specifically, in seven cases two people died, and in one case three people died in a pursuit.

Figure 1: Deaths associated with police contact, 2000-2010

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\(^8\) The specific search parameters used by Victoria Police included all Ethical Standards Department review files where the person involved was reported as ‘deceased’ between 1/1/2000 - 28/2/2010.
Figure 1 provides a breakdown of the type of deaths associated with police contact. Close to half of the 167 deaths reported by police were the result of suicide (46% or 77 cases), followed by police pursuit-related incidents (22% or 37 people) and other causes (22% or 37 people). This latter category includes people who were reported to have died in incidents involving pedestrian or vehicle accidents, pre-existing or sustained injuries, natural causes, or were recorded by police as ‘found deceased’.

In the past 10 years, 11 people (7%) have died from police shootings.

In addition, five people (3%) died in incidents where a third party was either in the presence of police or had contact with police shortly before the death. For example, in one case, a male killed two people after being released by police, and in another case, a woman reported concerns to police about a missing male who was later found dead by police.

Proximity to contact

Half (50% or 84 cases) of all deaths associated with police contact occurred after interaction with police. That is, police were not in the presence of the person when they died. In the majority of these cases (65% or 55 cases), death resulted from the suicide of a person who had recent contact with police.

Forty five per cent (45% or 76 cases) of all deaths reported between 2000 and February 2010 occurred during interaction with police. While more than a third (38% or 29 cases) of these deaths occurred as a result of police pursuits, people also died following suicide (25% or 19 people), police shootings (14% or 11 people), and other causes (20% or 15 cases).

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9 The following definitions were used by the project team to categorise cases: police shooting – any death that followed the discharge of a police firearm; police pursuit – any death related to an active or abandoned police pursuit, and any other death related to a police vehicle following another vehicle; suicide – any death where a person has taken their own life during or after police contact and any self-initiated death that occurred while police were either approaching or in sight of the person; other causes – any other death, for example deaths associated with natural causes, vehicle or pedestrian accidents not involving police vehicles, and physical or pre-existing injuries which may or may not have been the result of police contact, and third party – any death where a person who had contact with police directly contributed to the death of a third party, or any death where a person who reported a matter to police involving a third party was found deceased or the third party was found deceased.
Location of deaths

The majority (64%) of all deaths associated with police contact occurred either at private residences (34%) or in vehicles (30%). Figure 2 shows the location of these deaths.

Figure 2: Location of deaths associated with police contact, 2000-2010

Ten deaths (6%) were reported to have occurred in police premises such as police cells, stations or police vehicles. Six of these deaths were the result of other causes, and four deaths were the result of suicide in police custody.

Preliminary analysis of Victoria Police data shows that close to half of all deaths associated with police contact are suicides and deaths following police contact. As discussed above, it is these deaths that tend to be the subject of debates on defining and classifying police-related deaths.

OPI and Victoria Police are conducting further analyses of available police and coronial data. These results will be presented in the final report of this review.
Investigating deaths associated with police contact in Victoria

The provisions governing the management of investigations of police-related deaths in Victoria are set out in the Victoria Police Manual.\(^\text{10}\) While it is not the intention of this paper to detail each step of the investigative and oversight process, an overview of what generally happens once a death associated with police contact has been reported is provided below.

Investigative responsibility

Depending on the nature of the incident, most deaths associated with police contact will either be investigated by the Homicide Squad or the Major Collision Investigation Group. The Homicide Squad has responsibility for investigating deaths ‘resulting from contact between police and public’.\(^\text{11}\) This includes deaths resulting from:

\begin{itemize}
  \item the discharge of a firearm by a sworn employee;
  \item any other form of violence or force inflicted by a sworn employee;
  \item any action or inaction by a sworn employee;
  \item custody-related police operations, which include where police are attempting to detain a person (for example pursuits, sieges);
  \item persons in the process of escaping or attempting to escape from custody; and
  \item deaths of persons in custody of police, whether in cells or otherwise.
\end{itemize}

The Major Collision Investigation Group, on the other hand, must attend and investigate fatal or life-threatening collisions including:

\begin{itemize}
  \item collisions involving three or more fatalities;
  \item hit-run collisions involving fatal or threatening injuries; and
  \item collisions involving fatal or life-threatening injuries where there is evidence of criminal negligence by a surviving driver, a Victoria Police employee (on or off duty) is involved as a driver, or the collision resulted from a police pursuit.
\end{itemize}

\(^\text{10}\) Since OPI commenced its review in November 2009, Victoria Police released its revised Victoria Police Manual in April 2010. While this paper refers to the revised Victoria Police Manual, reference is made to sections of the former manual where relevant. It should also be noted that Victoria Police is currently finalising further changes to its revised Victoria Police Manual in response to ongoing work in this area. These finalised policies will be considered in the final report.

The Major Collision Investigation Group is also required to investigate any other fatal or life-threatening collisions where the involvement of police in the collision may cause harm to the reputation of Victoria Police.12

Attending scene

Once a death has occurred, Victoria Police Communications is responsible for notifying the necessary personnel and units to attend the scene.

In cases where a death has followed a police shooting or police pursuit, the relevant Inspector or Officer in Charge, the investigating unit (Homicide or Major Collision Investigation Group), the Ethical Standards Department and the State Coroner’s Office will all be notified in the first instance and attend the scene.13

It is common practice for senior officers and other specialist units (for example Victoria Police forensic services, operational tactics and safety training officers, Major Collision Investigation Group collision reconstructionists, regional crime investigation units, and the media unit) to also attend the scene of a police-related death. These specialist units are notified and attend at the discretion of the investigator.

For other deaths associated with police contact, such as deaths in police custody, the Homicide Squad and Ethical Standards Department will be notified and attend the scene.

Management of police involved

Victoria Police has an initial action checklist for managing critical incidents and an information sheet for members involved in critical incidents.14 Both documents set out what needs to happen to secure the incident or crime scene and manage police in terms of witness or evidence control and police welfare.

Witness and evidence control

One of the risks associated with the management of investigations of police-related deaths is the potential for police to discuss and be influenced by the versions of events provided by other police. To ensure control of the evidence, Victoria Police policy provides that police involved in critical incidents:

- are located, separated and isolated after the incident and advised not to discuss any issue arising from the incident with any police other than investigators;

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13 Victoria Police advise that the Victoria Police Communications Centre Standing Operating Procedures have recently been revised. The procedures now include an extensive list of incidents where Deputy Commissioners, Assistant Commissioners and the Ethical Standards Department must be notified.

• are assigned a nominated member, where practicable a supervisor independent of the incident, to remain with each member and address immediate welfare needs;

• are instructed not to wash their hands or remove/change clothing or footwear until advised;

• are required to secure all equipment (firearms and operational safety equipment) until the complete equipment belt is provided to the attending officer or investigator;

• may be asked to participate in a recorded re-enactment of the incident;

• are interviewed by the investigator; and

• participate in procedures that require the taking of samples for forensic testing, including the provision of their clothing.

Section 85B of the Police Regulation Act 1958 also provides that police involved in critical incidents may be directed to participate in drug or alcohol testing.

Welfare of police

Critical incidents are stressful and can be difficult experiences for police. To provide for the welfare of those involved in a death associated with police contact, police:

• are offered welfare and support services;

• may be examined by a Police Medical Officer;

• are given access to a Victoria Police psychologist;

• may contact the Police Association;

• are given legal representation;

• are encouraged to contact their family;

• may have a friend or peer support attend and remain with them; and

• are taken home and offered follow-up assistance if required.

Whether police are treated the same as members of the public who may be witnesses or involved in a sudden ‘unexplained’ death or a potential homicide will be examined further in the final report.
Welfare of families of deceased

Victoria Police members must inform, in person, any family of a person who dies in circumstances associated with police contact. Victoria Police offers a range of welfare and support services to family members through its Victim Advisory Unit and Victim Liaison Officers. The Victorian Coroners Court and the Victorian Department of Justice also offer support to families and affected individuals.

The effectiveness of these arrangements will be considered as part of the ongoing review.

Oversight

Ethical Standards Department

The investigation of deaths associated with police contact is overseen by the Ethical Standards Department of Victoria Police. The intended role of the Ethical Standards Department in these matters is to ensure there is ‘no impediment to the investigation, and that the integrity of the investigation is maintained by active oversight’. Victoria Police describes ‘active oversight’ as:

- continuous monitoring of the investigation;
- making any relevant comment or directing further inquiries if it is considered necessary to satisfy any future internal or external examination of the adequacy or integrity of the investigation;
- ensuring the member investigating the incident advises the senior Ethical Standards Department officer of all developments during the investigation; and
- ensuring the investigation is conducted without bias for or against any police or civilians involved.

An initial risk assessment of the incident is to be carried out within 24 hours of the police-related death. The purpose of this is to identify any risks or issues likely to affect the investigation or organisation. The Ethical Standards Department review officer is responsible for reporting any identified issues to his or her supervising officer and the investigating unit.

OPI

OPI has no legal authority to conduct an investigation into a death associated with police contact to the exclusion of or instead of Victoria Police. Nor does OPI have any legal authority to prevent Victoria Police from conducting an investigation.

Like other police oversight agencies in Australia, OPI’s primary responsibilities relate to police corruption and misconduct. Up until 2007, OPI had three statutory objects:

- to ensure that the highest ethical and professional standards are maintained in Victoria Police;

- to ensure that police corruption and serious misconduct are detected, investigated and prevented; and

- to educate Victoria Police and the general community regarding police corruption and serious misconduct, including the effect of police corruption and serious misconduct.

With the introduction of the Charter of Human Rights and Responsibilities Act 2006, a fourth OPI object was included:

- to ensure that members of Victoria Police have regard to the human rights set out in the Charter of Human Rights and Responsibilities.

In terms of deaths associated with police contact, OPI is responsible for ensuring the Victoria Police investigation is carried out to the appropriate ethical and professional standard. OPI determines levels of oversight on a case by case basis. This may range from an ‘after the fact’ review of the hard copy file provided by the Ethical Standards Department (OPI reviews the investigation file prior to it being provided to the State Coroner) to more active oversight of an investigation which might include requesting and receiving regular updates by Victoria Police on the progress of the investigation.

Section 44 of the Police Integrity Act 2008 empowers the Director to conduct ‘own motion’ investigations in respect of any matter that is relevant to the achievement of his or her objects. This includes, but is not limited to:

- an investigation into the conduct of a member of Victoria Police;

- an investigation into police corruption or serious misconduct generally; or

- an investigation into any of the policies, practices or procedures of Victoria Police or of a member of Victoria Police, or the failure of those policies, practices or procedures.

This means the Director can conduct a parallel investigation to Victoria Police or conduct his or her own investigation into any aspect surrounding a death. A parallel OPI investigation would rarely be feasible because of the duplication of Victoria Police effort. OPI has, however, used its legislative power to examine particular issues arising from police-related deaths, for example to highlight policy issues about the control of critical incidents and use of force.17

OPI is currently reviewing its oversight processes to formalise these arrangements with Victoria Police. This is discussed further in the last section of this paper.

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State Coroner

As discussed earlier, the State Coroner has a statutory responsibility to investigate reportable deaths including those described as ‘police-related’ or ‘associated with police contact’. While it is usual practice for Victoria Police to conduct such investigations on behalf of the State Coroner, it should be noted that the Coroners Act 2008 is silent on the power of the State Coroner to direct police to conduct an investigation into a death.

The absence of a specific power to direct police in investigations was raised by the Law Reform Committee in its review of the Coroners Act 1985. In particular, the Committee expressed concern about the ‘current arrangements’ of police directing investigations into police-related deaths and subsequently recommended that the Coroners Act be amended to: ‘provide that a coroner may give a police officer directions concerning investigations to be carried out for the purposes of an inquest or inquiry into a death or suspected death, whether or not the inquest or inquiry has commenced.’ In its report, the Committee stated that the power to direct police is: ‘particularly necessary in relation to coronial inquiries into deaths in police custody and deaths resulting from police actions in order to avoid the perception that there is a conflict of interest.’

The recommendation of the Law Reform Committee for the Coroner to have an explicit power to direct police was not accepted by the Government. In its response, the Government stated it would consider ‘alternative measures’ to address the issues raised by the Committee.

While the authority of the State Coroner to direct police in an investigation into a death is not specifically stated, the Coroners Act 2008 does provide the State Coroner with the ability to obtain information from people and places in support of a coronial investigation and inquest. This includes the ability to authorise police to exercise certain information-gathering powers under the Act in support of an investigation. For example, section 39 of the Act allows the State Coroner or a member of the police service authorised by the State Coroner to break, enter and search premises if required and to take copies of or seize any documents which may be relevant to the investigation. Similarly, sections 40 and 41 of the Act allow the State Coroner or a member of the police service authorised by

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19 Other concerns raised during the Inquiry included the timeliness and quality of investigations, and the accountability of the State Coroner for investigations conducted by police.
21 Part 4, Division 4, Coroners Act 2008.
the State Coroner to enter premises and direct a person to produce a document, access information, take photographs or make audio recordings etc.

In addition, section 36 of the Act provides that a member of the police service who has information that may be relevant to a coronial investigation into a death must give that information to the State Coroner to assist in the investigation, section 42 of the Act provides that for the purpose of an investigation the State Coroner may request specific documents or a prepared statement addressing ‘matters specified’ be provided to the State Coroner, and section 57 of the Act provides that at an inquest the State Coroner may request a person to give evidence that may be self-incriminating.22

The current and potential role of the State Coroner in investigations of deaths associated with police contact will be discussed further in the final report.

Investigative issues

Victoria Police protocols for investigating deaths associated with police contact have been developed to ‘maintain public confidence in the integrity and accountability’ of the organisation and to ensure a ‘thorough and impartial investigation’ is conducted.23 Conceptually, the current procedures governing the conduct and oversight of police investigations appear to achieve these aims. There is clear delineation of investigative responsibilities for certain types of deaths, set processes for securing the scene and managing members’ welfare, relevant and necessary information available for police, and guidance on the oversight of investigations.

Consultations with Victoria Police and OPI’s own experience in overseeing these investigations have, however, identified some issues associated with policy implementation and investigative practice. Three matters are specifically discussed here:

- the selection of the investigating officer;
- cautioning and taking statements from police; and
- oversight of the investigation by the Ethical Standards Department.

22 Section 57 of the Coroners Act 2008 requires the State Coroner to provide any person who gives evidence under this section with a certificate providing immunity from prosecution in any other proceedings based on the information provided to the State Coroner.

23 Victoria Police Ethical Standards Department Discipline Investigation Manual, Appendix Q2: Deaths resulting from contact between police and public.
Selection of investigating officer

Victoria Police does not have a formal process for the allocation of investigations of police-related deaths to particular investigators. Senior officers from the Homicide Squad and Major Collision Investigation Group are responsible for assigning investigations of these incidents to the designated investigator. While the selection of investigators is generally based on availability or rostering of officers, it is standard practice for the investigating officer to be of a higher rank than the officer involved in the incident. This seeks to ensure investigating officers are not culturally or personally inhibited by a traditional rank structure which may prevent them from confidently investigating a more senior officer.

The rank of investigating officers seems to be the only ‘criteria’ upon which investigations are assigned. Victoria Police does not engage in any formal screening or scrutiny of its officers to ensure there is no conflict of interest for the officer undertaking the investigation. Rather, the onus is on investigating officers to declare any conflicts of interest that may arise in their work. For example, an investigating officer may be a personal friend or former colleague of the police officer under investigation. In other words, it comes down to the integrity and foresight of individual officers to declare a conflict, and for supervising officers to manage it.

Victoria Police uses its general conflict of interest policy to manage any conflicts of interest in investigations. In relation to investigations the policy provides:

‘Police members must not undertake any duties in relation to a police operation, investigation or prosecution in which:

- they are the victim;
- their relatives or friends are involved; and
- they have a connection to a party in the matter.

If a police member becomes involved in such a situation, the member must request the attendance of an independent member to undertake the duties.

Where the above is not practical (for example at one member stations) police members must seek the advice of a supervisor. The supervisor must advise how to deal with the matter and record the decision.’

There are two points to be made here. First, a process of self-initiated declarations of conflict of interest may not be sufficiently robust to identify an issue at the outset. This is particularly apparent when officers may not know they have a conflict or not appreciate the problems perception alone may create. Thus some level of supervisory assessment is required.

Secondly, while the current Victoria Police conflict of interest policy requires officers to declare any issues associated with their involvement in a police-related death, there is no process or level of scrutiny to ensure that any conflicts are actually mitigated or managed appropriately. This is fundamental to conflict of interest management. As recently highlighted in OPI’s report Managing Conflict of Interest in Victoria Police (2010), OPI has concerns about how well conflict of interest is understood and managed by Victoria Police. OPI does, however, acknowledge the ongoing commitment of Victoria Police to this issue.

The aim of instilling a culture that understands and respects conflict of interest is not simply to ensure conflicts can be identified and eliminated – for example, by removing people from a particular matter or investigation – it is also to mitigate the risks associated with the conflict. In other words, it is about transparency and accountability in a process. In the interests of such, Victoria Police must not only identify any conflict but also account for how it is managed. Currently, there is no evidence that this is sufficiently part of Victoria Police culture.

Cautioning and taking statements from police

In any investigation of a death, when police suspect or have reasonable grounds to believe that a person may have committed a crime, the suspect will be informed of, and afforded their rights, to communicate with a friend, relative and legal practitioner, cautioned and a formal interview conducted under Subdivision 30A of Part 3, Division 1 of the Crimes Act 1958. This differs from the procedure for those who are regarded as witnesses.

The effect of cautioning a person and conducting a record of interview is that any admission or confession made by the person from the time of being cautioned by police may be tendered as evidence against them in criminal proceedings. Suspects also have a range of other legal and procedural rights. The Crimes Act 1958 provisions apply to members of the public involved in criminal matters and police officers involved in deaths associated with police contact. In one respect, however, they are not applied equally.

Usually, if a member of the public has discharged a firearm that results in the death of another person, that person will be automatically treated as a suspect and cautioned by police. However, if a member of the police service discharges a firearm that results in the death of another person, the member will not usually be cautioned in the first instance. In effect, the member will not be treated as a suspect. Victoria Police advises that a member of the police service would generally only be cautioned if there was only one police officer involved in an incident and no other witnesses to it.

25 Sections 464A(3) (caution), 464C (right to communicate) and 464H (recording), Crimes Act 1958.
The Victoria Police practice of not cautioning police in most police shootings is said to be justified for two reasons. First, police investigators can often determine before speaking to the police members involved that the firearm was likely to have been discharged in self-defence. This determination can often be made from the statements of other police and civilian witnesses, Victoria Police communications, and in some cases physical evidence at the scene. Secondly, it allows police involved in a police shooting to speak more openly and freely about the incident and to provide a fuller account of what happened.

The practice of not cautioning police involved in police shootings would generally preclude any initial account or statement provided by them from being used in criminal proceedings against the member who made the statement.

Taking statements

Section 464H of the Crimes Act 1958 provides that any information provided by the police investigator to a suspect as required under sub-sections 464A(3), 464C(1) and any admissions or confession made by a suspect to police investigators as part of a criminal investigation must be audio- or video-recorded. An interview of police or public witnesses to an incident does not have the same requirement. In these cases, police investigators may take written, audio- or video-recorded statements, usually depending on the preference of the witness.\(^\text{26}\) In investigations of deaths associated with police contact, the law requires that police, whether they be suspects or witnesses, be accorded the same rights as any other citizen.

A question arising from this review is if there should be a mandatory requirement for video-recording interviews of police involved in deaths.

The purpose of interviewing a suspect or taking a statement from a witness is to get the most accurate and independent free narrative of what occurred, preferably as soon as possible after the incident – in other words, while it is still fresh. There are two key advantages of video-recording police interviews. The first is it more accurately captures the account of a person, because what is said, how it is said, and the body language or non-verbal cues of a witness can all be seen by those viewing the tape. The second is that it protects both the investigator and witness from any potential allegations of collusion or bias. To this end, video-recording most readily meets requirements for transparency and accountability in the investigative process.

Some suggest that it may be unfair to expect police to participate in video-recorded interviews immediately following a difficult and stressful incident – such as a police-related death – because the reaction of the police member to the incident might prevent the officer from giving a fair and accurate account at that time. In addition, the demeanour of the police officer at the time of giving the statement may be uncharacteristic. Therefore, any account provided by police soon after any incident may be unfairly interpreted.

\(^{26}\) Suspects and witnesses also have the right to decline to be interviewed or make a statement.
Victoria Police has advised that the Homicide Squad has recently adopted a process whereby police members will be initially asked to consent to a video-recorded interview. However, if police members do not want to be video-recorded they will be offered the option of providing an audio-recorded or written statement taken by an investigator. The challenge for this review is to weigh up the advantages of obtaining a police officer’s account on video with the risks associated with that process.

The issues associated with cautioning and formally interviewing police, including those relating to police who choose not to give a statement or an account in investigations of police-related deaths, will be examined further in the final report.

Oversight of the investigation

Oversight of investigations into police-related deaths is essential to ensure the transparency and accountability of the investigative process and its outcomes. Strong internal and external oversight builds public confidence in the integrity of the system.

The quality and level of oversight of investigations of police-related deaths by the Ethical Standards Department was raised as an issue during OPI’s consultations and in public submissions. Generally, it was agreed that this oversight is currently not as strong as it could be, and some Ethical Standards Department review officers are more ‘actively’ involved in investigations than others. This has resulted in the quality and level of oversight by the Ethical Standards Department being very much dependent on the individual assigned to oversee and/or review the investigation.

Some reasons put forward in our consultations for less active oversight by some officers include:

- inexperienced or junior members overseeing the investigations;\(^{27}\)
- a reluctance on the part of oversight officers to question or advise investigating officers due to a lack of confidence or technical expertise;
- workload and competing priorities of oversight officers; and
- a general lack of understanding about the role of the Ethical Standards Department in police-related deaths.

It is this last point that is most crucial to this discussion. Perhaps one of the more significant impediments to the effective oversight of investigations of police-related deaths is that the oversight role is generally not well-understood by Ethical Standards Department officers, by investigative units, by police witnesses and the wider community.

\(^{27}\) Victoria Police has since advised that the assignment of review officers to the oversight of investigations is commensurate with the skills and experience of the review officer, the seriousness of the incident under investigation and the risks associated with it.
This lack of understanding may lead to a lack of cooperation between key stakeholders and may also cause tension or strained relationships between oversight and investigative officers or oversight officers and police witnesses, which may be counter-productive. For example, investigative officers may not appreciate being advised on process or procedure to ensure the integrity of the investigation. This might include reminding investigators to separate witnesses or to include the Ethical Standards Department officers on any ‘walk- or drive-through’ of the incident scene. Similarly, police witnesses may interpret the presence of Ethical Standards Department as an indication of perceived wrong-doing or personal fault and actively resist or resent the Department’s involvement.

OPI has identified two particular shortcomings with the investigation oversight conducted by the Ethical Standards Department. The first is that the oversight is generally an ‘after the fact’ review of the hard copy file provided by the investigator. In other words, the investigation file is reviewed after it is completed but prior to being finalised or provided to the Coroner. The problem with this is that a review of a file may not allow an oversight officer to establish whether all witnesses were interviewed, whether all necessary and appropriate questions were asked and whether evidence was tampered with or excluded from the investigation. Essentially, if an oversight officer is not physically present or involved during an investigation, the officer can only review what is provided to them on paper.

Closely related to this is a second issue. It seems that the oversight provided by the Ethical Standards Department tends to focus on reviewing the facts of an incident or what actually happened. However, the critical role of the Ethical Standards Department in investigations of deaths associated with police contact is to ensure the integrity of the process used by investigators. It is the investigators’ role to get to the facts or determine what actually happened. To this extent, what actually happened leading up to the death is secondary to how police investigators determined what did happen.

Recently, Victoria Police released new oversight guidelines designed to improve the understanding of the Ethical Standards Department’s role in investigations of deaths associated with police contact. Victoria Police is also in the process of consolidating a set of Model Principles of Oversight to be used by Ethical Standards Department staff to formally monitor and report on the performance of the investigation. The finalised protocols will be examined in the final report.
Police investigating police: issues

This section identifies some general issues about the current investigative model used in Victoria and other Australia jurisdictions arising from OPI’s research and consultations. In particular, it discusses some of the advantages and disadvantages of ‘police investigating police’.

Advantages

In terms of the effectiveness of an investigation into a death associated with police contact, there are benefits in police conducting these investigations – including:

- skills and expertise of police investigators;
- resourcing;
- knowledge of policing environment; and
- current internal and external oversight arrangements.

Each of these is discussed below.

Skills and expertise

A common theme throughout OPI’s consultations is that Homicide Squad detectives and Major Collision investigators are best equipped to undertake investigations associated with police contact because of their specialist skills and experience. This argument is strengthened by assertions that investigations of police-related deaths are conducted using the same processes used to investigate any other death.

Resourcing

Policing services are provided ‘24/7’, and police organisations have at their disposal a range of specialist units, technology and other resources to help identify, collect and process evidence relevant to an investigation. For example, forensic specialists and scientists and accident reconstructionists and engineers. Although police services are not the only agencies to employ specialists, it does highlight one of the benefits of police services undertaking the primary investigative role – being able to readily deploy experts with law enforcement experience who can physically and lawfully access the scene, process information, and navigate an investigation.

This is most significant when considering the need to maximise investigative effort during the ‘golden hour’ – a critical period after an incident in which people, places and evidence can be secured. Given the ready availability of specialist police resources, police services are considered by some to be best placed to manage and conduct an investigation of a police-related death.
Knowledge of policing environment

It has been asserted that police investigators are more likely than external investigators to command the respect of fellow police officers, thus facilitating greater cooperation from those under investigation, and by those supporting the investigation. Just as the public needs to have confidence in the investigative process, so too do police. Culturally, police may feel more comfortable with a police-led investigation. They are more likely to have confidence in the ability of the investigator (credibility) and confidence in the investigator to appreciate the nature of the working environment of police (empathy). In other words, police might prefer that police officers conduct the investigation in the assumption that police officers are more likely to understand the context in which other police officers undertake their duties and make operational decisions. Of course, it is this very reason that has led others to argue that police are unsuited to this investigative role.

Internal and external oversight

A further argument in support of police-led investigations is that the current framework includes internal and external oversight arrangements to identify any issues with investigations of deaths associated with police contact.

In evidence to the Law Reform Committee’s inquiry into the Coroners Act 1985, Victoria Police highlighted internal and external oversight as an important means by which the organisation ensures the integrity of investigations:

‘Our processes are that in that sort of situation (police shooting) our Ethical Standards Department has a very strong role in overseeing the way investigations are carried out. There is also the role of the Coroner to oversee the investigation. Also at the moment if any issues arise the Office of Police Integrity has oversight and plays an investigative role as well. Although we have an initial response in terms of our investigation, there are a number of checks and balances in terms of our ethical standards to Parliament and the OPI.’

During our consultations, two additional safeguards were emphasised as strengthening the accountability and transparency of investigations into deaths associated with police contact – science and technology and the State Coroner.

The use of science and technology by police means there is often independent evidence for investigators and those overseeing the investigation to confirm or dispute evidence provided in an investigative brief. For example, closed circuit television may capture the relevant incident, audio may capture conversations with and instructions given to the people involved, pathologists and forensic scientists can interpret cause of injury or death, and traffic data may show the journey of vehicles, brake patterns, and speeds travelled. The point here is, provided this type of information is collected and made

available, investigations of police-related deaths are rarely limited to the personal accounts provided or statements taken by the police involved. This evidence can also be examined by those investigating or overseeing deaths associated with police contact, the State Coroner, and the representatives of persons interested.

It was also acknowledged that police investigators do themselves no favours by preparing a weak or incomplete brief of evidence for the State Coroner. This is because any faults or issues with the investigation will be identified and possibly heavily-criticised as part of the coronial inquest. In other words, the brief is not just accepted by the State Coroner without question. The State Coroner will often appoint independent counsel to assist at the inquest of a death associated with police contact. Counsel might be retained six or more months prior to inquest, which allows counsel assisting time to request and obtain any other evidence or information necessary for the examination of the death. This includes addressing any gaps or deficiencies in the investigative brief prepared by the police.

Disadvantages

Conflict of interest
As identified at the outset of this paper, the consistent criticism of police investigating police-related deaths is that it involves a conflict of interest.

The community legal sector, bereaved family members, and other interested groups have all questioned the appropriateness of police involvement in such investigations. The shared view is that police-led investigations may lack the transparency, accountability and integrity required of such investigations. Much of this concern stems from the belief or perception that police will be tempted – even subconsciously – to conduct an investigation in such a way as to protect their colleagues from any adverse findings, to protect the reputation of the organisation or to safeguard against any legal liability, criminal or civil.

For example, in its submission to OPI’s review, the Human Rights Law Resource Centre stated:

‘The mere fact that police investigate their own raises the perception of, and the possibility for, impartiality, collusion, corruption and bias in the investigation. This undermines transparency and credibility of the process, fails to maintain standards of conduct of the members of the police and diminishes public confidence in the ability of the system to bring responsible persons to justice and to prevent similar incidents occurring in the future.’\textsuperscript{29}

\textsuperscript{29} Human Rights Law Resource Centre (2010), submission to OPI review.
In their submission, David and Margrit Kaufmann, whose son was fatally shot by Victoria Police in 2002, also noted:

‘In our opinion, an inquest into a police shooting, where the investigation has been conducted by the police, does not bring closure to a person’s death, but total dissatisfaction with the existing system. Therefore the public perception, of police investigating police being a total conflict of interest, prevails.’ 30

In evidence to the Victorian Law Reform Committee Inquiry into the Coroners Act 1985, Victoria Police acknowledged a potential conflict of interest in relation to investigations of deaths of on-duty police officers – in other words, a police officer who dies in the workplace:

‘Given the potential for WorkCover prosecution against Victoria Police, there could be a potential for conflict of interests with police conducting investigations into these deaths, as the outcomes of these investigations have a direct impact on the vulnerability of the organisation.’ 31

The Committee’s report notes Victoria Police suggested these investigations should be conducted by a non-police investigator.

Police investigators understandably take offence at assertions which call into question their professional integrity. Indeed, it is unfair to assume a police investigation cannot be undertaken impartially because it is conducted by a police investigator. However, in considering what weight these concerns should be given, regard must be had to the significant impact they can have on the public’s confidence and trust in the investigative and coronial process.

Inconsistent with human rights obligations

The Victorian Charter of Human Rights and Responsibilities Act 2006 imposes a number of obligations on Victoria Police. 32 In terms of deaths associated with police contact, the most pertinent of these rights is section 9, ‘the right to life’:

‘Every person has the right to life and has the right not to be arbitrarily deprived of life.’ 33

A consistent point made in public submissions to OPI’s review and our consultations to date is that the current model of police investigating police is inconsistent with section 9 of the Charter. This is because it is argued the ‘right to life’ carries with it a requirement for an ‘independent’ investigation of any death at the hands of the State.

30 David and Margrit Kaufmann (2010), submission to OPI review.
32 Section 1(2)(c) of the Charter imposes ‘an obligation on all public authorities to act in a way that is compatible with human rights’ and section 38(1) makes it ‘unlawful for a public authority to act in a way that is incompatible with a human right, or, in making a decision, to fail to give proper consideration to a relevant human right’.
33 It is recognised that section 10 of the Charter, protection from torture and cruel, inhuman or degrading treatment, is also relevant to these discussions.
Under the Victorian Charter, the ‘right to life’ does not explicitly include a right to an independent investigation. What it does contain, however, is a provision which states that international jurisprudence may be drawn upon in interpreting a right. Section 32(2), of the Charter provides:

‘International law and the judgments of domestic, foreign and international courts and tribunals relevant to a human right may be considered in interpreting a statutory provision.’

In overseas jurisdictions, it has been recognised that the ‘right to life’ implies an obligation to independently investigate deaths where the ‘right to life’ may have been denied. This body of human rights case law is drawn primarily from international tribunals such as the European Court of Human Rights.

In order to protect the ‘right to life’, the European Court of Human Rights holds that the State is obliged to investigate deaths where the ‘right to life’ may have been violated, and has outlined five key principles that must be fulfilled in order to ensure the investigation is ‘effective’ – independence, adequacy, promptness, sufficient public scrutiny and next-of-kin involvement.34 These requirements were cited in a number of submissions to OPI’s review as standards that should also be met by the State when investigating deaths associated with police contact in Victoria.

In his presentation to the OPI forum, Dr Graham Smith, consultant to the European Commissioner for Human Rights, summarised the five principles as:

1. **Independence**: the investigators or investigative body should have no hierarchical or institutional connection to the police involved in a police-related death and the investigation must be independent in practice. The European Commissioner for Human Rights supports investigation by a civilian oversight or an independent police complaints body.

2. **Adequacy**: the investigation must be capable of (1) determining whether the conduct was unlawful and (2) identifying and punishing those responsible. For example, there must be a thorough attempt to find witnesses, to take full and accurate statements, and to verify evidence provided by police. Adequacy also includes an additional duty to examine all of the facts to determine if police conduct was based on discriminatory motives.

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3. **Promptness:** an investigation must be conducted expeditiously to maintain public trust and confidence in the rule of law. It requires completion of an investigation within a reasonable period of time, which must be not unreasonably long or short in duration.

4. **Sufficient public scrutiny:** investigation procedures and decision-making should be open and transparent to ensure accountability. Sufficient public scrutiny maintains that reports and findings be published, although due to issues of confidentiality this must be decided on a case-by-case basis, and in some cases, hearings and inquiries be held in public.

5. **Next-of-kin involvement:** an investigation must allow the next-of-kin to be involved in the investigative process in recognition of their legitimate interests. The European Commissioner for Human Rights further recommends that victims should be consulted on the progress of the investigation, and have access to victim and welfare support and legal representation.

The European Court of Human Rights developed the five principles to ensure that deaths associated with police contact are subject to a rigorous examination and foster public confidence in the system. It should be noted that the European Court of Human Rights has not defined a specific model or procedures that member States should replicate in fulfilling these principles. Rather, the minimum requirement of member European States is to ensure that ‘arrangements are in place to comply with the five principles in the event that Article 2 (right to life) and Article 3 (prohibition of torture, inhuman and degrading punishment or treatment) of the European Convention on Human Rights is engaged.’


36  Section 7(2) of the Charter.

There are two important points to be made in relation to the Victorian Charter and its obligations on Victoria Police. The first is that the Charter also provides that a human right may be subject to reasonable limits in certain situations. In other words, the obligations imposed by a human right may be limited when other factors are taken into account. For example, in the case of the ‘right to life’, the obligation for an ‘independent’ investigation may be limited if the establishment of a new body to investigate these matters reduces the ‘adequacy’ of the investigation. In this case, the two obligations may need to be balanced.

To the extent the Charter allows for a balancing of obligations where any rights may be limited, the challenge for this review will be determining the mix between meeting the human rights obligations of the State and establishing the most appropriate investigative framework and oversight requirements.

Secondly, discussions at OPI’s forum suggest Victoria Police is capable of meeting four of the five minimum principles set by the European Court of Human Rights – adequacy, promptness, sufficient public scrutiny and next-of-kin involvement. The point of
contention, however, is whether the ‘right to life’ as set out in the Victorian Charter does require a separate organisation to conduct these investigations or whether the role of the State Coroner provides the requisite independence. For example, unlike some overseas jurisdictions, the Victorian *Coroners Act 2008* provides a framework that allows a more inquisitorial examination of a death associated with police contact. This will be considered further in the final report.

Furthermore, human rights case law in Victoria is limited. In the absence of a court or tribunal arbitrating over the applicability of international interpretation, it may be difficult to determine whether the ‘right to life’ in a Victorian context will carry the obligations imposed by international tribunals such as the European Court of Human Rights.

It is also important to recognise the different context in which human rights provisions have been introduced in overseas jurisdictions. In many cases, human rights safeguards were introduced to protect citizens from States which had used police services to abuse and violate the rights of citizens. In Australia, separate judicial and government institutions also help to protect its citizens.

Nevertheless, the Victorian Charter does state that international law and the judgments of domestic, foreign and international courts and tribunals relevant to a human right may be considered for the purpose of interpretation. The procedural obligations identified by international and foreign courts may be considered a good practice benchmark through which to assess the integrity and effectiveness of these investigations.\(^{37}\)

**System challenges**

Three other issues are worth noting about the current investigative model. These issues are discussed as disadvantages but represent challenges to current arguments in support of police investigating police. The first relates to the use of police investigators.

**Police investigators**

While police investigators undoubtedly bring specialised training and contemporary experience to the investigative field, this does not mean investigations of deaths associated with police contact cannot be undertaken by non-police investigators or a non-police agency. There are several examples of organisations that use specialist investigators. For example, insurance companies engage appropriately skilled investigators for fraud matters, worksafe authorities engage scientific investigators to look at deaths in the workplace, and medical examiners engage specialist practitioners to investigate deaths in hospitals. Not all of these people have policing backgrounds.

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\(^{37}\) In its submission to the OPI review, the Victorian Equal Opportunity and Human Rights Commission recommends that an assessment of whether Victoria Police has fulfilled its obligations under section 38(1) of the Charter should also be undertaken in relation to deaths associated with Victoria Police contact.
At the OPI forum, the Independent Police Complaints Commission (UK) described its program for training non-police investigators. It noted that a three month training program, followed by in-house mentoring with specialist investigators, meant that non-police investigators could adequately perform their role. Other overseas oversight and integrity agencies – such as the Police Ombudsman for Northern Ireland and Special Investigation Unit in Ontario – also use civilian investigators for police-related matters including deaths associated with police contact.

The point to be made here is that the investigation of deaths associated with police contact need not be the exclusive domain of police services. Other agencies or investigators could be trained and resourced to undertake such investigations. The questions to be considered are: whether they can be adequately trained and equipped to undertake them effectively. Is this an effective use of public resources? And is this sustainable?

**Purpose of investigation**

The second challenge to police investigating police concerns the nature of the issues under investigation. As noted earlier, investigations of deaths associated with police contact are multifaceted. They involve a coronial inquiry. They may involve disciplinary issues. They may involve consideration of police procedures and practice. The expertise of police investigators clearly lies in criminal investigations. Deaths associated with police contact, however, are as much an investigation into use of force or duty of care or adherence to Victoria Police policy or process. To this end, the Homicide Squad or Major Collision Investigation Group may not be the most appropriate unit to lead an examination of these issues.

Within Victoria Police, matters concerning the conduct or behaviour of police are generally investigated or managed by the Ethical Standards Department – and in some cases OPI. Within Victoria Police, the Ethical Standards Department is responsible for issues related to professional standards and integrity. This is not to say the Homicide Squad or Major Collision should not be conducting these investigations, but it does identify a weakness in the rationale for investigations of police-related deaths to be undertaken solely by these units.

**Support for affected families**

The third challenge relates to the support provided to families of the deceased. As acknowledged at OPI’s forum, it may be difficult for families of the deceased to accept 1) welfare support from the organisation involved in a police-related death or 2) assurances from them that their investigation will be vigorous and impartial. As put to OPI, ‘at the end of the day you have disgruntled families that don’t trust the police’. 

... it may be difficult for families ... to accept welfare support from the organisation involved in a police-related death
In addition, some people have reported being unhappy with the quality of the support provided. Some concerns expressed by families affected by police-related deaths were summarised in a submission to OPI’s review. It included:

- Lack of caring and civil communication about the death with families;
- The criminalisation of the deceased through the police investigation;
- Lack of family involvement in the scope and direction of the initial investigation;
- Focus on negative rather than positive aspects of the deceased’s history without any attention to the histories of the police members associated with the death;
- Hostile and aggressive initial treatment of grief-struck and shocked family members;
- Failure to provide the family with access to welfare assistance, counselling or explanation during the investigation;
- Failure to enable and facilitate an independent autopsy for the family or provide a written document of rights around the autopsy;
- Police publicly supporting the actions of the members associated with the death before the outcome of the inquest; and
- Police providing information to the media that is critical of the deceased.\footnote{Flemington and Kensington Community Legal Centre (2010), submission to OPI review (endorsed by the Darebin Community Legal Centre).}

Similar comments were made by other families in their submissions to the review.

The adverse feelings towards police by affected families and third parties may not stem solely from the police-related death. Rather, families may have experienced years of difficult or frustrating interaction with police and other State services. Whatever the source of these feelings, it does make it difficult for families and affected third parties to be involved in or have confidence in the integrity and accountability of an investigative process managed by people they may not trust.
Research and consultations

This section summarises the predominant models used in overseas jurisdictions for investigating deaths associated with police contact. It also sets out some of the views and opinions expressed in the public submissions to the review and at OPI's forum. This will help inform suggested options for enhancing the current investigative processes and overall framework for investigating police-related deaths in Victoria.

Research on other investigative models

**Australian States and Territories**

Most Australian States and Territories use similar investigative and oversight models to examine deaths associated with police contact. Generally, State and Territory police services are responsible for conducting the investigation into a police-related death, with the level of oversight by integrity agencies determined on a case-by-case basis. Most Australian oversight agencies also have the jurisdiction, in certain circumstances, to conduct an investigation into a police-related death but not to the exclusion of the police service involved. While oversight agencies generally lack the resources to conduct these investigations, it is also not the primary responsibility of oversight or integrity agencies to conduct investigations of deaths associated with police contact.

The exception to the dominant investigative and oversight model in Australia is Queensland. Recently, the Crime and Misconduct Commission announced it would take over responsibility for investigations of deaths in custody from the Queensland Police Service. This follows the State Coroner's findings in the *Inquest into the death of Mulrunji* (May 2010) which was critical of the Queensland Police Service investigation and its review. The Queensland State Coroner is currently developing a new investigative and oversight model in consultation with the Crime and Misconduct Commission and the Queensland Police Service. OPI will monitor the progress of this initiative.

**International jurisdictions**

While most Australian oversight agencies were established against a background of police misconduct and corruption, in overseas jurisdictions such as England, Northern Ireland, South Africa and Ontario, investigative oversight agencies have been established against a background of racial, religious or ethnic violence, and concern about the treatment of minority communities. As such, the investigative focus of these agencies tends to be on police-related deaths and serious assaults, not just corruption.
There are five predominant models used in overseas jurisdictions for investigating deaths associated with police contact. These include:

- investigation by another police service;
- hybrid civilian/police model;
- civilian managed investigation;
- embedded civilian observer; and
- independent model.

Each of these models is briefly discussed below.\textsuperscript{39}

**Investigation by another police service**

In parts of Canada, such as Quebec, British Columbia and Nova Scotia, police-related deaths are investigated by another police service. For example, the provincial police service in Quebec investigates shootings by municipal police services. In British Columbia, a municipal police service will be responsible for investigating a police-related death involving another municipal police service, and in Nova Scotia a special integrated unit – including members from the Royal Canadian Mounted Police and the Halifax Regional Police – is responsible for investigating police-related deaths. In short, the police service responsible for investigating the death is not the police service of the member involved in the shooting. In Quebec and British Columbia, this model also includes oversight by a civilian agency.

The use of police officers from another police services allows ‘for a perception of independence and objectivity of the investigation and [minimises] the negative effects of internal loyalty and solidarity’.\textsuperscript{40} As fellow police officers, investigators are considered to have a good understanding and awareness of policing culture, command the respect of the police service and officers under investigation, and are skilled and experienced investigators.

The use of an external police service to investigate police-related deaths has received some criticism similar to that levelled at internal police investigations. For example, with reference to complaint investigations, the Commission for Public Complaints Against the Royal Canadian Mounted Police noted ‘there is little evidence that external police officers do actually obtain higher levels of police cooperation from other police to justify their involvement, and without public oversight external investigations of this nature often

\textsuperscript{39} Much of the information used in this section has been sourced from the Commission for Public Complaints Against the Royal Canadian Mounted Police (2009) report, Police Investigating Police, which included a review of models. The report is available at http://www.cpc-cpp.gc.ca/prt/inv/police/index-eng.aspx

\textsuperscript{40} Commission for Public Complaints Against the Royal Canadian Mounted Police (2009), Police Investigating Police, p 78.
produce similar findings to an internal investigation and result in a low level of substantiated complaints.\(^{41}\)

**Hybrid civilian/police model**

The province of Alberta in Canada uses a hybrid civilian/police model to investigate police-related deaths. Called the Alberta Serious Incident Response Team (the Response Team) it was established in January 2008 and is led by a civilian director.\(^{42}\) The Response Team employs a combination of civilian investigators and police investigators seconded from the Royal Canadian Mounted Police and Calgary and Edmonton municipal police services. This mix of civilian and police investigators is designed to ensure seconded police officers do not investigate members of their own police service. The role of the Response Team is to investigate cases of deaths and serious injuries referred by the Solicitor General. It does not take or manage complaints directly from the public.

The Director of the Response Team maintains that the hybrid civilian/police model marries the advantages of police experience and resources with independence.\(^{43}\) Seconded police officers are considered to have investigative experience, understand police culture and attract greater respect and cooperation from police members. Disadvantages of the hybrid model include the potential dilution of civilian culture which may follow the introduction of seconded police officers, and the sympathy seconded officers may have for fellow officers. In addition, it may be difficult to attract suitably-experienced police investigators to a civilian-controlled agency.

**Civilian-managed investigation**

The Independent Police Complaints Commission (IPCC) in England and Wales has the option to manage an investigation into a police-related death.\(^{44}\) Under this model, the IPCC can direct and control the investigation, which is undertaken by the police service involved in the incident.

With managed investigations, the IPCC is responsible for setting the terms of reference for the investigation in consultation with the police service. The police service nominates the officer who will conduct the investigation, which is approved by an IPCC Commissioner. An IPCC Regional Director or Investigator then manages the investigation and receives regular progress reports. He or she also works closely with the police service, particularly

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44 The IPCC has four ‘modes of investigation’ available for dealing with serious complaints and allegations of misconduct against the police in England and Wales. These include independent, managed, supervised and local investigations. See http://www.ipcc.gov.uk/index/about_ipcc/investigations.htm and http://www.ipcc.gov.uk/cy/mou.pdf
in the early stages, to ensure the investigation is carried out in accordance with IPCC direction.

The IPCC uses managed investigations to investigate those police-related deaths that are of ‘such significance and probable public concern’ that the investigation needs IPCC direction and control but not an independent investigation. The advantages of civilian-managed investigations include the involvement of police in the investigation (bringing experience and expertise), and the involvement of a civilian manager (bringing objectivity and impartiality to the investigative process).

A disadvantage, however, is that civilian management may be too remote to ensure the integrity of the investigation. For example, civilian management may not necessarily ensure that all witnesses were identified and interviewed and that all pertinent questions were asked. The model therefore carries with it the risk of the oversight body carrying all the responsibility for the investigation, without necessarily being well-placed to ensure its integrity.

The Commission for Public Complaints Against the Royal Canadian Mounted Police recently recommended that a new review body be set up in Canada for investigating police-related incidents involving death and serious injury. Under this proposed model, the new review body would have legislative authority to:

- refer an RCMP member investigation to another police service or to another criminal investigative body in Canada;
- monitor any criminal investigation relating to a member of the RCMP; and
- undertake joint investigations.

Embedded in the proposed model are a range of structural and procedural changes which require the level of investigative and oversight response to be determined by the seriousness of the incident. The Commission acknowledges that ‘the [Commission’s] recommended option underlines the importance of police in the process (as part of the solution) while also recognising that an enhanced degree of civilian engagement in the criminal investigation process is fundamental to ensure its impartiality and integrity.’

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45 Commission for Public Complaints Against the Royal Canadian Mounted Police (2009), Police Investigating Police, p 96. The Commission has advised that a bill is currently before the Canadian House of Commons. If enacted, the legislation will replace the Commission with a new independent civilian and complaints review body to manage these investigations.
**Embedded civilian observer**

Embedded civilian observer models are used in some jurisdictions in Canada where a person is employed to oversee and assess the impartiality of police investigations. The Commission for Public Complaints recommended a civilian observer model be used for all Royal Canadian Mounted Police-related deaths – which are investigated by another police service – following a pilot program in British Columbia.46

Civilian observers are engaged at the discretion of the Commission and can attend – under certain circumstances – the scene of an incident, certain meetings and be briefed by the Office of Investigative Standards and Practices. The Commission maintains it is crucial for the observer to be present as early as possible to ensure the impartiality of the investigation.

> ’It is essential for the Observer to be present when the Team Commander is making his/her selections of team members, a stage in the process when the question of impartiality is critical [this is facilitated by the use of an ’impartiality questionnaire’]. Similarly, it is important for the Observer to be present at the first team briefing, where the known facts of the case and the investigative approach are laid out, and where tasks are assigned.’47

The Los Angeles Police Department also uses a civilian observer (the Inspector General) in its internal investigations of police shootings. Under this model, the Inspector General is responsible for monitoring and reporting on the investigation to the Board of Police Commissioners, which is the head of the Los Angeles Police Department. It is the responsibility of the Board of Commissioners to make determinations about whether police shootings are in line with departmental policy.48

While the rationale for using a civilian observer is to improve confidence and strengthen the integrity of the investigative process, this model does not remove or address the issues associated with police conducting the investigation, which is the key concern of some community and legal groups, and members of the public.

**Independent model**

The independent model involves an agency separate to the police carrying out the investigation of a death associated with police contact. Agencies conducting independent investigations of police-related deaths include the Special Investigations Unit in Ontario, the Police Ombudsman for Northern Ireland, the Garda Ombudsman in the Republic of Ireland, the Independent Complaints Directorate in South Africa, the Independent Police Review Authority in Chicago, the Independent Police Conduct Authority in New Zealand, and the IPCC in England and Wales.

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46 Commission for Public Complaints Against the Royal Canadian Mounted Police (2009), Police Investigating Police, p 100.


48 Los Angeles Police Department website: http://www.lapdonline.org/police_commission/content_basic_view/900
With the exception of the Special Investigations Unit in Ontario, all of these agencies also have one or more other functions or responsibilities. For example, to investigate or oversee investigations of a range of other matters such as serious assaults, allegations of misconduct and corruption, other serious criminal offences, public complaints and use of force issues.

While independent agencies are institutionally separate from the police service under investigation, those agencies operating under this model differ in their level of ‘independence’ from police. For example, independent agencies may employ current or seconded police officers or ex-police officers, in addition to civilian investigators who have never worked for a police service. Some independent agencies may also rely on the police service for some aspects of the investigation, such as securing the incident scene of a police-related death until the independent agency arrives on the scene or the investigation is handed over to it, and some forensic or specialist services.

Assuming the separate agency is properly resourced, the key advantage of the independent model is it provides maximum assurance to interested parties and the public that the investigation will be objective, impartial and rigorous.

Some disadvantages with the independent model include:

- tension between using current and former police officers (who have the advantages of contacts, contemporary investigative experience and an understanding of the organisational culture) and civilian investigators who are independent of any police influence but can be expensive to train and may lack the contacts, experience and respect former police officers enjoy;

- agencies that rely heavily upon former police officers may attract criticism as they may not be considered impartial;49

- the cost involved in either establishing a stand-alone agency or making investigations of police-related deaths part of an existing oversight agency’s core business;

- police members may not have any confidence in or cooperate with a system perceived to be staffed by inexperienced civilian investigators or people who lack understanding or appreciation of police culture; and

- agencies may lose the confidence of police services, the legal fraternity and wider community if it cannot attract and retain competent investigators or undertake investigations competently.

An additional risk identified for independent agencies with other functions is that the work of the organisation may become dominated by investigations of police-related deaths, leaving fewer resources to be spent on other responsibilities, such as investigating allegations of police corruption and misconduct.

49 Hopkins, T (2009), An effective system for investigating complaints against police, Victoria Law Foundation.
It is recognised that the potential use, either fully or in part, of overseas models in Victoria has attracted some criticism, particularly given differences in history, population, geography and existing legislative provisions in this State. Nonetheless, it is important to consider what is in place elsewhere – the strengths and challenges of other models – as part of a thorough review of the current processes and framework for investigating deaths associated with police contact in Victoria. More detailed analyses of these models will be presented in the final report of this review.

Public submissions

On 5 June 2010, OPI called for public submissions from interested parties wanting to share their knowledge, experience or opinions regarding deaths associated with police contact. In total, 15 submissions were received, addressing some or all of the terms of reference.50

There were three main perspectives from which submissions to the review were written: family members directly affected by a police-related death; community legal groups who support and represent people affected by police-related deaths; and police and oversight practitioners who have experience in these investigations.

The public submissions reinforce the view that people affected by police-related deaths – including family members and police officers – experience the negative effects of these incidents long after a police investigation or a coronial inquest has concluded, particularly if they felt aggrieved by the investigative process. In one submission, a family member describes the ‘disappointment and [sadness]’ at hearing that ‘nothing appears to have been learnt’ in this area in the 80 years since a relative died in police custody. The author states that the incident is still ‘distressing for family members’.51

Similarly, a member of police described their negative experience of being the subject of an investigation following a death associated with police contact. Contrary to views that police prefer police-led investigations, this person called for an independent agency to take over investigations into these matters to allow for the better treatment of police. The police member recalls how they were ‘treated like a criminal’ ‘not afforded any rights’ and ‘made to feel totally responsible’ and ‘guilty’ for the death, describing the incident as having a ‘serious impact’ on all parts of their life.52

Naturally, all submissions to the review suggested changes – minor and major – to the current investigative process and model. While there was some consistency in what these changes should be, there were also differences in the views and opinions provided on the terms of reference.

50 Two submissions are confidential at the request of the authors and are not referred to in this issues paper.
51 Mrs Kelly McGrath (2010), submission to OPI review.
52 Name withheld by author (2010), submission to OPI review.
Some of the consistent themes emerging from the public submissions include that:

- the definition of a police-related death should include at the very least any death arising from police action (for example police shooting, police pursuit, or any other use of force), police inaction (for example failing to do something to control a situation or protect a person) and deaths in custody (for example deaths in police cells, police vans or while police are making an arrest).

- police officers involved in police-related deaths should be treated no differently from members of the public involved in a criminal investigation. This includes how police are managed as suspects and witnesses, how statements are taken and recorded by police investigators, and the legal defences and rights available to police.

- investigations of police-related deaths should be consistent with the five principles identified by the European Court of Human Rights as necessary for an effective investigation. In other words, that investigations be independent, adequate, prompt, involve next-of-kin, and be open to public scrutiny.

On the other hand, differences of opinion were apparent on three key issues, including:

- which organisation should conduct investigations of deaths associated with police contact – Victoria Police or a separate agency? Some have suggested that the current system is essentially the ‘best’ but could be enhanced with stronger oversight and/or some procedural changes. Others, however, have called for a new independent framework, given that changes to policies and processes won’t address current concerns about conflict of interest. To this end, there have been calls for a new body to be established in Victoria to conduct these investigations, for OPI to be empowered and resourced to take over these investigations, and for a Federal Independent Investigation Commission to be established with capacity to act immediately in all States and Territories;

- the type of investigators to be used in these matters. While some submissions supported the use of experienced specialist police investigators, other submissions suggested that any investigative body be partially- or fully-civilianised, that staff include people from non-policing backgrounds, and that the body not include seconded police officers; and

- whether some deaths should be classified as police-related at all – for example those occurring in police presence or in the vicinity of police operations (for example in cases where police are not involved or engaged with the person) and those following police contact (for example where a person is not in custody, care or control of police). These cases tend to question the inclusion of deaths that are not or do not seem to be proximate to police in either place or time.

Specific recommendations made in the public submissions about current policy, processes and the overall model for conducting investigations of police-related deaths will be considered in OPI’s final report.
OPI forum

OPI held a forum on investigations of deaths associated with police contact on 29 and 30 July 2010. The forum brought together representatives from more than 20 agencies, including police services, oversight agencies, coroners’ offices, and community and legal groups within Australia and overseas.

The aim of the forum was to discuss some of the issues set out in the terms of reference and to learn more about the experiences and respective models used in national and international jurisdictions.

Presentations delivered at the forum included those from:

- the Independent Commission for Police Complaints (United Kingdom);
- the Commission for Public Complaints Against the Royal Canadian Mounted Police;
- Dr Graham Smith, consultant to the European Commissioner for Human Rights; and
- the Queensland State Coroner.

It was the first time a national forum had been convened with the range of stakeholders and parties involved in the investigation and oversight of police-related deaths.

Forum discussions relating to defining deaths associated with police contact have already been referred to throughout this paper. In relation to participants’ views on the current framework, there was consensus on the main challenges that need to be addressed. These include:

- maintaining public confidence in the integrity of investigations;
- improving treatment and support for people affected (families and police officers) by police-related deaths;
- ensuring that police rights are preserved;
- reducing the risk of police collaborating on statements;
- accurately capturing data and reporting on police-related deaths; and
- determining who should investigate these incidents.
One of the key outcomes of the forum was the identification of principles to underpin an investigation framework. There was agreement by forum participants that any investigative or oversight model should be characterised by the following 10 principles: 53

1. Rigour: ensuring efficiency and effectiveness in the process, and that agencies are adequately resourced to achieve their goals.

2. Impartiality: those charged with investigating and overseeing a matter are able to carry out their duties objectively and without sympathy or prejudice.

3. Independence: those involved in investigation and oversight are sufficiently uninvolved with those subject of an investigation.

4. Integrity: the public has confidence in the process and its outcomes.

5. Accountability: the process and its outcomes are transparent and open to public scrutiny. It is important to ensure that appropriate action is taken for any wrongs identified.

6. Expertise/competence/professionalism: the best-equipped people are responsible for carrying out investigations and oversight.

7. Systemic perspective: any conduct, policy, procedural or training issues are able to be identified and for learning and prevention to be incorporated into the goals of the model.

8. Promptness/timeliness: that any investigation is carried out in a reasonable time period.

9. Inclusion of affected people: that families and police be adequately and properly included in the investigative process and that sufficient welfare and legal support is provided where needed.

10. Proportionality: that the investigative and oversight response reflects the nature and circumstances of the police-related death.

The outcomes of the OPI forum have provided an important and useful platform for continuing collaborative work in this area. A number of short- and long-term goals were identified by attendees to help focus these efforts. These included:

- OPI and Victoria Police will formalise a framework for the investigation and oversight of deaths associated with police contact;
- improving effective communication with next-of-kin;
- informing the general public about oversight and investigative processes;

53 Other principles identified by attendees included leadership; investigative, oversight and policy framework; and clarity of purpose and focus of an investigation.
• addressing the police media response to police-related deaths – for example the tendency to voice support for police officers by exonerating them immediately;

• strengthening OPI’s active oversight and if necessary seeking further resources;

• improving access for affected persons to independent and continuous support, and legal representation;

• improving the timeliness of coronial inquests, and if necessary seeking further resources;

• introducing national training standards for investigators;

• establishing benchmarks for evaluating or assessing the integrity of investigations;

• regular public reporting on police-related deaths and ‘near miss’ or serious injury incidents;

• maintaining, at least in the short-term, responsibility for investigations of police-related deaths with the Homicide Squad and Major Collision Investigation Group; and

• applying learnings from investigations of police-related deaths.

Progress on these goals is discussed in the next section of this paper.
Current work

Since OPI commenced its review in November 2009, OPI and Victoria Police have progressed work aimed at improving the current investigative and oversight framework for investigating deaths associated with police contact.

Following discussions at the forum, OPI has developed interim guidelines, *OPI’s Response Protocol*, for tightening OPI’s oversight response to these matters. The response protocol outlines the steps to be taken once Victoria Police, or any other source, has informed OPI of a death associated with police contact. This includes criteria for determining OPI’s level of response, internal and external people to be advised of the incident, and what internal processes need to be initiated to manage the case. The interim guidelines formalise the current process used by OPI and will be used as the basis for ongoing work in this area.

Victoria Police

Victoria Police has advised it has commenced its own review of current policies and procedures, including the formalisation of principles to help guide the management and oversight of investigations into police-related deaths. Shortly after the OPI forum, Victoria Police convened a workshop to discuss some of the principles arising from the forum discussions and how they can be more readily incorporated into the investigative and oversight process. It should be acknowledged that there was consensus at the workshop that many of the principles already underpin Victoria Police practice. The main issue is that the existence and importance of these principles needs to be reinforced and communicated to staff. To this extent, much of the work relating to investigative principles involves the promotion of principles and educating police.

New organisational documents on the guiding principles, management of critical incidents, and the oversight response of Victoria Police have been or are in the process of being developed. Victoria Police should be commended for its commitment to pursuing best practice in these areas. OPI will continue to have input into and monitor the work of Victoria Police to ensure consistency between the two organisations and that it meets the necessary integrity standards required of investigations of deaths associated with police contact.

OPI will continue to have input into and monitor the work of Victoria Police…
Next steps

This paper has been prepared to provide an overview of OPI’s progress to date, including the issues raised during the review and some of the preliminary thinking on what needs to be considered to move forward. During the coming months, OPI will continue its consultations with relevant stakeholders – such as Victoria Police, the State Coroner and community and legal groups – on a range of suggested options for enhancing the current system.

OPI will coordinate a series of working groups to progress many of the short- and long-term goals identified at the forum. These working groups will bring together the key stakeholders from relevant areas to develop more specific action plans for addressing issues identified as part of this review. For example, community and legal groups will be engaged to progress issues around supporting individuals affected by police-related deaths, Victoria Police will be engaged to progress issues around their media response to these incidents, and the Coroner’s Office will be engaged to discuss issues associated with resourcing and timeliness of investigations and inquests. While it is envisaged these working groups will be long-term initiatives, early deliberations and any outcomes will be presented in the final report to this review.

In terms of project milestones, OPI is on track to:

• complete its investigation file review aimed at assessing the integrity of Victoria Police investigations and identifying any issues for policy or procedural attention;

• finalise the data analysis of police-related deaths in Victoria, including the type and characteristics of these deaths; and

• consolidate the findings and any recommendations to be made from this review.

It is envisaged that any options for improving the current investigative and oversight framework will be grouped into two categories:

1) options for strengthening the integrity of current policies and procedures (short-term options); and

2) options for strengthening the integrity of the overall framework (long-term options).

These options will be set out by OPI in its final report, which is expected to be tabled in the Victorian Parliament in 2011.


Appendix One

Terms of Reference

Investigations of Deaths Associated with Police Contact

Objective

To produce a report to Parliament that considers:

1. The sufficiency and appropriateness of Victoria Police policies and procedures and relevant legislative frameworks for conducting investigations into deaths associated with police contact.

2. Options to existing law and practice regulating the conduct of such investigations.

Background

In late 2009, the Director, Police Integrity commissioned research into the appropriateness of Victoria Police investigating deaths associated with police contact. Part of the rationale for the research was to address concerns about conflict of interest – perceived or real – that come with police investigating their own officers and to consider the impact of the Victorian Charter of Human Rights and Responsibilities Act 2008.

Scope

In considering the sufficiency and appropriateness of Victoria Police policies and procedures for investigating deaths associated with police contact, the focus of the report will be:

1. Public perception: what are the concerns or issues associated with police investigating police that are involved in deaths associated with police contact?

2. Definition of deaths associated with police contact: what type of deaths should be considered “police-related” and investigated accordingly?

3. Current Victoria Police policy and process: what are the strengths and weaknesses of the current process used by Victoria Police? What is the reality of the policy in practice?

4. Investigative responsibility: who should conduct investigations into police-related deaths?
5. Management of police officers involved in the incident: how should police be managed in these cases – for example as witnesses or suspects? Should they be cautioned? How should police statements be recorded? Should police be treated the same as members of the public involved in a criminal investigation?

6. Level of internal and external oversight: what should the respective roles and responsibilities of internal and external oversight units be?

7. Human rights and independence: what satisfies the obligations under the Victorian Charter of Human Rights and Responsibilities? What constitutes an ‘independent and effective’ investigation into police-related deaths? Does this mean a separate organisation should conduct the investigation or can independence and effectiveness be realised by other means?

8. The relationship between Victoria Police and the State Coroner: what is the reality of the relationship between the investigative unit and the State Coroner in police-related deaths? Who is ultimately responsible for the investigation and what are the respective roles and authority of police and the State Coroner? What could/should OPI’s role be?

9. Other models for investigating police-related deaths: what type of models are used in other jurisdictions – interstate and overseas?

10. Options for improving the current system in Victoria: how can the current system in Victoria be improved?
Appendix Two

Submissions to review

1. Peter Komiazyk
2. Eclectic Consumers Collective
3. Kelly McGrath
4. Name withheld by author
5. Confidential submission
6. Charlie Bezzina
7. Darebin Community Legal Centre
8. Human Rights Law Resource Centre
9. Robyn James
10. Robert Lecek and Ms Lillian Trewick
11. David and Margrit Kaufmann
12. Flemington and Kensington Community Legal Centres
   (on behalf of the families of Tyler Cassidy and Graeme Jensen)
13. Victorian Equal Opportunity and Human Rights Commission
14. Confidential submission
15. Police Integrity Commission, New South Wales
Appendix Three

OPI forum participants, 29 and 30 July 2010

Australian Human Rights
Commission

Commission for Public Complaints
Against the Royal Canadian Mounted
Police (presentation via video link)

Commonwealth Ombudsman

Coronial Advisory Council, Victoria

Corruption and Crime Commission,
Western Australia

Crime and Misconduct Commission,
Queensland

Department of Justice, Victoria

Dr Graham Smith (presentation via
video link)

Dr Ian Freckelton SC

Federation of Community Legal
Centres

Independent Police Conduct
Authority (NZ)

Independent Police Complaints
Commission, (UK)

Mental Illness Fellowship Victoria

Northern Territory Ombudsman

Police Complaints Authority, South
Australia

Professor Andrew Goldsmith

South Australia Police

Tasmanian Integrity Commission

The Police Association – Victoria

Queensland State Coroner

Victorian Equal Opportunity and
Human Rights Commission

Victoria Police

Victorian State Coroner