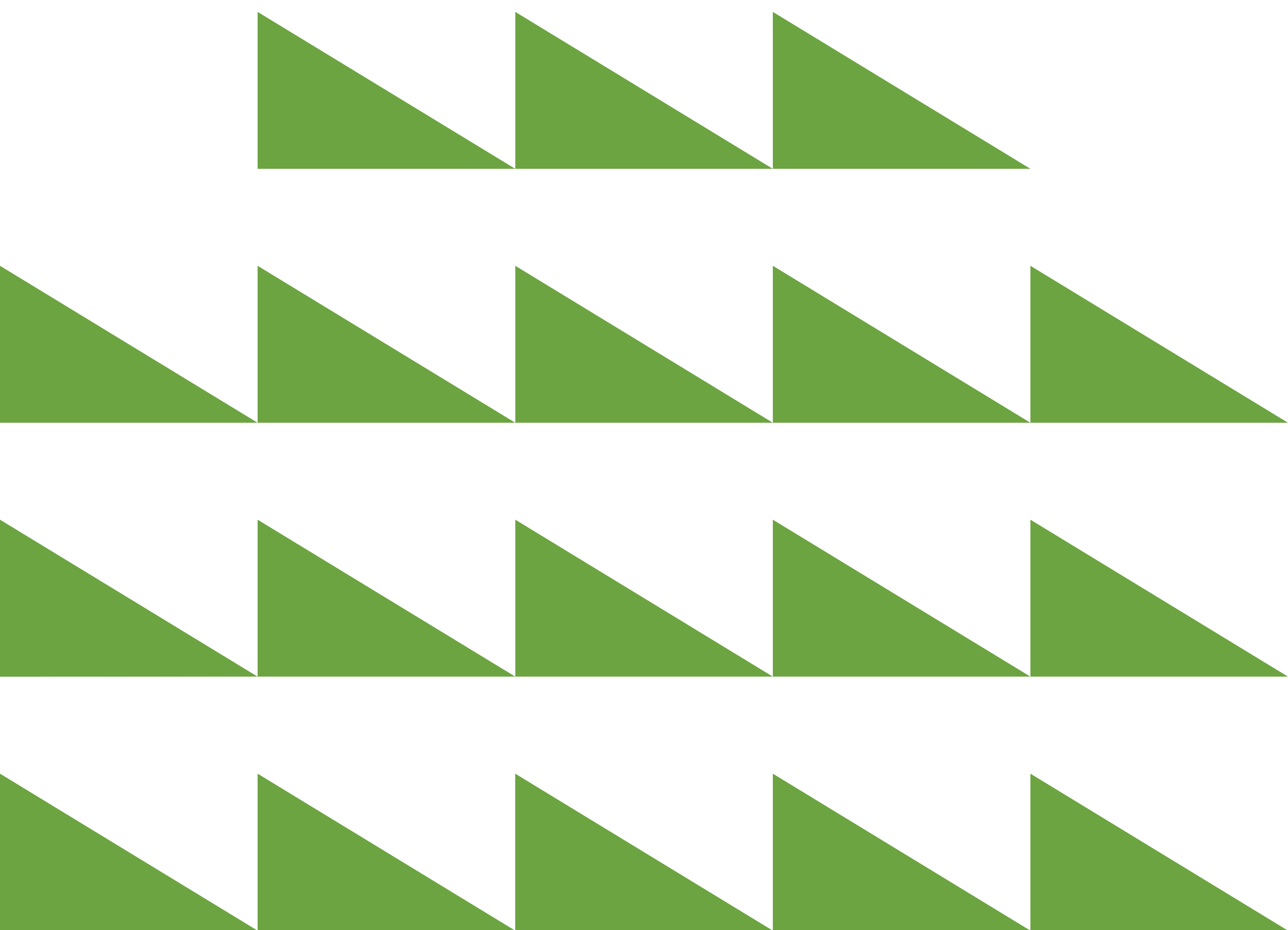
independent broad-based anti-corruption commission

Victoria

Audit of Victoria Police's oversight of serious incidents

March 2018



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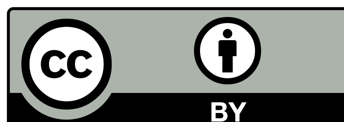

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Definitions

	Explanation
CCTV	Closed-circuit television
CCC Qld	Corruption and Crime Commission Queensland
CCC WA	Corruption and Crime Commission Western Australia
CIRT	Critical Incident Response Team
CMS	IBAC's case management system
EPSO	Ethics and Professional Standards Officer
IMG	Integrity Management Guide
IMP	Integrity Management Program
LAC	Local Area Commander
LEAP	Law enforcement assistance program (a Victoria Police database)
LECC	Law Enforcement Conduct Commission
LMR	Local management resolution
MIM	Management intervention model
OPI	Former Office of Police Integrity
ORC	Oversight Review Committee
Oversights	Victoria Police initiates an oversight process following a death or serious injury resulting from contact between police and the public (and in response to some other incidents). The purpose of these oversights is to identify any issues in practices or standards that contributed to the incident, and any improvements to systems and practices that might prevent similar incidents in the future.
PCU	Police Conduct Unit
PDA	Professional development and assessment plan
PSA	Police service area
PSC	Professional Standards Command
PSO	Protective services officer
Reviews	Distinct from IBAC's audit of oversight files, IBAC's Assessment and Review area conducts reviews of selected Victoria Police oversight files. These reviews examine individual oversights at the conclusion of Victoria Police's oversight process to ensure they are fair and thorough.
ROCSID	Register of Complaints, Serious Incidents and Discipline (a Victoria Police database)
RPC	Road Policing Command
SOG	Special Operations Group
SOP	Standard operating procedure
VEOHRC	Victorian Equal Opportunity and Human Rights Commission

Acronym	Explanation
VPM	Victoria Police manual
VPMG	Victoria Police manual guideline
VPMP	Victoria Police manual policy

1 Overview

To determine how effectively Victoria Police oversights serious incidents involving its officers, the Independent Broad-based Anti-corruption Commission (IBAC) audited more than 140 oversight files closed by Victoria Police during the 2015/16 financial year. The audit examined Victoria Police's oversight of serious incidents resulting in death and serious injury following police contact. The audit identified that there are aspects of Victoria Police's oversight process that are concerning and which could be improved.

When a person dies or is seriously injured following an interaction with police, Victoria Police conducts an oversight of the incident and any subsequent investigation. Victoria Police's oversight process seeks to identify whether the serious incident was preventable or whether improvements could be made to police policies or practices to prevent similar incidents from occurring. Victoria Police also examines whether the investigation of the death or serious injury met the standards expected for handling serious incidents.[1]

Victoria Police conducts an oversight in response to the following serious incidents[2]:

- a death or serious injury resulting from contact between police and the public
- a death or serious injury to a person in police custody
- an attempted suicide by a person in police custody
- an incident involving the discharge of a firearm by police
- an escape from custody
- any serious vehicle collision involving police.[3]

This report presents the findings of IBAC's audit of Victoria Police oversight files (known as C1-8 files). The audit assessed whether Victoria Police's oversights were thorough and impartial and met the standards required of such reviews. IBAC also examined relevant Victoria Police policies, conducted data analysis, and reviewed case studies. IBAC has made recommendations for Victoria Police to improve its oversight of serious incidents which Victoria Police has accepted. IBAC will monitor how Victoria Police implements these recommendations.

The audit is part of an ongoing program of audits that IBAC conducts on how Victoria Police handles complaints. These audits help Victoria Police build capacity to prevent corrupt conduct and police misconduct by identifying areas of improvement around complaint handling. IBAC's audits also identify good practice that could be considered more broadly by Victoria Police. In doing so, audits help build public confidence in the integrity of Victoria Police's processes and in IBAC's independent police oversight role.

[1] Victoria Police Oversight File Guide, 2013.

[2] For the purposes of this audit, the term 'serious incident' is used to collectively refer to incidents that are overseen through Victoria Police's C1-8 file process. This includes what Victoria Police refers to as 'death or serious injury incidents' – which some other police organisations refer to as 'critical incidents' – as well as other incidents requiring C1-8 oversight, such as escapes from custody.

[3] Victoria Police's Integrity Management Guide, April 2016, p 60.

1.1 Key findings

The audit identified areas of concern with how Victoria Police oversighted some serious incidents.

IBAC found:

- Conflicts of interests associated with Victoria Police's oversight of serious incidents were generally poorly identified and managed. Thirty-two per cent of the files audited did not include the mandatory conflict of interest form. Where conflict of interest forms were on file, there were significant shortcomings in how these forms were completed and how conflicts were managed. The poor management of conflict of interest erodes confidence in the integrity of the oversight process.
- More than half of the oversights conducted by Victoria Police failed to consider evidence that should have been included. The audit found there was an over-reliance on police statements in relation to serious incidents. Many oversights failed to include statements from independent witnesses that could assist in verifying police versions or critically examine police statements against other evidence such as CCTV.
- There was inadequate supervision of almost a third of oversights, including instances where supervisors did not remedy significant shortcomings in the oversight. Of particular concern was poor or inadequate supervision provided by the Ethics and Professional Standards Officers (EPSOs). EPSOs are inspectors assigned to each region, department and command to provide guidance around oversights and complaints.
- There were inconsistencies in the reclassification of oversight files when issues with the performance of officers were identified. Twelve per cent of files were reclassified by Victoria Police because performance issues were identified. However, IBAC found similar performance issues were identified in a further five per cent of files that were not reclassified. This limited how those performance issues could be recorded and addressed.
- There were significant limitations identified in how the outcomes of oversights were recorded in Victoria Police's complaints database (ROCSID). The audit identified that all oversights are given the same determination of 'no complaint' and 98 per cent of oversights had the same recommendation of 'no action'.[4] These determinations and recommendations did not effectively describe the outcomes of the oversight process, the range of possible improvements that were identified through oversights and the types of recommendations that were made as a result.
- Human rights is a key oversight principle. However, 61 per cent of the oversights audited by IBAC did not address human rights. Even where human rights were discussed, some oversights failed to identify relevant human rights issues, did not address rights in sufficient detail, or demonstrated a poor understanding by mischaracterising other issues as 'rights'.
- More than a third of oversights took longer than the permitted time of 90 days to complete. These delays were mostly caused by poor procedures, including slow file movements and the need to undertake further work to correct inadequate oversight. There were also significant delays with communicating the outcomes of reviews to officers, with 19 per cent of oversights taking more than 60 days.
- A pattern of deficiencies was identified in oversights of incidents involving the Special Operations Group (SOG). Oversights of SOG incidents were generally conducted by the SOG itself or the Critical Incident Response Team (CIRT) and were characterised by clear conflicts of interest and a lack of thorough oversight. This is particularly concerning given the serious nature of the incidents that require SOG involvement.
- While Victoria Police notified IBAC of the majority of serious incidents that were examined by this audit, there was no statutory requirement to do so (unless they were the subject of a complaint). In September 2017, in response to the audit, Victoria Police commenced notifying IBAC by automated email whenever an oversight file is created. This process should ensure IBAC is notified of all Victoria Police oversight files.

[4] Although some oversight files were reclassified where poor performance or misconduct is identified, the audit found that such reclassification was applied inconsis-

1.2 Recommendations

Following IBAC's audit of Victoria Police's oversight files, IBAC recommends that Victoria Police:

1. creates a standard memorandum to be sent to supervisors responsible for allocating oversights, providing clear advice that the oversighter should be independent to both the incident and investigator, and reminding these supervisors of the purpose of the oversight process
2. ensures that all oversighters complete the conflict of interest declaration at the commencement of the oversight process, that the form is included on the file, and where there is a conflict declared, the supervisor puts a plan in place to avoid any reasonable apprehension of partiality
3. examines ways to improve the supervision provided by EPSOs to ensure greater consistency in how oversights are completed, including in relation to reclassification, timeliness, record keeping and how deficiencies are addressed
4. standardises how oversight matters are reclassified to ensure consistency in cases where performance issues are identified
5. revises the determinations and recommendations that are made at the conclusion of oversights to better describe the outcomes of the oversight process[5]
6. provides oversighters with clear information and training on the Victorian Charter of Human Rights to assist in identifying human rights that have been breached
7. requires that incidents involving the SOG be overseen by Professional Standards Command (PSC).
8. works with IBAC to improve the system for notifying IBAC of all deaths and serious injuries following police contact.[6]

Victoria Police has accepted IBAC's recommendations and IBAC will monitor their implementation. IBAC has requested that Victoria Police provide an interim report on its implementation of the audit's recommendations by September 2018 and a final report by March 2019.

[5] IBAC acknowledges that Victoria Police is currently reviewing its complaint handling and discipline system as part of its response to the Victorian Equal Opportunity and Human Rights Commission's *Independent review into sex discrimination and sexual harassment, including predatory behaviour, in Victoria Police*.

[6] In September 2017, in response to the audit, Victoria Police commenced notifying IBAC by automated email whenever an oversight file is created. This process should ensure IBAC is notified of all oversight files.

1.3 Audit methodology

All Victoria Police oversight files closed during the 2015/16 financial year fell within the scope of IBAC's audit. Files that were initially classified as oversight (C1-8) files but were subsequently reclassified (for example, because performance issues were identified) were also included.

In all, this represented 156 files, of which 142 were audited. The 14 files not audited were assessed as being out of scope (for example, because a file had been reopened by Victoria Police) or were unavailable for legitimate reasons at the time the audit was conducted. IBAC audited hard copy files and, where relevant, examined information stored on Victoria Police's ROCSID complaints database. The files included oversights completed by PSC, as well as those allocated to Victoria Police regions, departments and commands.

IBAC acknowledges that in some instances oversighters may have undertaken work that was not documented on the file or on ROCSID. However, the absence of such documentation from files limits the capacity of Victoria Police supervisors and IBAC to effectively review files.

Figure 1 outlines the audited files by classification, highlighting the 19 files that were originally classified as oversight (C1-8) files but which were reclassified.

FIGURE 1: AUDITED FILES BY COMPLAINT CLASSIFICATION

Classification	Complaint type	Reason for reclassification	Number	% of total files audited[8]
C1-8	Incident investigation/oversight		123	87%
C2-1	Minor misconduct	Complaint received	1	1%
C2-5	Management intervention model (MIM)[9]	Performance issues identified	17	12%
C3-2	Misconduct connected to duty	Complaint received	1	1%
Total			142	100%

7 ROCSID (the Register of Complaints, Serious Incidents and Discipline) is Victoria Police's complaints database.

8 Note that percentages in this report are rounded to the nearest whole percentage, meaning some table columns that record percentages may not total 100 per cent while still reflecting the whole data set.

9 MIMs relate to lower level matters that may involve minor breaches of rules and procedures.

Each file was examined against an instrument[10] consisting of 108 questions covering five broad areas:

- *pre-oversight process*, including the process of classifying and allocating incidents, notifying IBAC, identifying subject officers, and identifying conflicts of interest
- *oversight process*, including contacting relevant parties, scene management and evidence
- *outcomes* of the oversight, including findings, recommendations and human rights issues
- *timeliness* of the oversight process
- *record keeping*.

1.3.1 Consultations with Victoria Police

IBAC formally advised the Chief Commissioner of Victoria Police of its intention to conduct the audit. IBAC engaged with senior officers from PSC to assist in determining the scope of the audit, and ongoing assistance has been provided by PSC to facilitate access to files within the audit's scope. The draft key findings and report were provided to Victoria Police to provide an opportunity to confirm factual accuracy.

1.3.2 Limitations

The audit examined oversights that had been completed during 2015/16. It did not examine oversights of serious incidents that may have occurred during 2015/16 (or earlier) but had not been completed by July 2016.

The auditing process was undertaken by three IBAC officers. Controls were applied to maximise consistency in the audit process, including the use of guidance notes to provide context and clarification, and weekly meetings of the audit team to discuss and resolve issues. However, it is acknowledged that the audit process relied upon the exercise of judgment by each audit officer.

Distinct from this audit of oversight files, IBAC's Assessment and Review area conducts reviews of selected Victoria Police oversight files. The reviews undertaken by Assessment and Review examine individual oversights and complaints at the conclusion of Victoria Police's oversight and investigation process to ensure they are fair and thorough. Although reviews undertaken by Assessment and Review have a different purpose and methodology to this audit, there is some consistency in the areas examined, such as highlighting conflicts of interest and timeliness issues.

IBAC also maintains an 'own motion'[11] determination into selected deaths and serious injuries associated with police contact. This 'own motion' determination supports IBAC's oversight of serious incidents and is outlined in more detail in section 2.5.

[10] A copy of the audit instrument is included as an appendix to this report.

[11] IBAC can start an 'own motion' investigation at any time, in relation to any matter that falls within its jurisdiction.

2 Victoria Police's system for oversighting serious incidents

2.1 Introduction

Victoria Police's system for oversighting serious incidents is managed by PSC. Complaints and oversight matters are assessed by PSC and classified according to their nature and seriousness. The most complex matters are retained for investigation or oversight by PSC while less complex matters are allocated to Victoria Police regions, departments or commands.

Oversight files differ from complaint files in significant ways. The purpose of complaint files is to investigate a complaint, make determinations about any allegations, and make recommendations for action (such as disciplinary or criminal action). In contrast, the purpose of oversight files is to examine an incident and determine whether policies, procedures and guidelines were adhered to, and to determine whether any action is necessary to prevent similar incidents in the future.[12]

IBAC'S ROLE REGARDING VICTORIA POLICE

IBAC plays a vital role in providing independent oversight of Victoria Police. IBAC's role includes:

- receiving complaints and notifications about corrupt conduct and police personnel conduct (including complaints received by Victoria Police and mandatorily reported to IBAC)
- assessing those complaints and notifications to determine which will be referred to Victoria Police for action, which will be dismissed, and which will be investigated by IBAC
- providing or disclosing information to the Chief Commissioner relevant to the performance of the duties and functions of Victoria Police
- reviewing investigations of selected matters referred to Victoria Police to ensure those matters were handled appropriately and fairly
- oversighting deaths and serious injuries associated with police contact pursuant to a standing 'own motion'
- conducting 'own motion' investigations about police personnel conduct or corrupt conduct
- conducting private and public examinations to assist investigations into police personnel conduct and, in the case of public examinations, exposing systemic issues, encouraging people with relevant information to come forward and to serve as a deterrent to others
- ensuring police officers have regard to the Charter of Human Rights, including through reviews and audits of Victoria Police complaint investigations
- undertaking research and other strategic initiatives, including auditing how Victoria Police handles its complaints
- informing and educating the community and Victoria Police about police misconduct and corruption, and ways it can be prevented.

[12] Victoria Police Oversight File Guide.

2.2 Legislation and policies relating to serious incident oversight

While the *Victoria Police Act 2013* provides a legislative regime in relation to complaints about police,[13] it does not provide specific guidelines in relation to oversight of serious incidents.[14]

Victoria Police's oversight process is outlined in Victoria Police's Integrity Management Guide (IMG). The IMG states that PSC will create an oversight file to examine specific incidents, including:

- deaths or serious injuries resulting from contact between police and the public
- deaths or serious injuries to a person in police custody
- attempted suicides by individuals in police custody
- incidents involving discharge of a firearm by police
- escapes from custody
- any serious vehicle collision involving police.[15]

Further details of Victoria Police's approach to oversighting serious incidents is provided by the Victoria Police Manual (VPM). The VPM is comprised of:

- policy rules which are mandatory and provide the minimum standards that employees must apply
- procedures and guidelines which support the interpretation and application of policy rules.

2.2.1 Policies relating to deaths and serious injuries involving police

Deaths and serious injuries involving police are the most serious incidents subject to oversight files and are addressed by dedicated Victoria Police manual policies (VPMP) and Victoria Police manual guidelines (VPMG). The policy addressing 'death or serious injury/illness incidents involving police' highlights that deaths or serious injuries that occur in the presence or custody of police can raise questions about Victoria Police's policies, procedures or practices, as well as the integrity of officers. To address these concerns, investigations of such incidents are subject to oversight.

In doing so, the policy makes a distinction between the investigation of the incident and the oversight of the investigation. An *investigation* of a death or serious injury may be undertaken by Victoria Police's Homicide Squad, the Major Collision Investigation Group or another squad or unit nominated by a deputy commissioner. However, the *oversight* of that investigation is undertaken by PSC or delegated by PSC to a region, command or department.

The policy addressing death or serious injury/illness incidents involving police is supported by the guidelines, which include information about initial actions that should be taken, such as drug and alcohol testing of officers involved as well as guidance around the oversight process.

[13] Part 9 of the *Victoria Police Act 2013* addresses complaints and investigations.

[14] The *Victoria Police Act 2013* includes some provisions relevant to serious incidents, but no formal system for oversighting such incidents. Relevant sections of the Act include section 59 which states that a police officer may assist a coroner in the investigation of a death or fire, and section 82 which defines a critical incident for the purposes of drug and alcohol testing.

[15] Victoria Police's Integrity Management Guide, April 2016, p 60.

Significantly, the guidelines include nine oversight principles that should be the focus of any oversight process. These principles are:

- managing conflict of interest
- accountability
- proportionality
- monitoring
- capability
- timeliness
- human rights
- organisational learning
- inclusiveness and openness with relevant parties.

2.2.2 Other policies relating to oversight

The VPM does not include provisions for the oversight of other serious incidents, such as escapes from custody or the accidental discharge of a police firearm. Nevertheless, these incidents are subject to Victoria Police's oversight process.

The guidelines on complaint management and investigations specifies that oversight (C1-8) files must be completed within 90 days. This is calculated as the period between the date of the incident and the date the investigation is completed, and any required action is approved by PSC.[16]

2.3 Role of the coroner in serious incidents

Where a death is associated with police contact, the investigation of that death may be undertaken by nominated Victoria Police officers on behalf of the coroner under the *Coroners Act 2008*. In these circumstances, PSC creates an oversight file to oversight the investigation.

[16] Victoria Police manual guidelines, Complaint management and investigations, section 6.6.

2.4 Distinction between oversights of investigations and incidents

This audit distinguished between files that oversighted *investigations* and files oversighting *incidents*. This is because oversight files relating to incidents as opposed to investigations raise different needs in terms of adequate oversight. Both types of oversight were examined by IBAC's audit.

Investigation oversights occurred where the coroner had appointed a Victoria Police officer to investigate a death following police contact. The primary purpose of the oversight in those cases was to critically examine the actions of the investigator against the oversight principles. Even though the prime focus of the oversighter in such instances was the actions of the coroner-appointed investigator, such files should have also given consideration to the incident that gave rise to the investigation to identify possible improvements in policy, procedures or equipment.

Oversight of incidents concerns files unrelated to a death (and therefore there is no investigator appointed by the coroner). These incidents include injuries associated with police contact or escapes from police custody. The focus of the oversight in such cases is on the incident itself and whether improvements could be made regarding the officers' actions, or associated policies or procedures.

2.5 Role of IBAC in serious incidents

There is no explicit statutory provision requiring IBAC to oversight serious incidents. However, section 15 of the *Independent Broad-based Anti-corruption Act 2011* (the IBAC Act) outlines IBAC's functions including assessing police personnel conduct, ensuring that the highest ethical and professional standards are maintained by police officers, and ensuring police officers have regard to the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006*. These functions provide grounds for IBAC oversight of serious incidents involving Victoria Police.

IBAC's Commissioner signed an 'own motion'[17] determination in 2013 that IBAC will review selected:

- deaths associated with police contact
- serious injury associated with police contact
- risks of death or serious injury associated with police contact
- the independence, effectiveness, timeliness and sufficiency of Victoria Police investigations into such deaths, serious injuries or risks thereof associated with police contact
- the application and effectiveness of Victoria Police systems and practices that may be relevant to deaths, serious injuries or risks thereof associated with police contact.

Pursuant to this determination, PSC would provide IBAC with notifications of oversight files relevant to IBAC's 'own motion' review. This included most (but not all) oversight files (for example, oversight files relating to escapes from police custody or police pursuits do not fall within the scope of the 'own motion' review unless they result in death or serious injury).

[17] IBAC can start an 'own motion' investigation at any time, in relation to any matter that falls within its jurisdiction.

PSC would notify IBAC of relevant incidents by copying IBAC's Director Operations via email onto PSC's 'on-call logs'. These emails are distributed several times a day and alert senior PSC officers (and IBAC's Director Operations) of significant incidents. Although these emails provided notifications of most deaths or serious injuries involving police, there were some incidents that were not included. For example, an incident that appeared to be unrelated to police contact or not involve a death or serious injury would not be circulated in an 'on-call log', even if it was later discovered to be serious. Such cases represented a gap in the process for notifying IBAC of incidents resulting in deaths or serious injuries.

As a result of this gap being highlighted by the audit, in September 2017 Victoria Police started notifying IBAC by automated email whenever an oversight file is created. This process is similar to the system by which IBAC is notified of all complaints about Victoria Police officers made to Victoria Police, and it should ensure IBAC is notified of all oversight files in a timely way.

When IBAC receives a notification regarding an oversight file, it is examined by IBAC's Assessment and Review section which determines whether to review the file. When considering whether to review an oversight matter, Assessment and Review considers whether:

- the incident involved a death directly attributable to police contact
- police have possibly failed in their duty and this has contributed to a death or serious injury
- there were possible flaws in police policy and procedures that have contributed to a death or serious injury
- use of force, reasonable or otherwise, contributed to the death or serious injury
- a review is in the public interest.

If IBAC decides to review a matter, Victoria Police is notified. Upon completion of the Victoria Police investigation and oversight, the file is then forwarded to IBAC.

2.6 Previous reviews of serious incidents in Victoria

In 2011, the (former) Office of Police Integrity (OPI)[18] undertook a review of the investigation of deaths associated with police contact.[19] The review surveyed the systems, policies, literature and data relating to deaths associated with police contact. The review examined a limited sample of Victoria Police files relating to police-related deaths.

The purpose of the OPI review was to provide evidence to support ongoing reform of processes relating to police-related deaths. To this end, the review led to changes in the guidelines used by OPI and Victoria Police when responding to deaths associated with police contact.

In 2016, Victoria Police reviewed its policy on death and serious injury/illness incidents involving police to provide greater clarity and awareness about the role of the oversighter. A focus of this review was clarifying the roles of coronial-appointed investigators and oversighters following a death involving police contact. Based on this review, PSC has advised IBAC it is developing changes to policies including clarifying the roles of investigators and oversighters.

2.7 Interstate comparisons

Other Australian jurisdictions differ in their oversight of serious incidents involving police. However, all states follow a broad model where police have primary investigative responsibility for serious incidents, with independent oversight by anti-corruption or integrity agencies. For example:

- In New South Wales, the recently established Law Enforcement Conduct Commission (LECC) may monitor the conduct of a New South Wales Police Force investigation of a 'critical incident' if the LECC decides that it is in the public interest to do so.[20]
- In Queensland, the Crime and Corruption Commission (CCC Qld) is informed of all police-related deaths as well as other significant events involving police, and may elect to attend an incident if there are public interest concerns. Where the CCC Qld considers that further investigation is warranted, these matters can be referred to Queensland Police or retained by the CCC Qld.[21]
- In Western Australia, the Corruption and Crime Commission (CCC WA) is informed of all deaths or serious injuries involving Western Australian police. Primary responsibility for investigating such incidents sits with Western Australia Police, with the CCC WA able to oversight those matters it believes warrant further scrutiny.[22]

[18] The OPI was the Victorian independent police oversight established by the Victorian Government in November 2004. OPI ceased operation in 9 February 2013 and was replaced by IBAC.

[19] Office of Police Integrity, 2011, 'Review of the investigative process following a death associated with police contact', <www.ibac.vic.gov.au/docs/default-source/reviews/opi/review-of-the-investigative-process-following-a-death-associated-with-police-contact---tabled-june-2011.pdf>

[20] Part 8 of the *Law Enforcement Conduct Commission Act 2016.*

[21] Crime and Corruption Commission (Queensland), Annual report 2015/16, p 56.

[22] Consultations with Western Australia Police Professional Standards, 10 May 2017.

3 Findings from the audit

The IBAC audit examined five areas of the oversight process:

- pre-oversight process
- oversight process
- outcomes
- timeliness
- record keeping.

The following sections outline relevant Victoria Police policies applying to each area, the data collected through the audit and, where appropriate, suggestions for improvements.

3.1 Pre-oversight process

3.1.1 Key findings: pre-oversight process

In relation to the pre-oversight process, IBAC identified inconsistencies regarding:

- whether IBAC is notified about incidents involving deaths or serious injuries involving contact with police
- how conflicts of interest are identified and managed in relation to oversight matters
- how oversight files are reclassified.

Under IBAC's 'own motion' review, PSC notifies IBAC of serious incidents including deaths and serious injuries involving Victoria Police. The audit identified that IBAC did not receive a notification in relation to 28 of the 65 files that fell within the scope of the 'own motion' review. These 28 files included 16 deaths associated with police contact. Liaison with PSC indicates that where a serious incident was not included in PSC's 'on-call logs' emails, it is unlikely that a notification would have been provided to IBAC (given there is no legislated requirement to notify IBAC of these incidents). This represented a significant gap in IBAC's awareness of serious incidents. This has since been addressed by Victoria Police introducing an automated notification process under which IBAC is advised when an oversight file is created.

The audit identified that conflicts of interest in relation to oversight files were poorly identified and managed. Forty-six of the files audited (32 per cent) did not include the mandatory conflict of interest form. Where conflict of interest forms were included, there were significant shortcomings in how these forms were completed and how conflicts of interest were managed. Twenty-one files included a conflict of interest that was identified on the conflict of interest form but this conflict was not managed or addressed. Twenty-five files included conflict of interest forms that had not been signed or approved by a supervisor. The poor management of conflict of interest in relation to oversight files undermines confidence in the integrity of the oversight process.

Seventeen of the oversight files audited had been reclassified because performance issues were identified in relation to one or more of the officers involved. However, the audit identified seven other files where, despite similar performance issues being identified, they were not reclassified. EPSOs should ensure greater consistency around the reclassification of oversight files, given their quality-control role in reviewing oversight files prior to completion.

3.1.2 Classification

3.1.2.1 Policy and practice

Victoria Police's IMG outlines that C1-8 files are created by PSC for oversight of specific incidents, including:

- death or serious injury resulting from contact between police and the public
- death or serious injury to a person in police custody
- attempted suicide by a person in police custody
- incidents involving discharge of a firearm by police
- escapes from custody
- any serious vehicle collision involving police.

Such incidents must be immediately reported to PSC under the VPM.[23]

If an oversighter identifies conduct issues associated with an incident or investigation they are reviewing, PSC may reclassify the file to better reflect the nature of the activity being examined and, potentially, to allow disciplinary action to be pursued. The file categories available to PSC for the reclassification of C1-8 files are outlined in Figure 2 (on the next page).

[23] Victoria Police manual policy, Complaints and discipline, section 4.

FIGURE 2: PSC FILE CLASSIFICATION CATEGORIES FOR THE RECLASSIFICATION OF C1-8 FILES [24]

Classification	Complaint type
C2-4	Local management resolution (LMR) *LMRs aim to resolve low-level incidents within seven days of the matter being forwarded to the relevant work area*
C2-5	Management intervention model (MIM) *Allegations of a minor nature regarding service delivery, performance management or professional conduct*
C2-1	Minor misconduct *Includes minor assault at time of arrest, infringement notice received on duty, lower level discrimination under the Equal Opportunity Act, and lower level breaches of the Charter of Human Rights Act*
C3-2	Misconduct connected to duty *Includes serious assault, conduct punishable by imprisonment, alcohol or drug offences on duty, improper use of LEAP or other databases, higher level discrimination under the Equal Opportunity Act, and higher level breaches of the Charter of Human Rights Act*
C3-3	Criminality (not connected to duty) *Includes off-duty conduct punishable by imprisonment, off-duty alcohol or drug offences, criminal associations, and summons to court for any traffic matter*
C3-4	Corruption *Includes encouraging others to neglect duty or to be improperly influenced in exercising any function, fabricating or falsifying evidence, using excessive force or other improper tactics to procure confession or conviction, improperly interfering with or subverting a prosecution, concealing misconduct by other officers, and engaging in serious criminal conduct*

3.1.2.2 Analysis: classification and reclassification

The audit examined 142 files that were originally classified as oversight (C1-8) files and which were completed during 2015/16.

FIGURE 3: AUDITED FILES BY CLASSIFICATION

Classification	Complaint type	Number of files audited
C1-8	Incident investigation/oversight	123
C2-5	Management intervention model (MIM)	17
C2-1	Minor misconduct	1
C3-2	Misconduct connected to duty	1
Total		142

[24] Note that there are other PSC file categories, but they relate to specific circumstances unrelated to C1-8 files and thus are not relevant to the reclassification of C1-8 files.

Of the 142 files within the audit's scope, 123 remained as oversight files and 19 were reclassified.

Of the 19 files that were reclassified:

- Seventeen were reclassified as C2-5 (MIM) files. In all 17 instances, they were reclassified because performance issues were identified in relation to one or more of the involved officers.
- One was reclassified as a C2-1 file (minor misconduct) because a complaint was received in relation to the incident that gave rise to the oversight.
- One was reclassified as a C3-2 file (misconduct related to duty) because a complaint was received in relation to the incident that gave rise to the oversight.

The auditors agreed with the reclassification of all 19 of these files.

IBAC's audit identified eight C1-8 files which auditors assessed should have been reclassified by Victoria Police to C2-1, C2-5 or C3-2 files. In seven of these cases, performance issues were identified or workplace guidance was delivered to the officers involved. In the eighth case, it was because a complaint about the incident was received. These files highlighted issues with a consistent approach in how Victoria Police determines when oversight files should be reclassified. In some cases, the fact that workplace guidance was provided to officers prompted reclassification. In other instances, workplace guidance was provided or recommended, however the file remained as a C1-8.

CASE STUDIES 1, 2 AND 3

Examples of inconsistent approaches to reclassification of oversight files are highlighted by the following case studies:

- Case study 1
  Officers were given workplace guidance because they failed to consider removing a licenced firearm from an individual who had expressed suicidal thoughts. Despite workplace guidance being documented on the officers' professional development and assessment (PDA) plans[25], the C1-8 file was not reclassified.
- Case study 2
  Protective services officers (PSOs) were given workplace guidance after a failure to properly apply handcuffs resulted in an escape from custody. The final report on the file, the letters to the officers involved and memo from the regional EPSO all referred to the file as a C1-8 and did not highlight the need for reclassification. When the file was returned to PSC, it was reclassified as a C2-5. No notifications of the reclassification appeared to have been relayed to the EPSO, the oversighting officer or officers involved.
- Case study 3
  An officer discharged their firearm at a moving vehicle, and both the officer and their colleague failed to properly report the incident. The oversight report identified clear failings by the officers and recommended workplace guidance. Despite this recommendation, the file remained a C1-8 and 'no action' was recorded as taken in relation to the officers involved.

[25] PDA plans are individual developmental plans that identify opportunities for officers to identify learning opportunities and document performance feedback between officers and their supervisors.

3.1.2.3 Analysis: impact of reclassification on due dates for oversight files

The audit also identified issues around timeliness that arose when oversight files were reclassified.[26] The VPM specifies timeframes permitted for the investigation of different file classifications.[27] This includes a limit of 90 days for the completion of C1-8 files, calculated from the date the incident was lodged with PSC, to the date the oversight is completed and any required action is approved by PSC. However, it is unclear how this timeframe is affected when a C1-8 oversight file is reclassified to a C2-5 file, which has a 40-day limit for completion.

Of the 17 oversight files reclassified to C2-5 files that were within the audit's scope:

- six were completed within the 40-day limit for C2-5 files
- nine took longer than 40 days, but were completed within the 90-day limit for C1-8 files
- two took longer than 90-days to complete.

It was unclear to the auditors whether the nine files that took between 40 and 90 days to complete should have been considered overdue.

3.1.3 IBAC notification

3.1.3.1 Policy and practice

Victoria Police is obliged to notify IBAC of complaints received about corrupt conduct or police personnel misconduct by a Victoria Police employee or police recruit.[28] However, Victoria Police does not regard oversight matters as complaints and therefore considers these matters outside the scope of this obligation.

To ensure IBAC is notified of the most serious incidents involving Victoria Police, IBAC maintains an 'own motion' review into selected deaths and serious injuries associated with police contact.[29] PSC notifies IBAC of oversight matters per IBAC's 'own motion' review. At the time of the audit, this included most, but not all C1-8 files (for example, IBAC was not notified of oversights relating to escapes from police custody or police pursuits unless they result in death or serious injury). PSC notified IBAC of relevant incidents by copying IBAC's Director Operations onto PSC's 'on-call logs' emails.

3.1.3.2 Analysis: IBAC notification

The audit identified that the system of notifying IBAC of death or serious injuries via PSC's 'on-call logs' emails was not providing notifications of all deaths or serious injuries related to police contact. Although these emails provided notifications of most deaths or serious injuries involving police, there were some incidents that were not included. For example, an incident that appeared to be low level or to not involve a death or serious injury would not be circulated in an on-call log, even if it was later discovered to be serious.

Of the 142 files audited:

- seventy-seven were outside the scope of IBAC's 'own motion' review (eg escapes from custody)
- sixty-five were more serious incidents that were covered by IBAC's 'own motion' review.

[26] Timeliness is discussed in more detail in section 3.4 of this report.

[27] Victoria Police manual guidelines, Complaint management and investigations, section 6.6.

[28] *Independent Broad-based Anti-corruption Commission Act 2011*, section 57(2).

[29] For details of the scope of IBAC's own motion reviews, see Section 2.5.

Of the 65 serious incident files that were covered by IBAC's 'own motion' review, there were 28 files (43 per cent) that were not notified to IBAC. These 28 files dealt with the following categories of incident:

- sixteen were deaths associated with police contact
- nine were serious injuries associated with police contact
- two were incidents where police discharged a firearm in circumstances that gave rise to risks of death or serious injury
- one was an incident where Victoria Police subsequently received a written complaint which should have been notified to IBAC under section 57(2) of the IBAC Act.

In the 37 cases where IBAC was notified, notification was normally timely. Thirty-one of the 37 notifications (84 per cent) were made to IBAC within three days. Of the six files that took longer than three days, the longest notification period without a clear reason was 14 days.

In September 2017, in response to the audit, Victoria Police commenced notifying IBAC by automated email whenever an oversight file is created. This will ensure IBAC is notified of all oversight files.

3.1.4 Officers involved in oversight incidents

3.1.4.1 Policy and practice

ROCSID is Victoria Police's electronic case management system for complaints and serious incident oversight. ROCSID categorises officers involved in an incident in two ways:

- 'member involved' refers to an officer subject to a complaint or a performance issue
- 'person involved member' refers to officers involved in an incident but where there is no complaint or apparent performance issue regarding that officer.

There is currently no formal Victoria Police policy outlining when subject officers' complaint histories should be considered in the context of oversight matters. As a result of recommendations IBAC made in its *Audit of Victoria Police's complaint handling at the regional level* and IBAC's Operation Ross[30], PSC is reviewing its processes around probity reporting. This review is considering the content of probity reports and the circumstances in which they should be provided, including the provision of probity reporting to officers investigating complaints and oversighting incidents.

3.1.4.2 Analysis: identification of officers

The audit identified significant inconsistencies with how the identities of officers involved in serious incidents are recorded on ROCSID and hard copy oversight files. In 59 (42 per cent) of the 142 files audited, the auditors identified issues with the officers identified on either ROCSID or the hard copy file. These issues included:

- too many officers listed on either ROCSID or the hard copy file including officers who had little or no involvement in the serious incident being overseen (31 files)
- a failure to list all relevant officers involved in a serious incident (24 files)
- officers listed in the wrong ROCSID category (for example, as 'member involved' instead of 'person involved member') (two files)
- the incorrect officers being identified (two files).

[30] Both reports are available on the IBAC website.

CASE STUDY 4

An oversight file was created after an individual, who had been detained in a police cell overnight, died two days after their release. There had been multiple occasions of police contact with the deceased leading up to and just prior to their death.

The oversight file listed eight officers, being those officers who attended the scene upon notification of the death. In contrast, ROCSID recorded 17 officers as being involved in the incident, including officers who had contact with the person prior to their death as well as those officers who responded to the person's death.

The file included two sets of outcomes letters. The first batch of preliminary letters was sent to the eight officers identified on the file and also to the officers who had contact with the deceased prior to the individual's death. These letters noted the matter was yet to be determined by the coroner but that the findings of the oversight process were 'no complaint, no action'. A second batch of letters was sent following the coroner's finding, but were only sent to the eight officers identified on the file and who had responded to the death.

For consistency and accountability, every officer who received a preliminary outcome letter should also have received a final outcome letter. Further, the oversight file should have focused on those officers who had contact with the deceased and were involved in the events just prior to his death.

3.1.4.3 Analysis: complaint histories of officers involved

The audit identified that officers' complaint histories are rarely considered in the context of oversight files. There was evidence that complaint histories were considered in only four of the audited files (three per cent):

- One of these four files had been reclassified from a C1-8 (oversight) file to a C2-5 (MIM) file. The other three files remained C1-8 files.
- Three of the four files with complaint histories were files that had been overseen by PSC (rather than allocated to a region, department or command). These corresponded to the three C1-8 files. The fourth file (the C2-5) was overseen by a sergeant in Western Region.

IBAC highlighted the importance of considering the complaint histories of police officers involved in incidents or who are the subject of complaints in its 2016 audit of Victoria Police complaint handling systems at regional level. In response to IBAC's recommendation following that audit, Victoria Police advised that all complaint files forwarded to investigators now have a complaint history attached for all relevant officers.

CASE STUDY 5

An oversight file was created as a result of an escape from custody. The incident involved an attempt to arrest an individual at his home. The two officers spoke to the man and indicated that he needed to accompany them to the police station. The man asked the officers if he could go inside to get dressed. The officers agreed. The man entered the house and left via the back of the property while the officers waited outside the front of the house.

There was no indication on the file that the oversighter looked at the complaint histories of the two officers involved. IBAC found one of the officers had two other complaints relating to a failure of duty. One of these complaints, concerned a lack of action in relation to an assault. The complainant stated:

> *Officers stayed outside residence talking and no officer entered residence to assess injuries or speak to victim of assault until they were asked to by myself.*

As a result of the incident oversight, workplace guidance was provided to both officers. Had the complaint history of the officers been considered, it may have been considered appropriate to provide more formal or structured counselling, or to record the workplace guidance on the officer's PDA, given that a similar incident had previously occurred.

IBAC's audit officers conducted complaint history checks of officers involved in the files being audited. This process identified eight files where the complaint histories of officers involved in either the incident or the oversight raised concerns in relation to the oversight:

- In four files the assigned oversighters were identified as potentially unsuitable to conduct the oversight because of extensive complaint histories (including substantiated complaints) against the oversighter.
- Three files were highlighted because of the officers involved in the incident had complaint histories relevant to the incident being overseen.
- In one file, one of the officers supervising the oversight had a significant complaint history which called into question their appropriateness to supervise the file.

3.1.5 Conflict of interest

3.1.5.1 Policy and practice

Ensuring real or perceived conflicts of interest are identified and managed is fundamental to the purpose of the oversight system. Applying appropriate and objective scrutiny to serious incidents involving Victoria Police is essential to maintaining community confidence in the oversight process.

The VPM states that there must be a 'geographic separation' between the relevant parties to an oversight incident (meaning they should not work in the same police station or unit). This includes the need for separation between any officers involved in the incident itself, any investigators (appointed by the coroner or otherwise) to investigate the incident, and any officers undertaking oversight of the incident or investigation.[31]

[31] Victoria Police manual guidelines, Oversight of death or serious injury/illness involving police, section 3.2.

Officers involved in an oversight matter are required to complete a conflict of interest form (Victoria Police Form 1426). This form must be signed by the officer's supervisor who, in consultation with PSC, must determine whether there are any conflict of interest issues. If there is an actual, potential or perceived conflict of interest, the supervisor must determine whether the conflict can be managed or if the oversight should be assigned to an alternative officer.[32]

These policies are supported by a one-page 'oversight file guide' produced by PSC to assist officers assigned oversight files. According to the guide, C1-8 files should be allocated to an oversighter of sergeant level or above who is independent of the incident being overseen.

PSC has produced an 'oversight principles checklist' to guide oversighters through the issues they should consider. The first principle highlighted by the checklist is conflict of interest. Oversighters are directed to complete a conflict of interest declaration and confirm whether they have any substantial connection to police or other parties involved in the incident being oversighted. Supervisors are required to approve the declaration and to decide if there are any conflicts of interest that should be managed or that should disqualify the officer being allocated the file.

3.1.5.2 Analysis: conflict of interest forms

The audit identified that a significant number of oversight files did not include a conflict of interest form (Form 1426) despite the completion of such forms being mandatory for C1-8 files:

- Forty-six of the files audited (32 per cent) did not include a 1426 form
- In addition to these 46 files, there were three files that included at least one 1426 form but did not include all of the 1426 forms that should have been included.

The importance of completing conflict of interest declarations was highlighted by the fact that of the 96 files that included at least one conflict of interest form, there were 39 files (41 per cent) where at least one conflict of interest was identified.

However, even on files that included conflict of interest forms, there were significant shortcomings in how these forms were completed and how conflicts of interest were managed:

- Five files had clear conflicts that were not identified on the conflict of interest form.
- Twenty-one files included a conflict of interest that was identified on the conflict of interest form but this conflict was not managed or addressed.
- Twenty-five files included conflict of interest forms that had not been signed by a supervisor.
- Four files included conflict of interest forms that were dated and attached to the file after the oversight had already been completed, thereby negating most of their purpose.
- Five files had other conflict of interest form issues, such as forms being partially completed.

CASE STUDY 6

Police arrested a person in relation to an alleged family violence incident. Officers determined that there was not a basis to remand them and released the person on summons. Three days later the person killed themselves.

The oversight file was allocated to the region where the incident took place. The appointed oversighter had a clear conflict of interest. On the form 1426 attached to the file, the oversighter identified that they had known one of the officers involved in the incident 'since childhood'. Emails attached to the file support the assessment that the two officers knew each other well.

Despite this, the oversighter did not disqualify themselves from the case. Further, the form 1426 was not approved or signed by a supervisor, so there was no opportunity to manage the conflict or for a supervisor to intervene to exclude the appointed oversighter.

[32] Victoria Police manual guidelines, Oversight of death or serious injury/illness involving police, section 3.2.

CASE STUDY 7

An oversight file was created after a failure to follow guidelines around the handcuffing of a prisoner led to that prisoner's escape from police custody. The oversight file was allocated to the region where the incident took place.

The appointed oversighter completed a conflict of interest form and attached it to the file. The form was poorly completed and did not include basic information such as listing the officers involved in the incident. Further, the oversighting officer identified they had a social relationship with one of the officers involved that included playing on the same social sports team. Despite this, the oversighter indicated on the form that they did not believe this would give rise to any perceptions of a conflict of interest.

The oversighter failed to submit the conflict of interest form to a supervisor and the apparent conflict was not managed or addressed in any way.

3.1.5.3 Analysis: conflict of interest considered as part of the oversight process

The audit identified that a majority of files did not include evidence that the oversighter had considered conflict of interest issues as part of completing the oversight process. This is despite conflict of interest being the first of the oversight principles that should be considered pursuant to the guidelines provided by PSC.

IBAC identified only 23 files (16 per cent) where it was clear that the oversighter had considered conflict of interest issues related to the incident/investigation they were oversighting.[33]

FIGURE 4: CONSIDERATION GIVEN TO CONFLICT OF INTEREST ISSUES AS PART OF THE OVERSIGHT

Did the file indicate that conflict of interest issues were considered as part of the oversight?	Number of files
Yes	23
No	118
Unclear	1
Total	142

3.1.5.4 Analysis: oversight allocated to an appropriate officer

Oversight files should be allocated to an officer of sergeant level or above who is independent of the incident being overseen. IBAC assessed that the choice of oversighter was appropriate in 86 files out of the 142 files audited (61 per cent) and inappropriate in 56 files (39 per cent).

The reasons why auditors assessed oversighters to be inappropriate included:

- conflicts of interest were identified involving the oversighter (37 files)[34]
- the oversighter was not suitably senior to the officers involved (24 files).

[33] The inclusion of a Form 1426 alone on file was not interpreted by auditors as being sufficient consideration of conflicts of interest (as these forms only relate to conflicts involving the oversighter and not to conflicts related to the incident or investigation more generally). Instead, auditors were looking for a clear indication conflict of interest issues had been considered in relation to the oversight process, such as by mentioning conflicts of interest in the final report or by including an oversight principles report on the file.

[34] Note that the oversighter was assessed to be inappropriate in some cases because they had a conflict of interest *and* they were not suitably senior to the officers involved.

CASE STUDY 8

A Special Operations Group (SOG) sergeant was removing a SOG firearm from a police vehicle when it discharged into the floor of the vehicle. The sergeant was alone when the incident occurred.

During the file allocation stage, the EPSO sent a memo to the relevant superintendent specifically requesting (in bold) that:

> *In this case, the investigator must be independent of the SOG and be able to comment on the current operating procedures for firearms handling and make appropriate recommendations.*

Despite this direction, the file was allocated to a SOG senior sergeant. A conflict of interest form was attached to the file identifying that the oversighter had worked with the officer involved at both the SOG and previously at the Critical Incident Response Team (CIRT). The form did not address how this perceived conflict of interest would be managed.

The resulting file included no evidence related to the incident. The final report did not address SOG standard operating procedures (SOPs) in detail. The file should have included photos, CCTV, policy, SOPs, notes and records of contact between the oversighter and the officer involved (including an account from the officer of what occurred). There was no critical examination of the involved officer's account included on the file.

Despite the failure to allocate the file to an independent officer (as per the EPSO's instructions) and despite the poor oversight, the oversighter's supervisors and the EPSO approved the file and it was marked as complete.

This case study was one of five files within the audit's scope that examined incidents involving the SOG. None of these oversights were undertaken by PSC and in all cases, there were issues identified with the quality of the oversight. These issues included clear conflicts of interests, a lack of evidence and limited critical examination of the actions of the officers involved.

Some of the issues identified regarding conflicts of interest and seniority may be attributable to the advice regional officers received from EPSOs. IBAC identified multiple files where an instructional memo from the EPSO requested only that the oversighter be a sergeant or above and independent to the incident. The memo did not highlight the need for the oversighter to be independent of any of the officers involved in the incident *and* independent of any coronial appointed investigator, as required by the VPM. In these cases, it is understandable that a lack of clear instructions could have contributed to files being allocated to officers who were not independent.

3.2 Oversight process

3.2.1 Key findings: oversight process

The audit identified that oversighters did not always contact relevant parties as part of the oversight process. There were 25 files where there was not contact with relevant police officers and 41 files where the oversighter did not contact all of the relevant civilians. These were individuals who auditors perceived could have made significant contributions to the oversight and were not just incidental witnesses. Additionally, there were 10 files where there was no documented contact between the oversighter and the coroner-appointed investigator who was being overseen.

Poor or inadequate communication with relevant parties contributed to some oversight files being overly reliant on the statements of a few police officers as the primary source of evidence about an incident. The failure to seek independent statements made it difficult to verify the accuracy of police accounts. This was particularly evident in files involving medical staff, where statements had not been sought from medical professionals central to the incident being overseen.

IBAC's auditors assessed that 73 files (51 per cent) failed to consider evidence that should have been included. The most frequent types of evidence that were relevant but not included were statements from relevant civilians or police officers, CCTV recordings and inquest briefs. The lack of independent evidence included on some files undermines the purpose of oversight files to critically examine police accounts and actions.

The audit identified 46 files (32 per cent) where there was inadequate supervision, or where supervisors failed to correct significant shortcomings in the oversight. Particularly concerning were multiple files where EPSOs appeared to give poor advice or failed to address serious inadequacies associated with the files.

3.2.2 Contact with relevant parties

3.2.2.1 Policy and practice

Under the VPM, two key objectives of the oversight process are to maintain community confidence and engagement, and to address the welfare of all parties through the investigation and oversight processes.[35] To these ends, the VPM specifies that oversight must involve all next of kin, witnesses, employees and others involved or directly affected by the incident being overseen. This includes maintaining communication with these parties. In circumstances where there is both an investigator and an oversighter (for example, where an investigator has been appointed by the coroner), the investigator should be the primary point of contact with these parties.

PSC has also produced information sheets for parties involved in serious incidents.[36] These outline that relevant parties will be updated by investigators at 'various stages of the investigation'. For employees, it is also noted that if they are interviewed by an investigator in relation to an incident being overseen by PSC, then a PSC officer will be present at the interview.

[35] Victoria Police manual guidelines, Oversight of death or serious injury/illness involving police.

[36] Victoria Police information sheet, Information for employees involved in death or serious incident/illness incidents; Victoria Police information sheet, Information for relevant parties involved in the oversight of a death or serious incident/illness involving police.

For individuals involved in serious incidents who could be regarded as victims[37] under the *Victims' Charter Act 2006*, oversighting officers should ensure they are:

- given clear, timely and consistent information about their rights and entitlements
- referred to victim or legal support services
- treated with courtesy, respect and dignity
- informed of the progress of the investigation, unless the disclosure may jeopardise the investigation or the person requests not to be informed
- informed of any key stages in the investigation such as the charging of an offender, bail proceedings, outcomes of any court proceedings, appeals or discipline proceedings
- informed in writing of the results and the action taken or proposed to be taken at the completion of the investigation.[38]

Effective communication with relevant parties is one of the oversight principles.[39] Where officers are overseeing an investigation (rather than an incident) they should consider whether the investigating officer made appropriate and effective contact with relevant parties.

3.2.2.2 Analysis: communication issues identified by oversighters

Of the 142 files audited, there were 30 files (21 per cent) identified where the oversighter highlighted communication issues related to the incident or investigation in question. In all instances, IBAC's auditors agreed with the issues identified by the oversighter.

The issues identified by oversighters included:

- failure to communicate relevant information in a timely and effective manner (for example, failure to accurately communicate speed during a pursuit or request the need for backup)
- poor reporting of incidents to supervisors, PSC or other relevant Victoria Police areas
- failure of the officers involved to contact relevant civilians
- poor communication with medical professionals
- poor communication between officers involved in an incident.

Some files sought to address the communication issues through recommendations including improvements to policies or through the delivery of workplace guidance.

However, other files failed to identify or address communication issues in the incidents or investigations they were overseeing. Despite contact with relevant parties being one of the oversight principles, IBAC found many files did not identify positive or negative communication issues relevant to the incidents or investigations being examined. This included communication issues between the officers being overseen and parties including PSC, members of the public or medical professionals.

[37] Under section 3 of the *Victims' Charter Act*, 'victim' means a person who has suffered injury as a direct result of a criminal offence, whether or not that injury was reasonably foreseeable by the offender; or if a person has died as a direct result of a criminal offence committed against that person, a family member of that person; or if the person referred to in paragraph (a) is under 18 years of age or is incapable of managing his or her own affairs because of mental impairment, a family member of that person.

[38] Victoria Police manual guidelines, Complaint management and investigations.

[39] Victoria Police oversight principles checklist.

CASE STUDY 9

Police were called to an incident and the following day served an intervention order on one of the parties. The next day the subject of the intervention order overdosed on pharmaceutical medication and died three days later.

Despite the police contact with the individual in the lead-up to their death, PSC was not notified of the incident until seven months later. In allocating the file to the region for oversight, PSC directed that the oversight 'will need to address the reasons behind this matter not being brought to the attention of PSC and why it was not investigated initially by the attending CIU among other things'.

Despite these directions, the file contained no correspondence or other evidence exploring the delay. The final report stated that, 'It was concluded that the failure to report was caused by a circumstantial anomaly which could not be avoided having regards to all the circumstances'. There was no explanation of this anomaly and no recommendations made to prevent similar delays in the future.

3.2.2.3 Analysis: communication issues involving oversighters

As well as examining whether oversighters had considered communication issues, IBAC's auditors also looked at how oversighters had communicated with relevant parties to the incident. Auditors identified:

- twenty-five files (18 per cent) where the oversighter failed to contact all relevant police officers
- forty-one files (29 per cent) where the oversighter failed to contact all of the relevant civilians.

Auditors only considered police officers or civilians to be 'relevant' witnesses when there was a clear need for the person to be spoken to because they were in a position to make a substantial contribution to the oversight.

Communication issues included:

- Oversighters not including an account of an incident from the officers involved in the incident (based to the absence of any statements or other records on the file).
- Oversighters not including statements from civilians that would assist in verifying the statements made by police. Many files included only statements from police, making it difficult to independently verify their accuracy.
- Oversighters not including statements from medical professionals, particularly hospital staff. Such statements would be particularly useful in oversight files dealing with individuals detained for assessment under the *Mental Health Act 2014* and then left in the care of medical professionals. Auditors identified multiple files where officers stated that they had received assurances that the medical professional took responsibility for the detained individual; however, no statement from the medical professional had been sought or included on the oversight file.

3.2.3 Interaction with investigators

3.2.3.1 Policy and practice

Victoria Police has advised IBAC it is currently reviewing its policy on death and serious injury/illness incidents involving police to provide greater clarity and awareness about the role of the oversighter. A particular focus of this review is clarifying the roles of coronial-appointed investigators and oversighters following a death involving police contact. PSC anticipates the revised policy will lead to improved communication between investigators and oversighters, and greater mutual understanding of their respective roles.

3.2.3.2 Analysis: interaction between oversighters and investigators

There were 47 files within the audit's scope involving the oversight of an investigation. Of these files, auditors identified 37 files (79 per cent) with indications of contact between the oversighter and investigator and 10 files (21 per cent) where there was no documented contact between the oversighter and investigator.[40]

In addition to the 10 files where there was no documented contact between the investigator and oversighter, auditors identified two files where there were issues with how the investigative and oversight processes interacted:

- One file, examining a death after police contact, involved the same officer being appointed to investigate the death and oversight the investigation.
- The second file, which also examined a death after police contact, included a direction from the coroner's office to the investigator not to share information directly with the oversighter but to ensure that any requests for information by PSC were made to the coroner. Such a direction could lead to inconsistencies in how PSC accesses information necessary to oversight investigations.

3.2.4 Scene management and debriefs

3.2.4.1 Policy and practice

The VPMG on death or serious injury/illness defines these incidents as:

- a death or serious injury/illness in the presence or custody of an employee involving:
  - the discharge of a firearm or use of force by the employee
  - the use of a vehicle by the employee in the course of their duties
  - death or serious injury while the person was in the care or custody of an employee
  - attempts to bring a person into custody or attempted escapes from custody
  - any police actions or inactions during other policing activities or operations
- a death or serious injury/illness before or following police contact where there is an indication or could be a perception that police actions or inactions have caused or contributed to the death or injury/illness.

[40] In one of these 10 cases, both the oversighter and investigator worked at the same station, increasing the likelihood that there may have been contact that was not documented on the file.

The guidelines state that:

- the incident must be managed in accordance with VPMP emergency management response
- the scene must be managed and preserved as for a crime scene (as per VPMP scene management)
- the Police Commander must ensure that the actions on the Initial Action List for managing deaths or serious injury/illness incidents are completed
- the Police Commander must ensure that relevant investigators, managers and support services are notified through Police Communications and attend the scene as required. These may include:
  - coroner
  - Forensic Services Department
  - relevant regional or departmental supervisors and managers
  - media liaison
  - Professional Standards Command
  - Drug and Alcohol Testing Unit
  - welfare services including the Police Psychology Unit
  - Centre for Operational Safety, who may be requested to assist investigators if the incident involves use of operational safety equipment or tactics
- the Police Commander must also ensure that:
  - the information sheet for employees involved in death or serious injury/illness incidents is provided and explained to employees involved in the incident
  - employees involved in the incident are offered consultation with Police Psychology Unit as soon as possible.

IBAC's Assessment and Review area has advised it has identified, through reviews, that there can be inconsistencies in how officer welfare is addressed during and following serious incidents.

The VPMP on operational debriefings state that debriefs should be held following unplanned incidents. The nature of the incident will inform what type of debrief is required, what should be discussed and who should be involved. An informal, quick assessment, or 'hot' debrief, may be sufficient for routine or straightforward incidents that ran in line with plans or policy. A more formally convened, considered assessment, or 'full' debrief, may be necessary for high risk, large or protracted matters, where there were issues or concerns with the way that the operation or incident was conducted, or where there was a serious outcome. Full debriefs require the preparation of a written debrief report, which should be included on the file.[41]

The purpose of debriefs is to identify issues with the conduct of an incident to improve the efficiency, effectiveness and safety of future operations or incidents. Debriefs should identify problems that occurred and highlight areas that were handled well.[42]

3.2.4.2 Analysis: scene management and debriefs

The majority of files did not have identified issues in relation to scene management. Auditors did identify some issues in relation to scene management in relation to six files, including:

- three instances where delays in notifying PSC of serious incidents meant that PSC was unable to take control of scene management
- one file where the oversighter identified that the scene was not managed appropriately and spoke with officers involved about how this could be improved
- one file where it was unclear whether welfare support was provided to the officers involved
- one file that lacked information and supporting evidence (such as photos) in relation to management of a complex scene.

[41] Victoria Police manual guidelines, Operational debriefs.

[42] Victoria Police manual guidelines, Operational debriefs.

Auditors identified 23 files where an incident debrief report was attached to the file. Issues identified in connection with debriefs included:

- two files where formal debriefs appear to have been undertaken but no report was attached to the file
- one debrief report lacked the detail necessary for the report to be effective
- one debrief report made a recommendation in relation to pursuits but there was no indication this recommendation was followed up.

3.2.5 Evidence

3.2.5.1 Policy and practice

Victoria Police's policy guidelines do not outline the types of evidence that should be considered in relation to oversight files. However, Victoria Police's IMG outlines the types of inquiries that should be considered when a complaint is received.[43] This includes considering the following types of evidence:

- scene examination
- identification of witnesses
- CCTV footage
- interviews
- photographs of injuries, physical locations or vehicles
- other related documents.

These guidelines are also instructive for officers conducting oversight files, particularly oversights of incidents.

3.2.5.2 Analysis: evidence

Auditors assessed that 73 files (51 per cent) failed to consider evidence that should have been included. The most frequent types of evidence that were relevant but not included were:

- statements from relevant civilians – missing from 35 files where they were relevant
- statements from officers involved – missing from 28 files where they were relevant
- CCTV – missing from 20 files where it was relevant
- inquest briefs – missing from seven files where they should have been attached.

CASE STUDY 10

An oversight file was created following an incident where a man jumped out of an apartment on the fifth floor of a city building while in the presence of police.

Although there was no indication that police involvement in the matter contributed to the man's actions, there was a significant lack of information on the file. The PSC log stated that the notes of officers who had immediate contact with the man had been obtained, that civilian statements had been taken and that statements would be taken from officers on the day after the incident. But none of this material was attached to the file.

It is possible that this additional information may have highlighted issues with police actions on the day, and how practice and procedures could be improved. Without all the relevant information it was not possible for supervisors (or IBAC) to make this assessment.

[43] Victoria Police Integrity Management Guide, April 2015, p 15.

The audit found that there was a general over-reliance on police statements to establish a narrative in relation to serious incidents. This included a failure to seek independent statements that might verify police versions or to critically examine police statements against other evidence such as CCTV. This goes to the essence of the purpose of oversight files in ensuring serious incidents are managed appropriately to uphold public confidence in police.

3.2.6 Proportionality

3.2.6.1 Policy and practice

The Victoria Police oversight principles checklist notes that the oversighting officer should assess how the incident or investigation was managed with regard to nine principles, one of which is ensuring the investigation is proportional to the incident.[44] This includes an assessment of the resources dedicated to the incident or investigation as well as consideration of the risks of a loss of community confidence if the integrity of the oversight or investigation is not upheld.

3.2.6.2 Analysis: proportionality

Auditors assessed that the oversight was not proportional to the incident or investigation in 24 cases (17 per cent of files). In these instances, auditors assessed the oversight was lacking appropriate weight in terms of detail on the file, thoroughness of the oversight, or application of the oversight principles. Such files generally demonstrated a poor understanding of the purpose of oversight files and did not critically analyse the incident being overseen.

CASE STUDY 11

Police identified an intoxicated person sitting on a public bench in the early hours of the morning. After establishing that the individual was not drunk enough to be arrested, but that they did not have money for a taxi home, the two police officers took the person home in the divisional van. The individual exited the van at their house and the police officers departed. The next morning, the individual was found deceased on their front lawn after falling through a glass frame stored near their front door.

The incident involved a number of factors that increased the complexity of the oversight process:

- The police members involved did not notify their supervising sergeant that they were transporting the individual home.
- The CCTV in the van failed to record the incident.
- The deceased had (according to their sibling) previously been involved in an incident with the police where they claimed to have been assaulted and reportedly 'hated [the] police'.
- The deceased's next of kin expressed concerns about the transparency and truthfulness of the police investigation of the incident.
- There were inconsistencies in the statements provided by the two police officers who drove the person home.
- It was unclear which Victoria Police policies and duties of care applied when intoxicated individuals were transported home (but not arrested).

[44] Victoria Police oversight principles checklist.

Despite these complexities, the file was allocated to the region in which the incident occurred for oversight (despite being initially oversighted by PSC). The oversight conducted by the region was poor in a number of respects:

- The interim report attached to the file failed to address any of the issues listed previously or make any recommendations in relation to such issues. These issues should have been a significant focus of any oversight.
- There was no final report attached to the file.
- No conflict of interest form was submitted by the regional oversighter.

In addition to these issues, Victoria Police failed to notify IBAC of the incident.

The file should have been retained by PSC and a more detailed oversight undertaken, in proportion to the seriousness of the incident.

CASE STUDY 12

An oversight file was created after a Victoria Police PSO killed themselves. They had been monitored by Victoria Police because of welfare concerns and had been placed on a welfare register, allocated welfare managers and had contact with a sergeant in a welfare capacity less than a month before they died.

The oversighter's report found there were no work issues that contributed to the PSO's death. However, there was little information on the file to support this conclusion and no statements from relevant officers. The oversight file referred to a coronial brief but the brief was not attached. A memorandum from the oversighter's superintendent indicated that the oversight file may have been closed prior to the investigation of the death being completed.

The file demonstrated a poor understanding of the purpose of the oversight process, including whether it was the incident or the subsequent investigation that should be overseen. The oversight was not proportional to the incident and lacked evidence of engagement with the coroner-appointed investigator. The file also highlighted the limitations of applying the C1-8 oversight model to police suicides, raising questions as to whether an alternative review process is more appropriate.

3.2.7 Supervision and review

3.2.7.1 Policy and practice

In practice, oversight files are reviewed by oversighting officers' line management (usually inspector and superintendent level) and are subject to a 'quality assurance' check by relevant EPSOs. When files are returned to PSC, they are subject to a final check before being closed.

In addition to the oversight process applied to individual files, the Oversight Review Committee (ORC) meets quarterly to apply high-level oversight to investigations relating to death or serious injury/illness incidents involving police contact as well as other identified incidents.[45] The committee examines all aspects of the investigation and oversight against the oversight principles. These reviews are intended to identify and support recommendations arising in oversight files, and to facilitate an organisational culture that emphasises continuous improvement.

3.2.7.2 Analysis: supervision

The audit identified that in 29 of the 142 files (20 per cent), a supervisor identified the need for further work or had otherwise intervened to improve the quality of the file. Examples included:

- one file where a supervisor directed the oversighting officer to amend their final report to clearly address the oversight principles
- one file where a supervisor corrected significant shortcomings in the oversight including an overly brief final report, a failure to address policy, and a failure to identify performance issues with the officers involved.

Notwithstanding these examples of good supervision, the audit identified 46 files (32 per cent) where there was inadequate supervision, or where supervisors failed to identify or correct significant shortcomings in the file. IBAC's auditors noted that it was possible that informal or verbal guidance was provided but not documented on the file. Such guidance should have been documented or noted on the file and, in any case, any verbal directions that were given did not lead to the file's shortcomings being remedied.

Of particular concern were multiple files where EPSOs appeared to give poor advice or failed to address serious issues associated with oversight files. The audit identified several files where the oversighter undertook a thorough review, identified failings with the actions of the officers involved and made recommendations for them to receive workplace guidance. However, the EPSO overruled the oversighter and advised that the recommended workplace guidance related to matters peripheral to the substance of the file. Consequently, the EPSO advised that workplace guidance should not be recorded against the officers on ROCSID or on their PDAs.

CASE STUDY 13

Two officers sought to serve a summons on an individual who had a record of substance abuse and aggressive behaviour towards police. The officers decided to serve the summons on the individual at midnight in a caravan park. When the officers arrived the subject was drunk and asleep. Upon being awoken, the individual was aggressive towards police and sustained scratches to his face upon being restrained.

A debrief attached to the oversight file was critical of the officers' risk assessment and their decisions on how and when to serve the summons. The debrief recommended the officers receive workplace guidance.

Despite this, the EPSO determined that workplace guidance should not be recorded on ROCSID because the officers' actions had not 'contributed to the complainant's injury which from all evidence, appears to have been caused by his own contact and state of intoxication'.

Such advice focuses on the manner in which the individual was restrained, rather than on the broader situation, including planning and risk assessments. This narrow approach undermines the purpose of the oversight process and the opportunity such reviews present to identify improvements to practice and policies.

[45] Victoria Police manual guidelines, Oversight of death or serious injury/illness incidents involving police, section 8.

3.3 Outcomes

3.3.1 Key findings: outcomes

The audit highlighted the limitations in how ROCSID is used to record the outcomes of oversight files. The audit identified that all oversight files are determined to be 'no complaint' and 98 per cent of oversights have a recommendation of 'no action'. These do not effectively describe the outcomes of the oversight process, the range of possible improvements that are identified through oversights and the types of recommendations that are made as a result. In particular, the recommendation 'Action on any identified deficiency in premises, equipment, policies, practices or procedures' is underutilised, despite it being an appropriate recommendation for files where improvements are recommended.

The audit also identified shortcomings in how recommendations are followed up. Ensuring recommendations are appropriately considered and implemented supports the purpose of oversight files in not only identifying potential improvements to policies or processes, but enacting change to prevent similar serious incidents.

Despite human rights representing one of the oversight principles, 61 per cent of audited files did not address human rights. Of those files that did discuss human rights, some failed to identify clear human rights issues, did not address rights in sufficient detail, or demonstrated a poor understanding of human rights by mischaracterising issues as relevant 'rights'.

3.3.2 Determinations

3.3.2.1 Policy and practice

PSC manages oversight files using the same processes as complaint files (and other PSC file types). Part of this approach involves ascribing a determination to the file at the conclusion of the oversight or investigation.

The VPM complaint management and investigations guidelines outline 11 determinations applicable to all file types other than MIMs and LMRs.[46]

The outcomes of MIMs and LMRs should be recorded as either 'resolved' or 'not resolved'.[47]

[46] Victoria Police manual guidelines, Complaint management and investigations, section 12.2.

[47] Victoria Police manual guidelines, Management intervention model, section 8.4.

FIGURE 5: DETERMINATIONS LISTED IN THE VICTORIA POLICE MANUAL

Determination	Description
Substantiated	complaint found to be true
Lesser deficiency	a matter uncovered during an investigation not forming part of the complaint laid (such as a failure to complete an official document), requiring remedial action
Not substantiated	the weight of available evidence does not support the account of events as described by the complainant but is weighted in favour of the account given by the employee
Unable to determine	the available evidence does not permit the investigator to establish whether the complaint is true or not
Not proceeded with	the complaint is not proceeded with, due to the unwillingness of the complainant to supply information but is unwilling to withdraw the complaint, or there is some other reason for being unable to take the complaint further
Withdrawn	a complainant having made a formal complaint, of their own volition makes a request that the complaint investigation cease
No complaint	a query or complaint by a person that is subsequently found to be an action sanctioned by law, or a complaint lodged by a third party which is denied by the alleged victim who has no complaint to make
Unfounded	the available evidence clearly establishes that there are no grounds for the complaint whatsoever
Exonerated	the evidence clearly establishes that a particular employee is not involved in a complaint or is completely free from blame
False report	there is sufficient evidence to charge the complainant with making a false report to police.

3.3.2.2 Analysis: determinations

The audit highlighted that the available determinations are not suitable for oversight files. PSC currently applies a determination of 'no complaint' to completed oversight files – the audit examined 123 files that were not reclassified and the determination of 'no complaint' was applied to all of them.

However, the 'no complaint' determination has limited use in relation to oversight files. It does not reflect whether there were issues related to the incident – be they issues related to the actions of individual officers or opportunity for improvements to systems or policies. Because a single determination is applied to all oversight files, it does not serve any effective purpose in describing the nature of the outcome.

There were 17 files within the scope of the audit that were reclassified as MIM (C2-5) files because performance issues were identified or workplace guidance delivered. The only determinations that should be applied to C2-5 files are 'resolved' and 'not resolved'. However, the C2-5 files examined as part of the audit demonstrated inconsistencies in how determinations were applied:

- Eleven files were determined to be 'resolved' (including, in some cases, multiple determinations of 'resolved' where there was more than one officer identified as having performance issues).
- Two files were determined to be 'no complaint'.
- Four files included multiple determinations – listing both 'no complaint' and 'resolved' (including, in some cases, multiple determinations of 'resolved').

Two files examined by the audit were reclassified because a complaint was received:

- The C2-1 file included determinations of unfounded and unsubstantiated.
- The C3-2 file included a determination of unfounded.

In both of these cases, the determinations applied related to the specific allegations made as part of the complaint. The determinations as listed on ROCSID – being focused on the allegations – did not reflect that the file related to an incident that was also subject to oversight.

FIGURE 6: AUDITED FILES BY CLASSIFICATION AND DETERMINATION

Classification	File type	Number of files	Determination applied	Count[48] of determinations
C1-8	Incident investigation / oversight	123	No complaint	123
C2-5	Management intervention model (MIM)	17	Resolved	22
			No complaint	6
C2-1	Minor misconduct	1	Unfounded	4
			Unsubstantiated	1
C3-2	Misconduct connected to duty	1	Unfounded	1
Total		**142**		**157**

The audit identified nine files where there were discrepancies in the determinations listed on the file or ROCSID. These generally were cases where an inappropriate determination had been applied to the file by the oversighter in the final report which were subsequently corrected by the EPSO (such as final reports making determinations of 'unfounded', which were corrected to 'no complaint' by the EPSO).

However, there were multiple files where the oversighter identified performance issues and recommended workplace guidance for the officers involved in an incident, yet the files were not reclassified and a determination of 'no complaint' was recorded. Inconsistencies around determinations led to IBAC's auditors disagreeing with the determinations applied to 14 files (10 per cent).

[48] Note that some files had multiple determinations applied where issues were identified with the performance of multiple officers or where multiple allegations were made as part of the one complaint.

CASE STUDY 14

Police were called in relation to a terminally ill man who had expressed thoughts of killing himself to his palliative nurse. The man held a firearm licence and owned one firearm.

The officers who attended failed to identify that the man owned a firearm and failed to consider removing the firearm from his possession. The officers assessed that the man did not need to be apprehended to prevent serious and imminent harm to himself or others. The man killed himself the following day using the firearm.

The oversight file recommended the officers be given workplace guidance in relation to their failure to identify that the man owned a firearm and failure to consider removing that firearm. Despite workplace guidance being documented on the officers' PDA:

- the file was not reclassified as a C2-5 (MIM) file (it remained a C1-8 oversight file)
- the letters to the officers stated the determination was 'no complaint' and the action was 'no action'
- ROCSID recorded the determination as 'no complaint' and the action as 'no action'.

Further, no officers were listed on the ROCSID record of the incident.

3.3.3 Recommendations

3.3.3.1 Policy and practice

The Victoria Police oversight file guide states that two objectives of oversight files are to determine subsequent police actions in response to an incident and to provide recommendations to prevent similar occurrences. The VPMG also states that oversighters should consider organisational policy and process, and identify learning opportunities or possible improvements to policies or processes.[49]

The PSC file management system ascribes a recommendation to each allegation or file at the conclusion of the oversight or investigation for recording on ROCSID. Under the Victoria Police complaint management and investigations procedures and guidelines, this reflects what recommendation the investigator or oversighter believes is appropriate to address any issues identified during the investigation or oversight.

Recommended actions include:

- no action
- management intervention, including education, advice and guidance to address an employee's performance issue – often referred to as 'workplace guidance'
- admonishment
- discipline charges
- criminal charges
- action to manage underperformance
- action on any identified deficiency in Victoria Police premises, equipment, policies, practices or procedures.

[49] Victoria Police manual guidelines, Oversight of death or serious injury/illness incidents involving police, section 3.2.8.

3.3.3.2 Analysis: recommendations

As with determinations, the audit highlighted inconsistencies in how the available recommendations are applied to oversight files. In the vast majority of oversight files (98 per cent), the recommendation of 'no action' was applied, even in cases where the oversight process identified possible improvements to policies or procedures or, in some cases, workplace guidance for the officers involved. Only two oversight files used the recommendation, 'Action on any identified deficiency in premises, equipment, policies, practices or procedures', despite this being a more appropriate recommendation where improvements were recommended.

IBAC's audit team disagreed with the recommendations applied to 23 files (16 per cent). The reasons for disagreeing with the determinations in these cases included:

- recommendations of 'no action' being recorded when 'workplace guidance' was more appropriate because workplace guidance was delivered or recommended (10 files)
- files making clear recommendations in relation to policies, practices or equipment, yet 'no action' being listed as the recommendation (seven files)
- files failing to make recommendations to address clear shortcomings highlighted by the oversight (six files).

The audit identified 54 files where recommendations were made for further action. However, in 15 of these files (28 per cent) there was no indication of how the recommendations would be followed up. Ensuring recommendations are appropriately considered and implemented is an essential element in satisfying the purpose of oversight files.

CASE STUDY 15

An oversight file was created as a result of a serious injury to a motorcycle rider following a pursuit by a highway patrol officer.

As part of the oversight, it was identified that the highway patrol officer involved in the pursuit had travelled at excessive speed (175 km/h in a 50 km/h zone) in wet conditions. As a result, the officer was required to undergo remedial training and the file was reclassified as a MIM (C2-5) file.

A decision was made to forward the file to Roads Policing Command (RPC) for review. An inspector at RPC reviewed the file and identified two additional deficiencies in how the pursuit was undertaken. These included overtaking a bus while passing through an intersection, and speeding over a crest of a hill. As a result, the RPC inspector recommended that the officer be counselled about the further two deficiencies, an admonishment of the officer be considered and all three deficiencies be included on the officer's PDA.

PSC considered these recommendations but concluded that no further action be taken on the basis that 'revisiting the region's decision would challenge the principles of restorative justice and fairness'. As a result, the highway patrol officer was not made aware of further issues with his driving, and not provided with the opportunity to address these in future.

At the very least, the speeding issue should have been recorded on the officer's PDA to ensure future supervisors were aware of this issue.

FIGURE 7: AUDITED FILES BY CLASSIFICATION AND RECOMMENDATION

Classification	File type	Number of files	Recommendation applied	Count[50] of recommendations
C1-8	Incident investigation/ oversight	123	No action	121
			Action on any identified deficiency in premises, equipment, policies, practices or procedures	2
C2-5	Management intervention model (MIM)	17	No action	5
			Workplace guidance	23
C2-1	Minor misconduct	1	No action	5
C3-2	Misconduct connected to duty	1	No action	1
Total		142		157

[50] Note that some files had multiple recommendations applied where issues were identified with the performance of multiple officers or where multiple allegations were made as part of the one complaint. Each recommendation corresponds to a specific determination.

CASE STUDY 16

An oversight file was created after an officer drove through a red light at an intersection and collided with another vehicle. The officer had been dispatched to a priority one job and had activated the vehicle's lights but not its sirens.

Deficiencies were identified with the officer's driving, including failing to slow sufficiently before entering the intersection, failing to activate the siren as they approached the intersection, and not having a clear line of sight to the right of the intersection but entering the intersection at speed regardless.

The officer claimed under the *Road Safety Road Rules 2009 (Victoria)* that the road rules did not apply to the driver of a police vehicle, as they took reasonable care and were displaying their lights. If this exemption did not apply, they could have been charged with summary driving offences.

The oversighter sought internal legal advice about whether the exemption applied. This advice was inconclusive and stated that further information was needed including:

- Did the police driver look in all directions before going through the red light?
- Did the police driver slow before entering the intersection?
- Was the other vehicle speeding?

The oversighter did not provide this additional information. Nor was advice sought from PSC's Disciplinary Advisory Unit in relation to discipline charges. The oversight concluded that no further action was required.

CASE STUDY 17

A person was injured while being transported handcuffed in a police van. According to the arresting officers, they were unable to fasten a seatbelt on the individual because the person was being violent. The van swerved on the way to the station, the unsecured person was thrown across the van, hit their head and lost consciousness.

The oversight report recommended that consideration be given to lining the interior surface of vans with padded or softer material to reduce the risk of injuries. However, there was nothing on the file to indicate whether this recommendation was directed to an appropriate area of Victoria Police (such as Property or Transport divisions) or otherwise followed up.

CASE STUDY 18

An oversight file was created after a person attempted self-asphyxiation in a police cell. The oversighting officer developed recommendations in response to the incident, documenting them in the final report. These recommendations included: that a secondary check be conducted on detainees once they are advised they are to be remanded, especially if they are pre-disposed to self-harm; that all detainees should be checked once every 30 minutes; and that checks be documented on the attendance module. The oversighter recommended that the station SOPs be amended accordingly.

However, the oversight final report was not signed off by a supervising officer and there was no other material on the file to indicate that these recommendations had been communicated to an appropriate officer who would be in a position to approve and implement them.

CASE STUDY 19

An oversight file was created after a person was injured during their arrest. The individual was arrested and handcuffed by attending officers but resisted being placed in the back of a police divisional van. During the ensuing struggle, the person sustained serious injuries to their eye that required emergency surgery the following day.

The oversight process identified there was no CCTV footage from the camera attached to the divisional van for two reasons:

- The camera attached to divisional vans must be manually activated from the van's centre console. Police at this incident did not activate the camera before leaving the van, as they did not anticipate the need for CCTV and they did not have an opportunity to return to the console to activate the camera because of the resistance offered by the individual.
- Even if the camera had been activated, it would not have recorded the incident because the memory SD card was full.

The oversighter undertook further research and identified these were not isolated issues. They made recommendations on how these issues could be addressed and documented how these recommendations had been followed up (that is, through the roll-out of larger capacity hard drives for divisional van cameras and the development of a divisional van camera that automatically activated when a van's rear door had been opened).

In the absence of CCTV footage, the oversighter was resourceful and thorough in verifying the version of events provided by the police officers. The oversighter provided the statements of the individuals involved, together with the medical records of the injured individual, to an independent expert in forensic medicine to identify any inconsistencies. Further, the oversighter sought statements from independent civilians, recordings from D24 and other CCTV footage to verify the police officers' version of events. These disparate sources of evidence were consistent and were cross-referenced on the oversighter's interim report. The thoroughness of the oversight lent credibility to the determinations reached and the recommendations made for future improvements.

3.3.4 Human rights

3.3.4.1 Policy and practice

The *Charter of Human Rights Act 2006* requires Victoria Police to act in a way that is compatible with human rights and to ensure decision-making gives proper consideration to relevant human rights.

Victoria Police policy states the oversights and investigations must take into account the inherent rights and freedoms of all persons involved.[51] The oversighter and investigator are required to identify rights that were limited, and consider if there was reasonable justification for the limitation and how it was exercised. Human rights are listed as one of the oversight principles that must be considered as part of each oversight.

[51] Victoria Police manual guidelines, Oversight of death or serious injury/illness incidents involving police, section 3.2.7.

3.3.4.2 Analysis: human rights

The audit identified that human rights were addressed in only 55 (39 per cent) of the files audited. In the 55 files that did address human rights, the audit identified that there were issues with how human rights were addressed in 10 files. These issues included:

- not addressing human rights in sufficient detail
- failing to address clear human rights issues
- labelling issues as 'rights' that are not rights under the Charter or under another relevant instrument.

3.4 Timeliness

3.4.1 Key findings: timeliness

The audit identified that there were delays in the completion of more than a third (37 per cent) of the audited files. These delays were mostly associated with poor investigative procedures including slow file movements and the need to undertake further work to correct failings in a file. There were also significant delays associated with providing outcomes to officers involved in an incident or investigation, with 19 per cent of files taking more than 60 days to notify officers of outcomes.

There were inconsistencies identified in how oversight files dealt with delays caused by coronial inquests. Where an oversighter had completed their initial responsibilities, yet the coronial outcomes were pending, different approaches were used including marking the file as complete, 'diarising' the file, or leaving the file open. These different approaches led to some files appearing delayed when, in fact, the oversight had been completed in a timely fashion.

Auditors had concerns about the extensions granted to oversight files. In 43 per cent of files that were granted extensions, auditors identified issues, including an absence of extension documentation and a failure to complete the file by the extended due date.

3.4.2 Registration, allocation and oversight

3.4.2.1 Policy and practice

The Victoria Police guidelines on complaint management and investigations specify timeframes within which PSC files must be completed. These timeframes are calculated as the period between the date the complaint or incident was lodged with PSC and the date the investigation or oversight is completed and any required action is approved by PSC.[52]

Timeframes can be suspended if a delay is caused by an external factor. According to the policy guidelines, an investigation or oversight should not be paused because an officer, witness or investigator is on leave or engaged in other activities. Managers should consider reallocating an investigation if the investigator or oversighter is unable to attend to the file.[53]

3.4.2.2 Analysis: timeliness of registration, classification and allocation

The audit found that oversight files were generally registered, classified and allocated in a timely fashion. These activities are undertaken by PSC prior to a file being passed to an oversighter.

The significant delays (more than 20 days) associated with the registration and allocation of 11 files were generally not caused by systemic issues or issues with PSC processes. For example, the oversight of three files was delayed because an alternative review process was being undertaken first.

FIGURE 8: TIMEFRAMES FOR COMPLETION OF PSC FILES WITHIN THE SCOPE OF THE AUDIT

Classification	Complaint type	Days
C1-8	Incident investigation/ oversight	90
C2-1	Minor misconduct	90
C2-5	Management intervention model (MIM)	40
C3-2	Misconduct connected to duty	90

FIGURE 9: TIME TAKEN TO REGISTER, CLASSIFY AND ALLOCATE OVERSIGHT FILES

Process	Number of days taken					
	0 to 5	6 to 10	11 to 20	20+	Other	Total
Registration	104	15	13	8	2	**142**
Classification	138	1	1	0	2	**142**
Allocation	101	27	10	3	1	**142**

[52] Victoria Police manual guidelines, Complaint management and investigations, section 6.6 Timeframes.

[53] Victoria Police manual guidelines, Complaint management and investigations, section 6.7 Deferral of an investigation.

3.4.2.3 Analysis: timeliness of oversight

The audit found that a majority (63 per cent) of files within the audit's scope were completed within the 90-day time frame allowed for oversight files.[54] A further six per cent of files were completed within two weeks of the due date.

FIGURE 10: TIME TAKEN TO COMPLETE OVERSIGHT

	Number of days taken					
	0 to 90	91 to 105	106 to 150	150+	Other	Total
Number of files	90	9	10	32	1	142
Percentage of total	63%	6%	7%	23%	1%	100%

The audit identified that there were issues around the timeliness of 51 of the 142 files (36 per cent). These issues included:

- poor investigative procedures including slow file movements, files allocated to investigators going on leave, and the need to undertake further work to correct failings in a file – 21 files
- delays in notifying officers involved of outcomes – 15 files
- delays associated with coronial proceedings – five files
- delays in classification/allocation – five files
- other delays not reflective of poor practice, including files reclassified from a C1-8 to a C2-5 – five files.

Significantly, the audit identified that 32 files (23 per cent) took more than 150 days to complete (that is, they were more than two months overdue). These delays were attributable to:

- delays associated with coronial proceedings – 18 files
- poor investigative procedures including slow file movements, investigators going on leave and the need to undertake further work to correct failings in a file – eight files
- other delays not reflective of poor practice, including those caused by external departments (such as VicRoads), parallel disciplinary proceedings, or difficulties in contacting civilians – six files.

[54] Although 17 files were reclassified as MIM files (which have a 40-day permitted time frame for completion), these files were assessed by auditors against their original 90-day limit as many were only reclassified after the oversight had been completed.

Although the majority of significant delays were attributable to coronial proceedings and not poor practice by the oversighter, the audit did identify inconsistencies in how oversighters dealt with delays caused by coronial processes. Where an oversighter had completed their initial responsibilities, yet the coronial outcomes were pending, inconsistent approaches included:

- marking the file as complete once the initial oversight report had been completed
- 'diarising' the file pending the outcomes of the coronial process (effectively pausing the file, leaving the file open and providing periodic updates to PSC on the status of the coronial process)
- leaving the file open and submitting extension requests to extend the due date.

3.4.2.4 Analysis: timeliness of notification

The audit identified some issues in delays taken to notify the officers involved of the outcomes of an oversight process.

FIGURE 11: TIME TAKEN TO COMMUNICATE OUTCOMES OF OVERSIGHTS TO THE OFFICERS INVOLVED

	Number of days taken				
	0 to 60	61 to 120	121+	Other[55]	Total
Number of files	52	16	11	63	**142**
Percentage of total	37%	11%	8%	44%	**100%**

Although there is no formal time limit set on how quickly officers should be notified, the audit identified that in 27 files (19 per cent) it took more than 60 days to notify the officers involved of the outcomes. This delay represents the number of days from when the file was marked complete to the date on any letters or emails notifying the officers involved of the outcome.

[55] 'Other' includes files where there were no identifiable officers involved or where it is unclear when officers were notified of the outcome of the oversight.

3.4.3 Extensions

3.4.3.1 Policy and practice

Victoria Police policy guidelines allow oversighting officers to apply for extensions. The request for the extension and the approval must be attached to the file.[56] These requests must be made before the due completion date and should be approved by:

- Local Area Commanders (generally Inspector-level officers) for a first extension up to 30 days
- department heads (generally Assistant Commissioners) for subsequent extensions.

The guidelines specify that extensions should not be granted for the following reasons:

- subject officers (officers involved in the incident being overseen) are on leave or rest days
- the oversighter is on leave or rest days.[57]

3.4.3.2 Analysis: extensions

Extensions were sought in relation to 30 files within the audit's scope.

Of the 30 files where extensions were sought, auditors had concerns about the extensions granted in 13 files. These concerns included:

- files where no extension requests were attached to the file – eight files
- files were still overdue despite the extensions that were granted – three files
- other concerns including where extensions were sought for inappropriate reasons (that is, because the oversighting officer went on leave) – two files.

FIGURE 12: EXTENDED FILES BY THE NUMBER OF DAYS EXTENSION GRANTED

	Total number of extension days granted					
	0 to 30	**31 to 60**	**61 to 90**	**91+**	**Unclear**	**Total**
Number of files	11	5	3	8	3	30
Percentage of extended files	37%	17%	10%	27%	10%	100%

[56] Victoria Police manual guidelines, Complaint management and investigations, section 6.6 Time frames.

[57] Victoria Police manual guidelines, Complaint management and investigations, section 6.6 Time frames.

3.5 Record keeping

3.5.1 Key findings: record keeping

The audit identified that a majority (78 per cent) of oversight files did not include all of the relevant material. In particular, many files did not include completed conflict of interest forms or statements from relevant parties that would assist in independently verifying the accounts given by the police officers involved. Many files were also missing reports that addressed the oversight principles – either as stand-alone reports or as part of the final report included on the file. The absence of conflict of interest forms, independent evidence and reports against the oversight principles undermines the purpose of the oversight process as a means of critically examining the actions of police to prevent similar incidents in the future.

3.5.2 Policy and practice

Victoria Police's policy guidelines do not outline how oversight files should be compiled. However, Victoria Police IMG instructions on how complaint investigation files should be compiled serves as a useful reference for what material should be included on oversight files.[58] The IMG states that documents should be attached chronologically from the back of the file and should include final and interim reports, investigation plans, statements, medical reports and other relevant evidence.

3.5.3 Analysis: record keeping

IBAC auditors identified that there were issues with the documentation included on 111 files (78 per cent). These issues included a failure to include:

- conflict of interest forms (or forms that were attached but were not approved)
- statements from relevant parties (particularly civilians or medical professionals)
- reports that addressed the oversight principles
- copies of CCTV footage
- notification letters or emails to the officers involved in an incident
- briefs prepared for the coroner or reports from the coroner
- policies or standard operating procedures
- extension requests
- photos
- use of force forms.

[58] Victoria Police Integrity Management Guide, April 2015, p 14.

CASE STUDY 20

A person was arrested and interviewed by Victoria Police in relation to alleged sexual offences, then released pending summons. Three days later the person killed themselves and left a note discussing the allegations.

A local officer was assigned responsibility for investigating the death and preparing a brief for the coroner's inquest. The same officer was also assigned the oversight file relating to the investigation.

There were significant shortcomings associated with the record keeping for the investigation and oversight. The oversight file did not include any evidence, statements or supporting material. References were made to statements that had been submitted to the coroner, but the coroner's brief was not attached to the oversight file. Consequently it was difficult to determine whether conclusions reached in relation to the oversight process were justified.

In addition to the poor record keeping, the oversight lacked substance and analysis, with only cursory comments included to address conflicts of interest, proportionality and human rights. There were issues associated with the timeliness of the investigation that should also have been considered in the oversight report.

4 Conclusion

IBAC's audit of Victoria Police's oversight files examined how Victoria Police responds to incidents resulting in deaths or serious injuries associated with police contact. Ensuring such serious incidents are investigated thoroughly and fairly helps build public trust in Victoria Police.

Across the areas examined by IBAC's audit, auditors identified good practices and areas for improvement, and these have informed this report's key findings and recommendations. Some of these issues, particularly conflicts of interests and human rights, have been previously highlighted in IBAC's 2016 *Audit of Victoria Police's complaint handling systems at the regional level*.

IBAC acknowledges Victoria Police has initiated changes to improve complaint handling and oversight. These changes include a wide-ranging review of its complaint handling and discipline system in response to the Victorian Equal Opportunity and Human Rights Commission's reporton sex discrimination and sexual harassment in Victoria Police.

IBAC is planning further audits of Victoria Police's complaint-handling processes to identify issues and good practice across different regions, departments and commands. By highlighting areas for improvement, these audits contribute to Victoria Police strengthening how it manages complaints and oversights.

4.1 Recommendations

Following IBAC's audit of Victoria Police's oversight files, IBAC recommends that Victoria Police:

1. creates a standard memorandum to be sent to supervisors responsible for allocating oversights, providing clear advice that the oversighter should be independent to both the incident and investigator, and reminding these supervisors of the purpose of the oversight process
2. ensures that all oversighters complete the conflict of interest declaration at the commencement of the oversight process, that the form is included on the file, and where there is a conflict declared, the supervisor puts a plan in place to avoid any reasonable apprehension of partiality
3. examines ways to improve the supervision provided by EPSOs to ensure greater consistency in how oversights are completed, including in relation to reclassification, timeliness, record keeping and how deficiencies are addressed
4. standardises how oversight matters are reclassified to ensure consistency in cases where performance issues are identified
5. revises the determinations and recommendations that are made at the conclusion of oversights to better describe the outcomes of the oversight process[59]
6. provides oversighters with clear information and training on the Victorian Charter of Human Rights to assist in identifying human rights that have been breached
7. requires that incidents involving the SOG be overseen by Professional Standards Command (PSC)
8. works with IBAC to improve the system for notifying IBAC of all deaths and serious injuries following police contact.[60]

Victoria Police has accepted IBAC's recommendations and IBAC will monitor their implementation. IBAC has requested that Victoria Police provide an interim report on its implementation of the audit's recommendations by September 2018 and a final report by March 2019.

[59] IBAC acknowledges that Victoria Police is currently reviewing its complaint handling and discipline system as part of its response to the Victorian Equal Opportunity and Human Rights Commission's *Independent review into sex discrimination and sexual harassment, including predatory behaviour, in Victoria Police*.

[60] In September 2017, in response to the audit, Victoria Police commenced notifying IBAC by automated email whenever an oversight file is created. This process should ensure IBAC is notified of all oversight files.

5 Appendix – Audit instrument

5.1 Pre-oversight process

Issue	Audit instrument questions
Classification	• Does audit officer agree with the incident classification? — If no, why not: [free text]
Reclassification	• Was the incident reclassified? — If yes, what was the incident reclassified as? — If yes, what reason was given for the reclassification? — If no, does the audit officer think the matter should have been reclassified? • Does the audit officer agree with the incident reclassification? — If no, why not: [free text] (eg the incident should have been reclassified but it was not).
Notification of IBAC	• IBAC case reference number — Date IBAC notified — If IBAC was not notified, should it have been? [free text]. • IBAC review ID — Date IBAC received file for review — Date IBAC returned file to VicPol.
Identification of relevant officers	• Count the number of subject officers identified in the incident by rank. • Based on the available information, does the audit officer agree with number and identification of subject officers? — If not, why not: [free text]
Complaint/incident history checks	• Does the file indicate that subject officers' complaint/incident histories were considered? • Do the subject officers' have relevant complaint/incident histories? (ROCSID check) — Comment on subject officers' complaint/incident histories: [free text]

Issue	Audit instrument questions
Conflicts of interest	• Has VP Form 1426 (Oversight/Investigation Conflict of Interest Questionnaire and Approval) been completed? • Is there a conflict of interest? — If yes, then select from dropdown [include free text option if 'other' is selected] • Was a conflict of interest identified by Victoria Police? — If yes, how was the conflict of interest addressed by Victoria Police? (including by Form 1426) — If yes, who identified the conflict? — Comment on how the conflict of interest was addressed/adequacy of the management plan: [free text] • Was the incident overseen by PSC or assigned locally? — Was this appropriate? • Rank of the primary oversighter • Does the oversighting officer have a complaint/incident history which may impact on his/her ability to oversight the incident? — Comment on relevant complaint history: [free text] • Based on the available information, was the choice of oversighter appropriate? — If not, why not: [free text] (eg not senior to subject officers, supervisor of the subject officers).

5.2 Oversight process

Issue	Audit instrument questions
Contact with officers involved/subject officers	• Count of officers involved ('subject officers') • Count of subject officers: — contacted (includes providing a statement) — criminally interviewed — disciplinary hearing — resigned during oversight/investigative process. • Were all the subject officers contacted? — Reasons for not contacting a subject officer.
Contact with police witnesses	• Count of police witnesses: — identified/contacted. • Were all the relevant police witnesses contacted? — Reasons given for not making contact with police witnesses.
Contact with civilian witnesses (incl relatives)	• Count of civilian witnesses: — identified/contacted. • Were all of the relevant civilian witnesses contacted? — Reasons given for not making contact with civilian witnesses.
Contact with complainant (where reclassified)	• Count of complainants: — identified/contacted. • Were all of the relevant complainants contacted? — Reasons given for not making contact with complainants.
Contact with coronial investigators	• Was a coronial investigator appointed? • Was there contact between the oversighter and the investigator? • Were there any concerns with how the oversight and investigative processes interacted? (eg conflicts over roles, contact with witnesses etc)
Incident debriefs	• Were incident debriefs undertaken? — Were debrief reports included on the file?
Scene management	• Did the oversighter attend the scene of the incident? — Was the oversighter responsible for scene management? — Were there any concerns with how the scene was managed? (eg delays in attending scene, conflicts over responsibilities, failure to preserve evidence, officers separated, officers interviewed within a reasonable time?)
Evidence gathered	• Were there relevant types of evidence that should have been examined but were not? (Yes/no) — What were those types of evidence?

Issue	Audit instrument questions
Review of investigation	• Was the oversight reviewed by a supervisor? — Did the supervisor identify the need for further work? • Was the oversight reviewed by IBAC? — Did IBAC identify any deficiencies or issues? — Were these deficiencies/issues addressed?
Proportionality	• Does the audit officer consider the oversight proportional to the incident? — Why/not?

5.3 Outcomes

Issue	Audit instrument questions
Determinations	• What was the determination/finding? • Were there any differences in the determinations listed on the final report, the final letters and ROCSID? — Details of any difference between ROCSID and the paper files regarding the determination: [free text] • In the audit officer's opinion, was the determination/finding appropriate? — If no, reasons why the determination was inappropriate: [free text]
Recommendations	• What recommendations were made? • Were the recommendations appropriate? — If no, reasons why the recommendations were inappropriate: [free text] • Does the final report or issues cover sheet identify any deficiencies with: — Victoria Police procedures or policies? — Work unit procedures or policies? — Details of deficiencies identified. • Was there any record of a response to the recommendations or an indication of how they would be followed up?
Communication with relevant parties	• Were relevant civilian parties updated on the progress of the oversight, including that an oversight process was being undertaken? — If no, what was the reason for the lack of contact: [free text] • Were relevant civilian parties informed of the outcome of the oversight? — If no, should they have been?
Advice to subject officers	• Was the outcome of the oversight process communicated to subject officers? — What issues were evident in the communication with the subject officers?
Human rights breaches	• Does the final report address human rights? — Comments on how human rights were addressed: [free text]
Other oversight/ investigation	• Was the incident the focus of any other investigative or review processes (eg Coroner, Operational Safety Committee etc) — If yes, were the outcomes of the other process included on the file? — Were there any discrepancies between the processes?

5.4 Timeliness

Issue	Audit instrument questions
Time taken to register, classify and allocate	• Date incident: — occurred — classified — allocated — reclassified. • Autopopulate: — days from incident to classification — days from classification to allocation — days from allocation to reclassification. • Reasons for any delay in classification, reclassification or allocation — Consequence of any delay (eg issues with communication to families of deceased persons).
Time taken to complete oversight	• Date: — ROCSID due date for completion — ROCSID date file marked completed — of final report — advice received from coroner advising the completion of coronial processes. • Autopopulate: — days taken to complete oversight — days overdue — days between final report and file being marked closed on ROCSID. • Reasons for delays in completing the file — Were delays as a result of pending coroner advice?
Extensions	• Were any extensions sought? — Are all extension requests and approvals attached to the file? — Were extensions referred to the appropriate officer for approval? — Total period of extensions obtained (in days).

5.5 Record keeping

Issue	Audit instrument questions
Record keeping	• Was all relevant documentation included in the file? — Comment on what was missing: [free text] • Was the incident entered and managed on Interpose?

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