

Review of the investigative process following a death associated with police contact

Letter of transmittal

To

The Honourable the President of the Legislative Council

And

The Honourable the Speaker of the Legislative Assembly

This report is presented to Parliament in accordance with section 28(2) of the *Police Integrity Act 2008*. It details the outcome of a Review I commissioned in November 2009 that examined the Victoria Police policies and processes for investigating deaths associated with police contact. It also examined the relevant legislative framework for conducting investigations into deaths associated with police contact.

This Review has involved an unprecedented consultation and collaboration between stakeholders representing diverse interests.

I am very grateful for the extensive contribution made by participants to this Review. The time spent by so many reflects a commitment to improving systems and processes for the investigation of deaths associated with police contact in Victoria. The professionalism displayed by individuals who participated in this Review, in spite of disparate views, demonstrated a shared commitment to ensuring we learn from these tragedies to try and prevent their recurrence.



Michael Strong

DIRECTOR, POLICE INTEGRITY

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In our opinion, an inquest into a police shooting, where the investigation has been conducted by the police, does not bring closure to a person's death, but total dissatisfaction with the existing system. Therefore the public perception, of police investigating police, being a total conflict of interest, prevails.¹

The profound effect on a police member directly involved with a death 'in custody', in my experience, is horrific, as it effects all aspects of your life. The incident affected my work, my marriage, my family and my life. Even, after all these years, to recall the incident causes a great deal of emotion.²

[We need to acknowledge the] reality of the power relationships that are implicit and explicit in a death in custody situation. Given that all of the circumstances exist all over the country, where deaths in custody occur, if we are committed to avoiding that as a police force, community etc then we need to think long, hard, courageously and bravely. We need to think about what these systems look like in reality and on paper.³

Prevention is important. What worries me a little bit is the danger in saying that we need to avoid another Palm Island by developing some sort of idealist procedure. The process alone is not going to solve anything. How do you achieve this and how effectively do you achieve this independence? Any kind of independence will never be satisfied. There is so much distrust of the system and institutions. How do we deal with the prevention idea and not putting so much faith in the system?⁴

1 Springvale Monash Legal Service (2010), submission to OPI Review

2 Anonymous submission received 9 June 2010

3 Forum participant (2011)

4 Forum participant (2011)

Executive summary

Any death associated with police contact is a tragedy not only for the family and friends of the deceased, but also for the police involved.⁵ It is important that the investigation of a death associated with police contact is conducted in such a way as to give the public confidence that the circumstances surrounding the death will be subject to the highest levels of scrutiny. This is necessary to ensure that we may all learn from the death and take any necessary steps to prevent similar deaths recurring in the future.

This report sets out the findings of the Office of Police Integrity's (OPI's) Review of investigations of deaths associated with police contact (the Review).

The aim of an investigation into a death associated with police contact is a 'search for the truth' about what has happened to determine whether:

- the police action was reasonable and proportionate in the circumstances
- any inaction was the result of a failure to discharge the duties and responsibilities of the State
- there are any lessons to be learnt that may prevent a future death.

The Review involved unprecedented consultation and collaboration between stakeholders representing diverse interests.

A key focus of the Review's research and consultation was an examination of the legislative and policy framework for investigating deaths associated with police contact, both here and in other jurisdictions. This research identified the following principles borrowed from other jurisdictions to underpin an optimal framework:

- Independence
- Effectiveness
- Promptness (timeliness)
- Next of kin involvement
- Sufficient public scrutiny (transparency)

A second key area of focus was the improvement of current processes, in particular:

- investigative responsibility
- incident management
- obtaining police account of events

⁵ For the purposes of this report a death associated with police contact refers to a death arising from police use of force, a police pursuit or a death in the custody of police. See *Defining deaths associated with police contact*

- police media management
- transparency of processes
- informing and caring for next of kin.⁶

Ultimately it is a matter for Government to devise and implement any change to the current framework. Victoria is in a unique position to be examining these issues, as Queensland is in the process of implementing a new model that more directly involves the State Coroner in the investigation of a death associated with police contact.

Since the commencement of this Review, there have been a number of improvements to current processes. OPI and Victoria Police now have a routine notification protocol in place. The Victoria Police Ethical Standards Department has developed and implemented an enhanced oversight model to ensure the integrity of investigations carried out by specialist investigators. OPI has also developed and implemented a response protocol to ensure independent oversight of police processes. Multiple agencies have agreed to work collaboratively to ensure the next of kin and loved ones of people who have died in circumstances associated with a police contact have access to support and information.

Although there remain differing views about the extent to which the current system needs changing, there is consensus that despite the improvements which have been introduced since the commencement of this Review, there is still more to be done.

In particular, OPI considers that media statements made by some police shortly following a death associated with police contact undermine public confidence in the integrity of the investigation that has usually only just commenced.

Despite some differing views, the professional relationships between participants established in the course of this Review form a solid basis for continued consultation and collaboration among key stakeholders. This on-going cooperation is critical to the successful implementation of the recommendations in this report.

⁶ For the purposes of this report 'next of kin' and 'loved one' means 'close family member' or 'dependant' as defined by the *Victims of Crime Assistance Act 1996*

Overview

Police powers

The State provides police with exceptional powers in order to protect the rights of its citizens. Sometimes the exercise of those powers results in the loss of life. When someone dies because of the lawful exercise of police powers, we are all accountable.

When someone dies because of the lawful exercise of police powers, we are all accountable.

The State has a primary duty to protect life. In Victoria, this duty is enshrined in section 9 of the *Charter of Human Rights and Responsibilities Act 2006* (the Charter).

Every person has the right to life and has the right not to be arbitrarily deprived of life.⁷

The powers given to police to protect this and other rights are unique. The State has authorised police to act against those who would harm or threaten the rights of others. In order to preserve the peace and protect the rights of people police have the lawful authority to:

- use force including weapons (firearms, batons, capsicum spray) and compliance or restraint holds
- disobey traffic management controls
- deprive citizens of their liberty by physically restraining and detaining them
- seize and confiscate personal property
- apprehend people who appear to be mentally ill and pose a risk to themselves or others for the purposes of obtaining a mental health assessment.

At times, the action or inaction of police, results in the death of a person.

Police related deaths

While only a small number of contacts with police in Victoria result in death, any death associated with police contact is a tragedy. The repercussions are life-changing, not only for the family and friends of the deceased, but also for those police involved in the death and their friends and families. Many police involved in deaths associated with police contact never return to work and are scarred for life by the experience.

Because such a death is associated with the powers granted to police by the State, the State must conduct an enhanced investigation with the highest levels of rigour,

⁷ It is recognised that section 10 of the Charter, *protection from cruel and degrading treatment*, is also relevant to these discussions

scrutiny and accountability. This is essential to ensure we understand whether police, acting on behalf of the State, have used their authority appropriately. It is also essential to enable us to understand what has happened, why it happened and what, if anything, can be done to avoid a future tragedy.⁸

Investigation into unexpected deaths

When anyone dies unexpectedly as a result of the action or inaction of another person, police must investigate the death. The investigation into the death of the person must be undertaken with objectivity, neither presuming nor excluding the possibility that a crime may have occurred. Once a cause of death has been determined, police consider whether:

- the action or inaction that resulted in the death was reasonable and proportionate in the circumstances.

In this respect deaths associated with police contact are no different from any other unexpected death.

In other respects deaths associated with police contact are different. Because police are authorised by the State to take action that may result in death, the investigation of these deaths must also determine whether:

- any action or inaction was the result of a failure to discharge the duties and responsibilities of the State
- anything could have been done to prevent the death.

Context for this Review

On 11 December 2008, 15-year-old Tyler Cassidy was fatally shot by police. Following Tyler's death, concerns were raised by the Cassidy family and community legal groups about the involvement of Victoria Police in the coronial investigation. In particular it was argued that Victoria Police had a conflict of interest in conducting the investigation, as there was a *prima facie* breach of the *right to life* obligations imposed on the State by the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter).⁹

These arguments gathered momentum in June 2009 when the Queensland Court of Appeal, in ordering a new coronial inquiry, cast doubt on the integrity of the initial police investigation into the death of Mulrunji Doomadgee, who died in police custody on Palm Island.

⁸ *Legal Services Commission v Humberstone, R (On the application of)* [2010] EWCA Civ 1479 (21 December 2010)

⁹ While the timing of this Review coincided with increased public debate about the involvement of police in investigations of the Cassidy matter, this report is not about Tyler Cassidy. At the time of writing the Coroner is yet to deliver her findings in relation to his death

This Review was initiated in November 2009 in response to these and other concerns. In December 2009, two people died in Victoria Police custody within two days of each other.

Methodology

The methodology adopted by the Review Team involved preliminary research followed by an extensive consultation and collaboration phase with a diverse group of stakeholders.

An initial forum held in July 2010 included the Victorian and Queensland State Coroners and representatives from Victoria Police, the Police Association, interstate oversight agencies, community legal centres, victim support agencies, academia and human rights advocates.¹⁰ The forum heard from international experts regarding practices in Canada, the United Kingdom and New Zealand. These experts referred to the European Court of Human Rights principles for investigating deaths associated with police contact. These principles are:

- Independence
- Effectiveness
- Promptness (timeliness)
- Next of kin involvement
- Sufficient public scrutiny (transparency)

Forum participants expanded on these principles and agreed that the following should be taken into account in any deliberations about an optimal framework.

- Accountability
- Expertise and professionalism
- Impartiality
- Independence
- Integrity
- Inclusion of the affected
- Proportionality
- Promptness/timeliness
- Rigour
- Systemic perspective

Following the forum, the Director, Police Integrity initiated a standing 'own motion' to complement the Review and actively oversee deaths associated with police contact. OPI released a discussion paper in October 2010 based on forum discussions and further research.

¹⁰ See Appendix Four for Participants

Between January and March 2011, OPI convened a series of working groups with local forum participants that examined:

- Improving current processes
- Knowledge and media management
- Next of kin involvement
- Establishing a current approach

In May 2011, a second forum heard feedback from the working groups and discussed proposed recommendations.¹¹

Key issues

The appropriateness of Victoria Police conducting investigations into police related deaths has been central to this Review. Although some consider police to have the most relevant investigative expertise and a greater capacity to respond in a timely fashion, others question the independence and impartiality of police in conducting such investigations.

Some of those who contributed to this Review expressed concerns that Victoria Police has a conflict of interest in the outcome of the investigation. They say the police ‘search for the truth’ may conflict with their interest in protecting the reputation of Victoria Police and safeguarding legal or financial liability that may arise if a person is wronged by the actions of police. Concerns were also raised regarding a culture of loyalty and empathy within police services, in which members ‘look out for one another’.

The debate regarding the appropriateness of Victoria Police to conduct investigations into deaths associated with police contact is fuelled by a history of use of force and deaths in custody. Victoria Police has a unique history of deaths associated with police contact. Between 1980 and 1995, 35 people were fatally shot by Victoria Police. This was twice as many people who died at the hands of Victoria Police than in all other Australian jurisdictions combined over the same period.

Since 1995, Victoria Police has undertaken a series of reviews and changes to policies and systems aimed at reducing the number of deaths associated with police contact. These included Operational Tactics and Safety Training and the adoption of less than lethal weapons including capsicum spray. These initiatives have been the subject of a number of previous reviews by OPI.¹² The development of a framework and processes for the investigation of deaths associated with police contact must acknowledge the legacy of these experiences and, where germane, learn from them.

¹¹ See Appendix Four for Participants

¹² Office of Police Integrity November 2005 *Review of fatal shootings by Victoria Police*; July 2009 *Review of the Use of Force by and against Victoria Police*

Participants in this Review were unable to agree about the extent to which the existing framework, despite further improvements, needs to be modified to boost public confidence in the process. Some maintain public perceptions of conflict of interest can be reduced within the current framework. They argue that expertise, timeliness and taxpayers' money would be sacrificed in establishing any new investigative body independent of police. Opponents of this view argue that human rights principles should be paramount and require an investigation hierarchically and institutionally independent of Victoria Police to provide public confidence in the process. These views are explored in more detail in the body of this report. Ultimately it is a matter for Government to consider the competing views and determine what, if any, policy or legislative changes may be appropriate.

Despite the debate on some fundamental issues, there was consensus that current processes require improvement.

Prior to 2009, Victoria Police had inconsistent procedures for the investigation of deaths associated with police contact. For example, apparent suicides in police cells would generally be investigated by the local Criminal Investigation Unit. Specialist homicide investigators would only be called if resources were available and there were doubts about the cause of death. The selection of the investigation officer was based purely on rank and relied on a self-declaration of any conflict of interest. The level and quality of the oversight of the investigation by Victoria Police's Ethical Standards Department was also inconsistent. OPI's own role was unclear and our level of involvement in the oversight of Victoria Police's handling of such deaths tended to be minimal.

As a result of this Review, Victoria Police has developed a more consistent procedure for the investigation of deaths associated with police contact. Currently, Victoria Police specialist units, from the Homicide Squad or the Major Collision Investigation Group, are responsible for the primary investigation into the majority of police related deaths. Their role is to determine if there has been any criminal conduct and to prepare a brief for the Coroner. The Ethical Standards Department has an active oversight of the integrity of their investigation, based on a clear set of principles established in consultation with OPI and other participants in this Review. OPI has also established clear policies and procedures that enable, where appropriate and necessary, a consistent and active independent oversight.

Other improvements to current processes agreed to in principle by participants in this Review relate to providing independent support services for next of kin and increasing public confidence and understanding by improving access to information about the relevant processes.

Despite the consensus regarding these improvements, there is still more work to be done. Debate continues about some issues, in particular, what a police spokesperson should say to the media shortly following a death associated with police contact. Police maintain it is important that police leaders demonstrate public support for the

welfare of police who are involved in these tragedies. In providing this support some recent examples demonstrate a tendency to exculpate police from any wrongdoing before any investigation has established the facts. This not only pre-empts the outcome of the investigation, it invites perceptions of bias and stereotypes police as 'looking after their own' while undermining the integrity of the investigation and the coronial process.

Public confidence in the process demands accountability and a thorough, objective search for the truth. It is understandable that police want to support each other, but premature statements pre-empt the investigation findings and diminish community confidence in the integrity of the process and with it any chance of legitimate exoneration. Ultimately the best support police can give each other is by ensuring public confidence in the integrity of the investigation and the validity of its findings.

Key Recommendations

OPI recommends

1. That the Victorian Government acknowledges a death associated with police contact is a unique incident that requires a special response by the State.
2. That relevant Victorian Government departments adopt the working definition of 'death associated with police contact' set out in this report to assist with the identification of deaths associated with police contact that require a special response by the State.
3. That the Victorian Government consults with key stakeholders regarding an optimal legislative framework for the investigation and oversight of deaths associated with police contact in Victoria.
4. That the State Coroner, the Department of Justice and Victoria Police have regard to the improvements to current processes suggested in this report.

Introduction

The Director, Police Integrity has a statutory obligation to ensure the highest ethical and professional standards are maintained in Victoria Police and that members of Victoria Police have regard to the human rights set out in the Charter.¹³ In November 2009, the Director commissioned this Review to determine the appropriateness of Victoria Police investigating deaths associated with police contact. The purpose of the Review was to establish:

- the sufficiency and appropriateness of Victoria Police policies and procedures and relevant legislative frameworks for conducting investigations into deaths associated with police contact
- options to existing law and practice regulating the conduct of such investigations.¹⁴

The *Police Integrity Act 2008* gives the Director power to conduct an own motion investigation in respect of any matter that is relevant to the achievement of his objects. Complementary to this Review, on 3 September 2010, the Director signed a determination to conduct an own motion investigation into the following matters:

- deaths associated with police contact
- the independence, effectiveness, timeliness and sufficiency of the Victoria Police investigation into such deaths
- the application and effectiveness of Victoria Police policies, practices or procedures that may be relevant to deaths associated with police contact.¹⁵

Based on an analysis of the last ten years, there are, on average, 16 deaths in Victoria each year associated with:

- police use of force
- police pursuits
- police custody
- a police operation.

Between November 2009 (when this Review commenced) until 1 June 2011, there were five deaths in custody, one fatal shooting, no deaths related to police pursuit, one suicide by a member of police and another death less directly associated with police contact which required a 'special response' investigation.

¹³ See *Police Integrity Act 2008*

¹⁴ A copy of the terms of reference for the Review is at Appendix One

¹⁵ A copy of the own motion determination is at Appendix Two

OPI's own motion determination facilitated a pilot program of oversight of these deaths. The lessons learnt from the oversight of these recent deaths have contributed to the recommendations in this report.

In the OPI issues paper published in October 2010, OPI undertook to deliver a report to the Victorian Parliament which included a detailed analysis of the potential models for Victoria to investigate deaths associated with police contact. This report presents this analysis and makes suggestions for the development of a new framework for investigating deaths associated with police contact. It also makes recommendations intended to improve current processes. These recommendations aim to ensure that what can be learnt from these tragedies is incorporated into police practice, thus contributing to the prevention of deaths associated with police contact.

The recommendations presented in this report were informed by:

- a review of current legislation and systems for investigating deaths associated with police contact in Victoria and other jurisdictions
- extensive stakeholder consultation (two forums, 11 working groups)
- OPI's own motion review of the management and investigation of recent deaths associated with police contact.

This report is structured around principles established by the European Court of Human Rights and agreed to by participants in this Review as being relevant for the investigation of deaths associated with police contact in Victoria. These are:

- Independence
- Effectiveness
- Promptness (timeliness)
- Next of kin involvement
- Sufficient public scrutiny (transparency)

A detailed methodology is presented at Appendix Three. In order to discuss the optimal framework for the investigation of deaths associated with police contact in Victoria, it is first appropriate to define 'deaths associated with police contact'.

Defining deaths associated with police contact

There was consensus among participants in this Review that a death associated with police contact is a unique incident that requires a special response by the State.

...a death associated with police contact is a unique incident that requires a special response by the State.

There is no common or consistent definition of deaths associated with police contact in Victorian legislation.

The *Coroners Act 2008* and the *Police Regulation Act 1958* use terms which include deaths that are described as 'police related' or 'associated with police contact' or 'deaths in custody'.¹⁶

A consistent legislative definition of 'deaths associated with police contact' would assist the State of Victoria to consistently respond appropriately to these matters, collect data and report publicly. The existing differences in classification used in the *Coroners Act 2008* and the *Police Regulation Act 1958* reflect the specific operational or administrative requirements of the State Coroner and Victoria Police. For example:

- The term 'reportable deaths' is used by the Coroner's Office to determine which deaths, not just police related deaths, will be subject to a coronial investigation and, in some cases, a coronial inquest.
- The term 'critical incident' is used by Victoria Police to determine the operational and investigative response to an incident resulting not just in death, but also serious injury. For example, after any such incident members may be tested for drugs and alcohol under the *Police Regulation Act 1958*.

In acknowledgment of the specific operational and administrative functions the current legislative definitions fulfil, OPI focused on establishing a working definition that would:

- provide clarity to enable the State to respond appropriately to these matters
- facilitate consistent responses across agencies
- enable the collection of reliable data
- assist with public reporting of these incidents.

OPI consulted extensively with participants to the Review, drawing on deaths in Victoria and those in other jurisdictions as case studies for the types of deaths which

¹⁶ Office of Police Integrity October 2010 *Review of the investigation of deaths associated with police contact – Issues paper* p14–15

may be considered a 'death associated with police contact' requiring a special response or enhanced investigation. As one working group participant noted:

*All deaths are different.*¹⁷

OPI found widespread agreement that a definition should include deaths that relate to direct actions of police or which occur in police custody.

There was less agreement among participants regarding situations where the causal connection between police action, or inaction, was more tenuous. For example, when someone has died:

- as a result of a self-inflicted gunshot in police presence
- after a police pursuit has been terminated
- after being reported missing to police
- after police leave a scene or incident
- days or weeks after a person has been released from custody.

In order to ensure that the State responds consistently and appropriately to all deaths associated with police contact, it is important that any definition provides relevant agencies with sufficient discretion to include other deaths where the relationship to police contact may be less direct, yet relevant.

Participants at OPI's second forum agreed that a working definition of a 'death associated with police contact' should include, but not be limited to, deaths associated with:

- police use of force
- police pursuits
- police custody
- a police operation.

Other deaths that require a special response should be determined by the Victoria Police Ethical Standards Department in consultation with the Coroner or the Office of Police Integrity.

This working definition would:

- facilitate cohesive responses to similar incidents across Government
- trigger support mechanisms, including supports for next of kin and loved ones
- aid in the identification of these deaths for data collection and public reporting.

¹⁷ Working group participant

How many deaths are associated with police contact?

As part of this Review, OPI reviewed Victoria Police and coronial data regarding critical incidents and reportable deaths. A detailed analysis of this data can be found in the OPI issues paper.

When the above definition is applied in the Victorian context, there are, on average, 16 'special response' deaths associated with police contact in Victoria each year. That is, 16 deaths associated with either a police pursuit, police use of force, a death in custody or other death in circumstances that may be causally connected with police action or inaction.

*...there are, on average, 16
'special response' deaths
associated with police contact
in Victoria each year.*

Jurisdiction

Current investigative responses to deaths associated with police contact are dictated by the jurisdiction of the Coroners Court of Victoria, Victoria Police and the Office of Police Integrity,¹⁸ explained below.

The Coroners Court of Victoria

The *Coroners Act 2008* provides the State Coroner with a statutory obligation to investigate a broad range of deaths that may be associated with police contact, including:

- a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury
- the death of a person who immediately before death was a person placed in custody or care¹⁹
- the deaths of a person under the control, care or custody of the Secretary to the Department of Justice or a member of the police force.

The Act does not dictate what level of investigation is required, nor does it define ‘investigate’ or ‘investigation’.

In order to determine the extent of the investigation required, regard must be given to the objectives of the *Coroners Act 2008*. The preamble to the Act states that the role of Coroner:

...involves the independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice...

It appears to follow that there must be a sufficient investigation of a reportable death by a Coroner in order to determine the cause of that death and to contribute, among other things, to the prevention of future deaths.

¹⁸ For an overview of legislation relevant to the investigation of deaths associated with police contact please see *Appendix Seven: Summary of relevant legislation*

¹⁹ Office of Police Integrity October 2010 *Review of the investigation of deaths associated with police contact – Issues paper* p14

To assist with this investigation, the Coroner is given wide investigative powers, including:

- powers of entry, search, inspection and possession
- the power to direct persons to produce documents, or operate equipment, or access information
- the power to take photographs
- a range of powers including the power to do anything that is reasonably necessary for the Coroner to investigate the death
- the power to conduct an inquest.²⁰

The Act obliges the Coroner to *liaise with other investigative authorities, official bodies or statutory offices to avoid unnecessary duplication of inquiries and investigations.*²¹

Victoria Police

Presently Victoria Police conducts the primary investigation of deaths associated with police contact. First, to determine whether any criminal conduct has occurred and second to prepare the 'inquest brief' for the Coroner.

The *Coroners Act 2008* states what the brief must contain.²² The *Coroners Act 2008* does not indicate:

- who is required to prepare the inquest brief, or
- that the investigation by the police is to be regarded as investigation by the Coroner.

There is nothing in the *Coroners Act 2008* which gives the Coroner the authority to direct the police investigation.

Similarly, there is nothing in the *Police Regulation Act 1958* that obligates police to assist the Coroner. However, the *Coroners Act 2008* does require a member of the police force who has information that may be relevant to an investigation by a Coroner to give that information to the Coroner.²³

It is a convention that the initial investigation and inquest brief are prepared by Victoria Police subject to the direction of the Coroner, but this has no basis in statute.

²⁰ *Coroners Act 2008* ss39, 40, 42 and Division 2, Part 5

²¹ *Coroners Act 2008* s7

²² *Coroners Act 2008* s115(7)

²³ *Coroners Act 2008* s36

The legal position appears to be that the police and the Coroner conduct their own investigations. The product of the police investigation is provided to the Coroner to assist the Coroner's investigation. This is done as a matter of cooperation between two agencies for the purposes of law enforcement and the administration of justice.

OPI

The *Police Integrity Act 2008* does not require the Director to undertake an investigation into a death associated with police contact.

The *Police Integrity Act 2008* empowers the Director, Police Integrity to conduct an 'own motion' investigation in respect of any matter that is relevant to the achievement of the Director's objects.²⁴ The objects relevant to deaths associated with police contact are:

- To ensure the highest ethical and professional standards are maintained in the Victorian police force.
- To ensure that police corruption and serious misconduct is detected, investigated and prevented.
- To ensure that members of Victoria Police act with regard to the human rights set out in the Charter for Human Rights and Responsibilities.

There will be many deaths arising from police contact where there is no allegation or suspicion of police corruption or serious misconduct. On the other hand, there may be deaths where there is a need to determine whether serious misconduct contributed to the death.

The purpose of an investigation by the Director, Police Integrity may be to determine whether the highest ethical and professional standards were maintained during the events which resulted in, or contributed to, or were associated with, the death. Equally, the purpose of the Director's investigation might be to determine whether the highest ethical and professional standards were maintained during the investigation of the death.

Like the *Coroners Act 2008*, the *Police Integrity Act 2008* does not prescribe how an OPI investigation should be conducted.

The Director, Police Integrity can conduct a *parallel* investigation to Victoria Police or conduct their own investigation into any aspect surrounding a death. However, the Director has no legal authority to conduct an investigation into a police related death to the *exclusion of* or *instead of* Victoria Police.

²⁴ *Police Integrity Act 2008* s44

Investigative and oversight responsibility

The current legislative framework for the investigation and oversight of deaths associated with police contact is not optimal.

An optimal framework for the investigation of deaths associated with police contact in Victoria would have statutory provisions that assign specific responsibility for various stages of the investigation, or perhaps the entire investigation. Making these obligations clear would avoid duplication of effort, enhance transparency and most importantly accountability.

...statutory provisions that assign specific responsibility to those responsible for various stages of the investigation, or perhaps, the entire investigation... would avoid duplication of effort, enhance transparency and most importantly accountability.

An optimal framework for Victoria

In order to identify 'optimal practice', OPI reviewed Australian and international models for the investigation of deaths associated with police contact. OPI's issues paper presented five models used in overseas jurisdictions for investigating deaths associated with police contact. These were:

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

Appendix Eight is an extract of the OPI issues paper where these models are discussed in more detail. The OPI issues paper recognised that despite geographical, cultural, political and social differences that give rise to different models, there is value in understanding the strengths and weaknesses of the models in determining an optimal framework for Victoria.

In relation to investigative models in Australia, OPI found most jurisdictions have models similar to that which operated in Victoria prior to the commencement of this Review. In most other Australian jurisdictions, primary investigative responsibility vests with police, with limited independent oversight by anti-corruption or oversight agencies.

The exception is Queensland. Following the criticisms levelled at the police investigation of Mulrunji Dumadgee's death, the Queensland State Coroner is in the process of developing a new model in conjunction with the Crime and Misconduct Commission and Queensland Police. This model, which at the time of writing is still being finalised, vests sole responsibility for the investigation of a death associated with

police contact with the State Coroner. Police will be seconded to the State Coroner's multi-disciplinary team to assist the investigation.

...the current model in Victoria is best described as a police investigation with independent oversight.

Since the commencement of this Review and OPI's own motion investigation, changes to both Victoria Police and OPI processes mean the current model in Victoria is best described as a police investigation with independent oversight.

Oversight in this context describes a variety of actions related to supervision and accountability. The level of oversight conducted by the Victoria Police Ethical Standards Department and OPI is determined commensurate with the circumstances of the death and can be measured on a continuum from active to passive oversight.

Active oversight seeks to ensure accountability. It involves seeking information as the investigation is being undertaken. At its highest level, active oversight may include:

- attendance at the scene and autopsy
- reviewing evidence
- suggesting witnesses
- questioning witnesses
- sitting in on interviews
- regular meetings with the investigating officer/s
- detailed review of final brief
- preparation of a review report for the consideration of the Coroner.

Passive oversight seeks to pulse check accountability. Passive oversight involves receiving information with or without critical assessment, review and feedback. A passive oversight role may include receiving notification of an incident and conducting a paper-based review of relevant investigative material.

The internal oversight by the Victoria Police Ethical Standards Department and the independent oversight by OPI aim to ensure the integrity of the primary investigation. This in turn should ensure the best available evidence, including forensic evidence, is provided to the Coroner prior to the commencement of any public hearing.

In spite of recent changes, there was general consensus among those who contributed to the Review that all aspects of the existing model for the investigation of deaths associated with police contact should be subject to continuous improvement and re-evaluation.

Participants in the Review discussed the advantages and disadvantages of adopting models from other jurisdictions and broadly agreed that Victoria has the opportunity to develop a framework which is informed by lessons learnt in other jurisdictions and appropriate for the needs of the Victorian community.

Current arrangements for the investigations of deaths involving police fall well short of community expectations and international human rights standards... there exist models in overseas jurisdictions for the independent investigation of police involved deaths.²⁵

There was significant debate among participants in working groups as to what an optimal framework for the investigation of deaths associated with police contact in Victoria might be. For some, the optimal model was an institutionally-independent body resourced and capable of conducting all elements of the investigation. For others, an ideal system was one in which the State and community had so much faith in the

²⁵ Darebin Community Legal Centre Submission – 18 June 2010

integrity of its police service and coronial processes there would be no need for an independent body.

It was agreed the principles developed by the European Court of Human Rights should underpin any framework. To assist with development of an optimal legislative framework for the investigation and oversight of deaths associated with police contact, this report provides an analysis as to what these principles mean in the Victorian context, in theory and in practice.

The Principles

Participants at OPI's first forum identified ten key principles which should underpin the development of a framework for the investigation into deaths associated with police contact. These were:

- Accountability
- Expertise and professionalism
- Impartiality
- Independence
- Integrity
- Proportionality
- Inclusion of the affected next of kin or loved one
- Promptness/timeliness
- Rigour
- Systemic perspective

Through submissions and consultations with working group participants, these ten principles were refined to five key principles which mirror those developed by the European Court of Human Rights.

The *Charter of Human Rights and Responsibilities Act 2006* (the Charter) imposes a number of obligations on Victoria Police. In the case of a death associated with police contact, the most pertinent of these rights is section 9, the 'right to life':

*Every person has the right to life and has the right not to be arbitrarily deprived of life.*²⁶

In order to protect the 'right to life', the European Court of Human Rights considers the State obliged to investigate deaths where the 'right to life' may have been violated. The European Court of Human Rights has outlined five key principles that must be fulfilled in order to ensure the integrity of the investigation (see Figure 1). These are:

- Independence
- Effectiveness
- Promptness (timeliness)
- Next of kin involvement
- Sufficient public scrutiny (transparency)

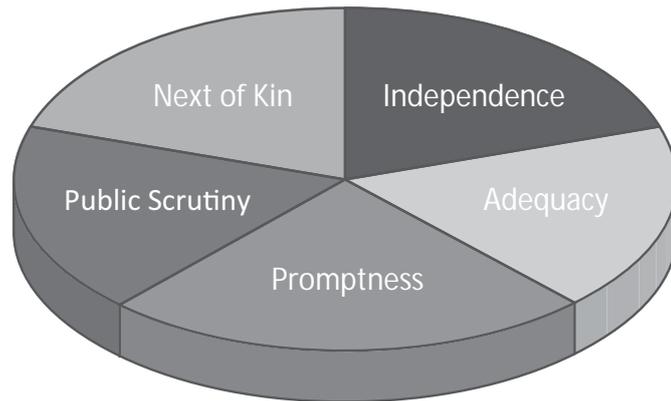
While these principles are established as standards for investigations into deaths caused by the State, they do not prescribe a specific form (or model) of investigation necessary for the State to fulfil its obligation to investigate a death.²⁷

²⁶ It is recognised that section 10 of the Charter, *protection from cruel and degrading treatment*, is also relevant to these discussions

²⁷ *Jordan v United Kingdom* (2001) 37 EHRR

There was consensus among participants in this Review that these principles are appropriate and relevant for Victoria in the development of a framework for the investigation of deaths associated with police contact. However, the relative weight that should be given to each of these principles, and the framework (or institutional structures) to support the investigation, were debated.

Figure 1: Balancing principles



The principles and their relevance to a framework for the investigation of deaths associated with police contact in Victoria are explained in this section.

Independence

Independence equates with impartiality.

The community deserves independent and effective investigations. Police officers involved deserve independent and effective investigations. I can't imagine what it is like to be a police officer involved in a death and being tarnished by real deficiencies in investigations, or oversight.²⁸

In the case of a death associated with police contact, the principle of independence raises issues of:

- institutional independence
- conflict of interest (individual and organisational)
- cultural independence.

²⁸ Forum Participant (2011)

Institutional independence

Institutional independence not only equates with impartiality, it negates perceptions of potential conflict of interest.

*The public is owed an explanation as to why we don't have an independent body. Where is the evidence? The Coroner is not conducting a human rights compliant investigation.*²⁹

Those calling for an independent investigative body in Victoria weigh the principle of independence heavily. They argue that the Charter requires the establishment of an independent body, because:

True independence is only achieved when an investigation is hierarchically, institutionally and practically independent of the organisation being investigated, that is:

- (a) The investigators are not from the same chain of command as those being investigated;*
- (b) The investigators are not from the same organisation as those being investigated; and*
- (c) The investigators do not uncritically rely on the version of events they have received from members of the body being investigated.*³⁰

The Victorian Charter provides that a human right may be subject to reasonable limits in certain situations.³¹ As explained in OPI's issues paper:

The obligations imposed by a human right may be limited when other factors are taken into account. For example, in the case of the right to life, the obligation for an 'independent' investigation may be limited if the establishment of a new body to investigate these matters reduces the 'effectiveness' of the investigation. In this case, the two obligations may need to be balanced.³²

There are many examples in international jurisdictions of independent institutions responsible for conducting investigations of deaths associated with police contact. These include the:

- Special Investigations Unit in Ontario, Canada
- Police Ombudsman for Northern Ireland

29 Forum participant (2011)

30 Human Rights Law Resource Centre (June 2010), Submission to OPI Review

31 Section 7(2), *Victorian Charter of Human Rights and Responsibilities Act 2006*

32 Office of Police Integrity October 2010 *Review of the investigation of deaths associated with police contact – Issues paper* p40

- Garda Ombudsman in the Republic of Ireland
- Independent Complaints Directorate in South Africa
- Independent Police Review Authority in Chicago, USA
- Independent Police Conduct Authority in New Zealand
- Independent Police Complaints Commission in England and Wales.³³

As discussed in OPI's issues paper:

With the exception of the Special Investigations Unit in Ontario, all of these agencies also have one or more other functions or responsibilities. For example, to investigate or oversee investigations of a range of other matters such as serious assaults, allegations of misconduct and corruption, other serious criminal offences, public complaints and use of force issues.

An additional risk identified for agencies with other functions is that the work of the organisation may become dominated by investigations of police related deaths, leaving fewer resources to be spent on other responsibilities, such as investigating allegations of police corruption and misconduct.³⁴

Discussion regarding the suitability of an independent body for Victoria considered the cost of establishing a stand-alone agency, or making investigations of police related deaths part of an existing oversight agency's core business. Unfortunately, despite requests to a number of agencies, OPI was not able to obtain accurate or meaningful data regarding the costs of investigating deaths in a stand-alone agency. Most agencies undertake multiple functions and are unable to provide reliable information that distinguishes the costs of investigating deaths associated with police contact from the overall costs of running the organisation.

At the time of writing, the Queensland State Coroner was also unable to provide cost estimates regarding his proposed model.

The working groups and participants in the second forum discussed at length the suitability of a Queensland coronial investigation model in the Victorian context. While some participants expressed support for the model, others expressed concerns that the involvement of the Coroner's office in the investigation could present a potential conflict of interest.

³³ The IPCA carries out 'independent' investigations of police related deaths but relies on a parallel police investigation for evidence to be used in criminal or disciplinary proceedings. The Government of New Zealand has announced its intention to legislate so IPCA is no longer reliant on the police investigation. See 'Cabinet approves changes to Independent Police Conduct Authority', <http://beehive.govt.nz/release/cabinet+approves+changes+independent+police+conduct+authority> Accessed 13 October 2010

³⁴ Office of Police Integrity October 2010 *Review of the investigation of deaths associated with police contact – Issues paper* p45–49

It was suggested that the involvement of the Coroner in the initial investigation will render the Coroner unable to independently critically assess the initial investigation.

Once the Queensland model is established, Victoria may be in a better position to evaluate its effectiveness and assess any resourcing implications.

Conflict of interest

Those advocating for an institutionally independent body to conduct investigations into deaths associated with police contact are fundamentally opposed to any model in which 'police investigate police',³⁵ primarily because of concerns regarding conflict of interest.³⁶

Conflict of interest (real, perceived or potential) can hinder both the investigative process and public confidence in that process.

A conflict of interest occurs when:

[a] personal interest comes into conflict with the professional interests of police when the personal interest could influence a policing decision. Vice versa, a professional interest comes into conflict with a personal interest when a policing decision could affect a personal interest of the decision maker. Either way, when personal interest is involved, there is a risk and a perception that the policing decision will not be made in a fair and impartial way.³⁷

Participants in this Review expressed concerns relating to conflict of interest in the investigation of deaths associated with police contact at the individual and organisational level.

At the individual level, a conflict of interest may occur when a personal interest of the investigating officer influences his or her investigative decisions. There was consensus among participants in this Review that individual conflicts of interest must be identified, disclosed and mitigated.

At the organisational level, concerns were raised that Victoria Police as an organisation has a conflict of interest in the outcome of the investigation. The search for the truth by Victoria Police may conflict with the need to protect its reputation and safeguard itself from any legal or financial liability that may arise if a person is wronged by the actions of an employee.

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

35 Office of Police Integrity October 2010 *Review of the investigation of deaths associated with police contact – Issues paper* p35–38

36 Office of Police Integrity October 2010 *Managing Conflict of Interest in Victoria Police* p5

37 Office of Police Integrity October 2010 *Managing Conflict of Interest in Victoria Police* p5

Given the potential for WorkCover prosecution against Victoria Police there could be a potential for conflict of interest with police conducting investigations into these deaths, as the outcomes of these investigations have a direct impact on the vulnerability of the organisation.³⁸

In the event of a death associated with police contact, risks to Victoria Police include being found liable under the *Wrongs Act 1958* and, or, under the *Occupational Health and Safety Act 2004*.

A submission made to this Review by a member of police involved in a death associated with police contact highlighted that conflict of interest at an organisational level can also lead to unfavourable treatment of the police involved.

So, if the investigation of such an incident can be removed from Police, then I support the initiative, as I believe that no other agency could possibly treat a member of the police force so harshly.³⁹

The development of a framework for the investigation of deaths associated with police contact must consider the impact of real, perceived and potential conflicts of interest on the integrity of the investigation and public confidence in the investigation, and the system that guides the investigation.

The framework should also take into account the reality that any institution established and funded by the State cannot consider itself free of any conflict of interest in investigating a death by the State.

The vast majority of Victoria Police members are law-abiding, dedicated and honourable employees who uphold the Victoria Police values of integrity, leadership, respect, support, flexibility and professionalism.

Throughout this Review participants regularly acknowledged the excellent work performed by Victoria Police, often in very difficult circumstances.

Some of the submissions made to this Review expressed concerns regarding a culture of loyalty and empathy within police services in which members 'look out for one another'. While loyalty is a virtue with many positive attributes, these concerns reflected a perception of an organisational culture among police in which *loyalty* was seen to make police vulnerable to overly-protective behaviour that could undermine the integrity of the investigation.

Public perception of Victoria Police's ability to investigate deaths associated with police contact has also been shaped by the legacy of fatal police shootings between 1980 and 1995. Despite a number of police being involved in suspicious fatal shootings,

³⁸ Law Reform Committee (2006), *Coroners Act 1985*, Parliamentary Paper No 229 Session 2003-2006, p209 Parliament of Victoria

³⁹ Anonymous submission received 9 June 2010

including the fatal shooting of suspects in the murder of two police officers, only one police officer ever faced criminal proceedings. He was acquitted.

Although these events occurred more than 15 years ago, their legacy remains. This history of so-called 'noble cause corruption' continues to influence the perception some still have of Victoria Police's capacity to be impartial and objective in investigating recent deaths associated with police contact, particularly if the deceased has a criminal record and is known to police.

Police investigators understandably take offence at assertions which call into question their professional integrity. It is unfair to assume that an investigation cannot be undertaken impartially because it is conducted by a police investigator.

OPI's own motion investigation found that Victoria Police investigations into recent deaths associated with police contact are of a high technical standard. The investigations reviewed were found to have been thorough, with all reasonable lines of inquiry pursued. OPI investigators remarked on the high level of professionalism and technical competency of Victoria Police investigators in conducting these investigations.

Deaths associated with police contact are a fertile ground for conflicts of interest. The nature of policing means many police know each other, if not personally, then at least by reputation. In some cases, police appear to consider themselves immune to bias in investigating or overseeing the investigation of former squad mates because they view themselves to be so ethical that they would not be unduly influenced by their pre-existing opinion of someone under investigation. This attitude inhibits their understanding of the impact this may have on public perception and confidence.

OPI's own motion investigation found that Victoria Police investigations into recent deaths associated with police contact are of a high technical standard.

Conflict of interest itself is not really the issue, the issue is how that conflict is managed. For example has the conflict been declared, how have the risks been mitigated, was there an independent evaluation of the mitigation strategy?

Cultural independence

Contributors to this Review agreed that public confidence should be a key object of a framework for the investigation of deaths associated with police contact. Preconceptions regarding a culture of police loyalty or prevailing attitudes that police will 'look out for their mates' can be detrimental to public confidence.

Conflict of interest itself is not really the issue – the issue is how that conflict is managed.

When the issue of cultural independence was raised in the course of this Review, serving and former members noted that there is not just 'one' Victoria Police culture.

They described Victoria Police as comprising numerous sub-cultures influenced by, among other things, the role a person has in the organisation.

In policing studies, organisational culture has been described as a set of assumptions created by a group as they learn to cope with problems. These assumptions are seen by the group to have 'worked well' in the past and are considered 'valid'. Because of this they are then taught to new members as the 'correct' way to perceive, think and feel in relation to those problems.⁴⁰ These assumptions can travel with people across institutions and shape the organisational culture of the institutions they reach.

Independent agencies in other jurisdictions studied in this Review generally employed a mix of current or seconded police officers, former police officers and civilian investigators who had never worked for a police service. Wherever there are current or former police, there is potential for policing organisational culture to transition with these personnel.

If Victoria was to establish an institutionally independent body and staff it with a large number of former police officers, there would still be a perception by some of insufficient cultural independence and bias.⁴¹

The advantages of staffing the body with current and former police officers include benefiting from their:

- contacts
- contemporary investigative experience
- understanding of police organisational culture.

Current police also know where to go and who to ask for information. An 'outsider' may not have the same knowledge and access.

If an independent body is to be established to investigate deaths associated with police contact, it would need to develop a considered and defined cultural plan to balance the recruitment of relevant institutional expertise while retaining cultural independence.

Absolute independence could possibly be achieved but it might be at the cost of organisational learning.

Victoria Police has a positive duty of care, as far as is reasonably practicable, to provide and maintain a working environment that is safe and without risks to health. In complying with this duty of care, Victoria Police must ensure that whatever can be learnt from a death associated with police is applied in policy and training to minimise the likelihood of any future death.

40 Edgar Schein. 1993. Organizational Culture and Leadership. In *Classics of Organization Theory*. Jay Shafritz and J. Steven Ott, eds. 2001. Fort Worth: Harcourt College Publishers. p373–374

41 Tamar Hopkins, *An effective system for investigating complaints against police*, Victoria Law Foundation, April 2009, p38

With an investigating body at arms-length from Victoria Police, there is a risk Victoria Police will be less able to understand all of the factors that contributed to the death and lose opportunities for improving practices aimed at preventing deaths. In order to maximise the opportunities for active and passive learning after a death associated with police contact, there *may* be an advantage in engaging Victoria Police in the investigative process.

Effectiveness

In the case of a death associated with police contact, the principle of effectiveness is concerned with issues relating to:

- investigative staff and institutional expertise
- application of resources
- proportionality of the investigation commensurate to the circumstances of the death
- adaptable and pragmatic processes
- community and police confidence.

Investigative staff and expertise

For an investigation to be effective those involved must have sufficient expertise. The skill set required to conduct an effective investigation into deaths associated with police contact has been subject to debate among participants in this Review.

Stakeholders acknowledged that the investigation into a death associated with police contact is different from the investigation of other deaths because some of the objectives of the investigation are different.

The 'golden hour' of investigations is particularly relevant where police are trying to locate a suspect. But in police related deaths, the person responsible is known and it is evidence gathering and the ability to reconstruct the scene that is of particular importance.⁴²

Another key difference between the investigation of a death associated with police contact and other unexpected deaths is that police have the lawful authority to exercise exceptional powers. The investigation of these deaths is conducted in order to determine if:

- the action was reasonable and proportionate in the circumstances
- the inaction was not the result of a failure to discharge the duties and responsibilities of the State
- whether anything could have been done to prevent the death.

⁴² Federation of Community Legal Centres, Human Rights Law Resource Centre, Darebin Community Legal Centre and Flemington Community Legal Centre (May 2010), submission to OPI Review

The OPI issues paper acknowledged the relationship between the different objectives and required investigative skills demanded by these investigations:

...investigations of deaths associated with police contact are multifaceted. They involve a coronial inquiry. They may involve disciplinary issues. They may involve consideration of police procedures and practice. The expertise of police investigators clearly lies in criminal investigations. Deaths associated with police contact however are as much an investigation into use of force or duty of care or adherence to Victoria Police policy or process. To this end, the Homicide Squad or Major Collision Investigation Group may not be the most appropriate unit to lead an examination of these issues.⁴³

During the course of the Review the need for specialist investigative skills to ensure the effectiveness of an enhanced investigation was the subject of debate.

Not all agree that the skills of a specialist investigative team are required for these investigations. Some participants in the Review argued that non-police investigators could be recruited from other departments and trained to develop expertise in investigating deaths associated with police contact.⁴⁴ They argue:

*The Royal Commission into Aboriginal deaths in Custody investigated and/or re-investigated 99 deaths. Investigators for this inquiry were all civilians and exposed many inadequacies with the initial police investigations.*⁴⁵

While the investigation of a death associated with police contact will not usually be regarded as a criminal investigation after the initial facts have been established, some argue that the requirements to conduct an enhanced investigation demand specialist skills identical to those required for a criminal investigation.

*The treatment of the crime scene and the expertise and resources is commensurable with any other suspicious death.*⁴⁶

Suspicious deaths are usually investigated by Victoria Police specialist units such as the Homicide Squad or the Major Collision Investigation Group. The investigators from these units have highly-developed technical and specialist forensic skills, for example specialist interviewing skills and incident reconstruction skills.

The knowledge and skills of these investigators have been acquired during years of on-the-job experience and training. Police departments in Australia invest significant resourcing to ensure staff in their specialist units have the most up-to-date skills and

43 Office of Police Integrity October 2010 *Review of the investigation of deaths associated with police contact – Issues paper* p42

44 Human Rights Law Resource Centre (June 2010), submission to OPI Review p9, para 35

45 Human Rights Law Resource Centre (June 2010), submission to OPI Review p9, para 32

46 Forum participant (2011)

knowledge. These specialist skills diminish if they are not used on a regular basis and kept up-to-date.

OPI's own experience is that ensuring civilian investigators have appropriate skills requires time and resources. Civilian investigators must be led, trained and mentored by those with law enforcement experience. Equipping a truly independent body to undertake a thorough investigation of each death associated with police contact would require replicating and duplicating investigative systems and forensic support structures currently within Victoria Police.

At least in an interim period any stand-alone independent body would have to draw on the contemporary expertise of police investigators, thus depriving existing law enforcement agencies of their resources.

Application of resources

To be effective, an investigation into a death associated with police contact requires resources. Resources that may be required include:

- skilled personnel
- forensic and ballistic capability
- vehicle examination unit
- scene attendance supports (vans, lights, travel kit, 24/7 staffing, forensic suits)
- transport (facilitating prompt attendance across the State)
- communications.

Investigators also need sufficient resources (and requisite powers) to:

- cordon (prevent entry to scene by unauthorised persons)
- control and divert traffic
- manage onlookers
- record, isolate and detain witnesses
- capacity to coordinate other services (this can include the Coroner, pathologist, undertaker, photographs, crime scene unit, dog squad)
- examine the scene
- collect exhibits.

Proportionality of the investigation commensurate with the circumstances of the death

Each death associated with police contact has its own unique set of circumstances. Similarly, each investigation into a death must be cognisant of these differences and respond accordingly.

Our position is whoever does it, does it well. They are not easy projects, they involve complex investigations, it's not easy, all deaths are different. These are complex issues.⁴⁷

Working group participants broadly agreed that for an investigation to be effective, it must be commensurate with the circumstances of the death. Any framework established to facilitate an investigation must allow flexibility to respond to differing circumstances as facts emerge.

A variety of responses need to be available to those conducting the investigation to ensure that the response is proportionate to the circumstances of the death. In the majority of these cases the police involved will also be traumatised. Investigators and the investigative body must be able to exercise an appropriate level of professional empathy while maintaining public confidence.

Any framework for the investigation of deaths associated with police contact must facilitate a response that can escalate or de-escalate based on the circumstances of the death and the facts as they emerge.

Community and police confidence

Participants in this Review agreed that an optimal framework for the investigation of deaths associated with police contact will be one in which the community has the utmost confidence in the integrity of the investigative process. This will largely be determined by the degree to which the investigative process is exposed to public scrutiny.

Police also need to have confidence in the integrity of the investigative process. In their role as police they need to feel confident that they can use their lawful powers prudently, but without hesitation, if it is necessary to protect the rights of others.

Police involved in a death associated with police contact, who have lawfully and professionally discharged their duty, need to have confidence in the integrity of the investigation to ensure that their version of events is heard without bias. If nothing could have been done to avoid the death, they need confidence in the integrity of the investigation to exonerate them.

If they have made an honest but reasonable mistake resulting in someone's death, police need confidence in the integrity of the investigation if they are to tell the truth without fear of punishment or reprisal, so others can learn from their mistake.

⁴⁷ Working group participant

To this end, the State must afford police an enhanced investigation demonstrating the highest levels of rigour, scrutiny and accountability.

Promptness

The promptness principle relates to timeliness.

Investigations into deaths associated with Victoria Police must be prompt and expeditious.⁴⁸

There are three time-critical points for investigations into deaths associated with police contact. These are:

- processing the scene where the incident occurred
- finalisation of the initial investigation and delivery of a brief to the Coroner
- delivery of coronial findings.

Under the current system, police are best placed to attend an incident scene quickly. As a 24/7 statewide emergency service, they will generally be first on the scene and have the authority and resources to control the area and preserve evidence. The first 'golden hour' following the incident is critical for the preservation of evidence.

The length of the time taken to complete an investigation varies and is contingent on numerous factors, including the complexity of the investigation, the number of witnesses involved and their availability.

Avoiding the situation where a person goes on leave and the file remains on lock up until they return weeks later. We have an investigation management plan to continue the investigation.⁴⁹

OPI's Review of seven recent deaths associated with police contact identified that it took Victoria Police between four and fourteen months (with an average of nine to twelve months) to gather the evidence and prepare a brief for the Coroner.

A key concern raised by participants in this Review was the length of time between an incident resulting in a death and the delivery of a coronial finding.

There is a major problem with inquests being held years after the incident.⁵⁰

For the next of kin and loved ones of the deceased, and the members of police involved, this period can be a time of protracted distress. The length of time before a coronial hearing is finalised varies and is dependent on the availability of coronial resources.

...it took Victoria Police... an average of nine to twelve months to gather the evidence and prepare a brief for the Coroner.

48 Victorian Equal Opportunity Human Rights Commission (June 2010), p6 (CD/10/237094)

49 Forum participant (2011)

50 Confidential (November 2010) submission to OPI

There was consensus among those who contributed to this Review that the primary investigation into deaths associated with police contact should generally have priority over other work.

Timeliness also enhances the capacity to learn from these deaths and apply that learning in police practice with the aim of reducing the number of deaths associated with police contact.

Next of kin involvement

The European Court of Human Rights jurisprudence requires the deceased's next of kin to be engaged in the investigative process to the extent necessary to safeguard their legitimate interests.⁵¹

Those who contributed to this Review identified key areas where engagement with next of kin and loved ones is paramount. These were:

- notification that the death has occurred
- information regarding the process
- information regarding rights of next of kin
- notification of investigative milestones
- referral to support services (including counselling, funeral assistance).

There was also consensus that the next of kin have an important role in ensuring there is an enhanced coronial investigation and, in some circumstances, should be entitled to legal representation.⁵²

Sufficient public scrutiny

Public scrutiny requires transparent processes with clear lines of accountability that engender public confidence.

*An investigation and its outcomes must have a certain level of transparency or scrutiny. For example, public scrutiny has been found to be lacking when reports and their findings were not published in either their full or extract forms.*⁵³

In an optimal framework, public confidence in both the investigation and the investigative process is engendered and maintained.

While confidentiality or privacy concerns prevent the sharing of all information related to an investigation of a death associated with police contact, public scrutiny

51 *Jordan v United Kingdom* [2003] 37 EHRR 52

52 *Legal Services Commission v Humberstone, R* (On the application of) [2010] EWCA Civ 1479 (21 December 2010)

53 See *McKerr v United Kingdom* (2002) 34 EHRR 20 p560

requires making as much non-sensitive information as is possible available and accessible to interested parties. This can include:

- making public information regarding the process and protocols
- informing the community of bare facts at the time of the incident, through media releases and statements
- informing next of kin of key investigative milestones
- publishing coronial findings
- collating and publishing statistics.

Agencies can contribute to public accountability in a variety of ways, including:

- reviews of investigations
- reviews of policy and compliance
- strategic reviews
- investigations into complaints
- statistical monitoring.

In the past, many of the deaths associated with police contact have identified weaknesses in a range of Government support structures, in particular, resourcing issues in hospital and mental health services. If as a State we are committed to reducing the number of deaths associated with police contact, a whole-of-government approach is required.

If as a State we are committed to reducing the number of deaths associated with police contact, a whole-of-government approach is required.

Some progress is being made in this regard by police in conjunction with other agencies through a Police Ambulance Crisis assessment team Emergency Response (PACER) pilot. These initiatives should be strongly encouraged.

Balancing the principles

There was consensus among those who contributed to this Review that the five principles (independence, effectiveness, promptness, next of kin involvement and public scrutiny), are appropriate and relevant for Victoria in any framework for the investigation of deaths associated with police contact. However, there was debate among participants about the relative weight each of these principles should be given.

An optimal framework should balance these principles so that they underpin the objective of ensuring that all investigations into deaths associated with police contact are both effective and instil public confidence.

Regardless of which framework Victoria ultimately adopts, there was consensus among participants in the Review that changes can and should be made to enhance the current process for the investigation of deaths associated with police contact. The majority of changes can largely be achieved within the existing legislative framework and should be agreed to and implemented as a priority.

Improving current processes

An important focus of the Review has been on improving current processes. OPI has already adopted a more active oversight role and will continue to oversee Victoria Police management of the investigation of deaths associated with police contact, commensurate with the circumstances of the death. OPI will also continue to have input into and monitor the work of Victoria Police to ensure a consistent approach to integrity standards as they apply to investigations into police related deaths.

Victoria Police has already implemented some improvements and demonstrated significant commitment to on-going reform of its own processes. Similarly, the majority of participants in OPI's working groups have all undertaken to enhance their current responses to deaths associated with police contact.

In order for the State to optimise current responses and increase the likelihood of preventing deaths associated with police contact, it is important that this issue remains a whole-of-government commitment.

Investigative responsibility

Prior to this Review

As the primary investigators of any death associated with police contact, Victoria Police investigators have always been responsible for the management of the investigation. This includes securing the incident scene, interviewing police, witnesses and third parties involved, collecting forensic and specialist evidence and preparing the written brief of evidence for the Coroner's consideration. During the investigation, police consult with the Coroner as required. Once the initial investigation is complete, the investigative brief is forwarded to the Coroner to assist the Coroner's investigation.

Prior to this Review, Victoria Police had an inconsistent approach to these investigations. Allocation of investigators was based on available resources. Little regard was given to perceived or actual conflict of interest. Oversight of investigations by the Ethical Standards Department varied in quality, depending on the individual to whom the file had been allocated. There were no processes in place to ensure a proportionate response to a death associated with police contact.

Since this Review

Victoria Police has embraced this Review and taken the opportunity to improve its management of investigations of deaths associated with police contact. Throughout this Review Victoria Police, particularly the Ethical Standards Department, has demonstrated a shift in thinking about how deaths associated with police contact

should be investigated and overseen. Solid progress has been made but more work needs to be done by all stakeholders including OPI.

Changes initiated and implemented by Victoria Police include:

- All deaths associated with police contact are now investigated by the Homicide Squad or Major Collision Investigation Group.
- The Ethical Standards Department now attends all deaths or serious injury incidents associated with police contact.
- New organisational documents on the guiding principles have been created, including:
 - development of an oversight checklist to be used by ESD when attending a critical incident
 - a Conflict of Interest Declaration form.
- 'Table top' exercises have been introduced. Convened by the Assistant Commissioner of the Ethical Standards Department with representatives from the Homicide Squad, Major Collision Investigation Group, Forensic Services and OPI, these forums reflect on lessons learnt from recent investigations.

At the same time OPI has:

- Developed and piloted draft guidelines for OPI's independent oversight response to deaths associated with police contact.
- Developed and implemented an OPI Response Protocol. This response protocol outlines the steps to be taken once Victoria Police, or any other source, has informed OPI a death associated with police contact has occurred. The protocol includes criteria for determining OPI's level of response, internal and external people to be advised of the incident, and what internal processes need to be initiated to manage the case. Draft guidelines formalise the current process used by OPI and will be used as the basis for ongoing work in this area.

Together Victoria Police and OPI have:

- Developed a routine notification process for deaths associated with police contact considered to require a 'special response'.

Assessment

When the Victoria Police Homicide Squad or Major Collision Investigation Group undertake the primary investigation into a death associated with police contact, they must prepare a brief of evidence that addresses the identity of the deceased, the cause of death and the circumstances in which the death occurred.⁵⁴ In this role, the investigators are *guardians of the evidence*. In the short and medium term, OPI

⁵⁴ *Coroners Act 2008 s67*

acknowledges these investigators as being the best placed experts to continue to conduct the primary investigation for the assistance of the Coroner.

The Victoria Police Ethical Standards Department should actively oversee the investigation by the Victoria Police specialist squads according to a clear set of guidelines based on agreed principles. The role of the oversight officer is to ensure the integrity of the investigation and evidence gathering process. In this role, the Ethical Standards Department maintains its traditional responsibilities for identifying potential conduct issues, breaches of discipline or flaws with policies or procedures. In this respect, Ethical Standards Department officers are the *guardians of the conduct and performance process*. In their active oversight role, they also become *guardians of the investigative process*, ensuring the integrity of the investigative process conducted by investigators from the Homicide Squad or the Major Collision Investigation Group.

OPI will monitor the work of the Ethical Standards Department according to a clear set of guidelines based on agreed principles and may also oversee the integrity of the investigative process. Acting as an *independent guardian of the process* through independent oversight, OPI can build community confidence in the Victoria Police investigation.

Community confidence in the police investigation can be further reinforced through the Coroner's hearing process. The Coroner is responsible for testing and critically examining the evidence gathered in the police investigation. The Coroner is the *independent inquisitor of the evidence* and has the primary authority over the search for the truth and must determine whether:

- the action of the police involved was reasonable and proportionate in the circumstances
- inaction was the result of a failure to discharge the duties and responsibilities of the State
- anything could have been done to prevent the death or could be done to prevent future deaths.

Until such time as an alternate framework is implemented, OPI considers the current arrangements, described above, suitably balance the principles of effectiveness, promptness and independence.

Incident Management

Prior to this Review

Prior to the commencement of this Review, Victoria Police had an inconsistent response for the investigation of deaths associated with police contact. Once Victoria Police Communications had been notified a police shooting or police pursuit resulting in death had occurred, they would contact the State Coroner, the Ethical Standards Department, the relevant investigating unit (the Homicide Squad or the Major Collision Investigation Group) and the regional Inspector or Officer in charge. According to the circumstances, some or all of the above attend the scene.

Where the initial notification related to a death in custody, or was associated with police contact through another means, investigators from the local Criminal Investigation Unit may have been deployed to attend the scene. Specialist Homicide Squad investigators would only be called in exceptional circumstances.

Senior officers from the Homicide Squad and Major Collision Investigation Group were responsible for assigning their investigations to an investigator. There were no formal procedures for allocating an investigator, although it was customary for the investigating officer to be of a higher rank than the officer involved in the incident.⁵⁵

It was common practice for senior officers and specialist units, such as Forensic Services, the Media Unit, Operational Tactics and Safety Training Officers and Regional Crime Investigation Units to attend the scene of a death associated with police contact at the discretion of the investigator.

Victoria Police did not, as a matter of procedure, ensure the investigating officer did not have a conflict of interest arising from the investigation. Investigating officers were required to self-declare a conflict, and if declared, their supervisors were responsible for the mitigation or management of that conflict, guided by Victoria Police's general conflict of interest policy.⁵⁶

Since this Review

Victoria Police has improved its response to deaths associated with police contact in a number of ways.

By the time OPI published its issues paper in October 2010, the Homicide Squad and the Ethical Standards Department attended every death in custody and other deaths clearly associated with police contact. The implementation of this change tacitly acknowledges the conflict of interest issues that may arise if an investigation into a death (that may involve duty failure by local police) is undertaken by the local Criminal Investigation Unit. The change also tacitly acknowledges that any death in the custody of police

⁵⁵ This seeks to ensure investigating officers are not culturally or personally inhibited by a traditional rank structure which may prevent them from confidently investigating a more senior officer

⁵⁶ See Victoria Police Manual – Policy Rules – *Managing conflict of interest*

should be afforded an enhanced investigation that utilises the expertise of a homicide investigator and warrants active oversight by the Ethical Standards Department.

Assessment

As a result of discussions in the Improving Current Processes working group there was consensus that Victoria Police policy and practices should ensure the following:

- When police attend a death associated with police contact their priority is to protect life and property, preserve the peace and manage the incidents (that is, isolate, contain, evacuate, negotiate, conclude, rehabilitate).
- Victoria Police communications should notify relevant operational units, the Ethical Standards Department and the Coroners Court of Victoria as soon as possible.
- In all matters warranting a special response, the Victoria Police Homicide Squad or Major Collision Investigation Group is responsible for the primary investigation.
- The Ethical Standards Department is responsible for the *active* oversight of the investigation, subject to no conflict of interest.
- Where the Homicide Squad, Major Collision Investigation Group or Ethical Standards Department has a conflict of interest which cannot be adequately resolved or mitigated, alternate arrangements are to be agreed to in consultation with the Coroner and OPI.

Obtaining police account of events

Victoria Police policies and procedures require all police present at the scene of an incident where a death has occurred to be separated and a decision to be made about who, if anyone, should undergo drug and alcohol testing. There are no specific directions in relation to obtaining statements from police.

Prior to this Review

Where there are clear indications of criminality or improper conduct, police have always been treated as other suspects and afforded their rights to a ‘criminal caution’ under the *Crimes Act 1958*.⁵⁷

In the majority of investigations into deaths associated with police contact, there has been no suspicion of criminal conduct. At some early stage in the investigation the police involved were asked to provide a statement to the investigating officer. Although there is no legal requirement for police to provide a statement, OPI was advised the request to provide a statement has been refused rarely, if ever. When and how the statement was taken varies. Sometimes, it was at the discretion of the investigator whether to video or audio record, type or take longhand written notes of statements. At other times, the

⁵⁷ Office of Police Integrity October 2010 *Review of the investigation of deaths associated with police contact – Issues paper* p31–33

police involved in an incident, on advice from their union, agreed to provide only a written statement. Anecdotal information provided to OPI suggests police witnesses consider that a written statement enables them to 'get it right' and be as precise and accurate as possible, in anticipation of coronial proceedings. In a submission to this Review, one former police officer described his experience of providing a statement, following a death he had been associated with, as follows:

From the moment investigators became involved, I was basically in custody, with a guard, isolated for in excess of 5 hours, allowed one phone call and spoken to as though I had already been convicted. I realised later, the extreme stress that I experienced. A death in custody has a profound effect on everyone. Members know this and dread the day they may be involved in one.⁵⁸

Since this Review

In the issues paper, OPI found that transparency and accountability are increased if investigators audio and visually record a 'free narrative' account of what happened given by the police involved in any incident involving in a death. A 'free narrative' account involves the witness providing his or her version of events in response to a request to *tell me what happened*. In a 'free narrative' account a person may be prompted, for example *what happened next* but is not asked direct or closed questions. Ideally, a 'free narrative' account should be obtained as soon as practicable after the death has occurred. An audiovisual recording contemporaneous with the incident most accurately captures the account of a person. 'What is said, how it is said, and the body language or non-verbal cues of a witness can all be seen by those viewing the tape'.⁵⁹ This process avoids connotations of 'reconstruction' that may be attributed to a carefully-crafted written statement. It also increases transparency by eliminating potential allegations of collusion or bias in the taking of the statement.

At the start of this Review, some in Victoria Police expressed concern regarding the audiovisual recording of police accounts, suggesting that it may be unfair to expect police to participate in such a process having just experienced such a traumatic event. They argued that no other witness is expected to undergo such a process. There was a particular concern in regard to accounts provided close to the event when the demeanour of the police member giving the account may be uncharacteristic and the account may be unfairly interpreted. They argue that in some instances it is appropriate for investigators to take statements from the police involved after they have had the opportunity to go home and rest. OPI accepts that in some instances police involved in an incident involving a death may be in an acute phase of post-traumatic stress that renders them incoherent.

⁵⁸ Anonymous submission received 9 June 2010

⁵⁹ Office of Police Integrity October 2010 *Review of the investigation of deaths associated with police contact – Issues paper* p31–33

At the time the OPI issues paper was published, Victoria Police advised of policy changes which gave preference to video recording of statements given in these cases. While some statements have been video recorded others have only been audio recorded. Other statements are not recorded at all but provided in writing. The variation in how the police account of events is obtained seems to be dependent on the negotiation skills of the investigator and the confidence in the investigative process of the person providing the account.

Assessment

Where there is evidence of criminality or improper conduct, the existing caution and formal interview process is appropriate, in line with criminal law. Where there is no suspicion of criminality or improper conduct, it is accepted that an investigation into a death associated with police contact is conducted on the premise that the actions of police were lawful. As one forum participant explained:

A blanket approach to cautioning a member would only hinder finding what actually occurred, because they will not answer questions and that will delay the investigation.⁶⁰

Participants in the Review agreed that the objective of communication with police involved in a death associated with police contact is to obtain the best and most accurate account of what happened.

How, and when, to seek an account of what happened was the subject of significant debate in the working groups. There was some discussion about the rights of police to remain silent, or to be protected from exposing themselves to discipline proceedings. Others argued that police, by virtue of the exceptional powers granted to them, have a duty to account for their exercise of those powers. Discussion focused on possible legislative amendments that might require police to provide an account of what happened with or without an indemnity.

Some police still consider it oppressive to take comprehensive statements at the scene from police involved in a death associated with police contact. These investigators argue that a 'free narrative' would take an average of two to three hours for each member of police involved. OPI agrees that it may not be appropriate to take a detailed account of the event at the scene. In some instances it may not be practicable because of the physical or psychological state of the police involved. However, in order to promote public confidence, OPI considers that in many circumstances it will be appropriate for a short 'free narrative' account to be audiovisually recorded before allowing the police involved to go home. After the scene has been processed an audiovisual recording of a 'walk through' should also occur.

⁶⁰ Forum participant (2011)

Suggested improvement

Given the lack of consensus on this issue it seems the best outcome to improve the current process is to encourage investigators to adopt consistent procedures. In the absence of any suspicion as to possible criminal conduct and where practicable investigators should:

- audio and visually record a ‘free narrative’ account of what happened by police involved in any incident involving a death associated with police contact as soon as possible after the incident has occurred.

Victoria Police should conduct statewide training about these changes to policies and procedures in relation to deaths associated with police contact.

Two years after the implementation of this recommendation a review should also be undertaken to ascertain whether this change in policy has achieved increased accountability and transparency in obtaining police accounts of events. This review should also consider if legislative amendment is needed to ensure the best possible account of the police version of events is obtained and can be subjected to public scrutiny in the Coronial hearing.

Police media management

Information reported in the media following a death associated with police contact has a significant impact on public perception.

...back to public perception and expectation – we need to continue to highlight what is said in the first 24 hours. Silly statements are not helpful. Statements around the appropriate welfare about police and victims are not an issue. Let’s call it what it is – if it is not an independent investigation than don’t call it this but a thorough investigation with independent oversight. Don’t massage the stuff – say it the way it is and then you minimise later problems caused by misleading the public. Be straightforward and transparent about what is actually occurring. The impact of public statements in first 24 is underestimated.⁶¹

...we can control what are opening statements are but not what the media do with it. It is important that we don’t undermine the role of the Coroner. Six seconds shown but ten minutes interviewed. It is a challenging role.⁶²

Prior to this Review

Contributors to this Review expressed concerns regarding:

Police publically supporting the actions of the members associated with the death before the outcome of the inquest; and

61 Working group participant

62 Forum participant (2011)

*Police providing information to the media that is critical of the deceased.*⁶³

All police receive basic training in managing the media, although senior commissioned officers receive more extensive training.

The Victoria Police Media Guide also gives police written information on general principles for scene media management, likely media questions, interview techniques and plain language suggestions.

Assessment

The working groups agreed that it is important for the response to media to acknowledge that a tragedy has occurred. It was also agreed that it is important to reassure the community as to public safety. However, there was significant debate about the level of detail that should be provided. In OPI's view it should be limited to bare facts.

A review of police statements to media regarding six recent deaths associated with police contact identified the following themes:

- extensive details regarding event and circumstances of death
- pre-emptive statements regarding fact
- criminalisation of the deceased
- sentiment
- support for police and exoneration.

Some senior police consider that it is important for them to show public support for police under their charge. Public statements supporting local police in these circumstances is now expected. The Review was told silence regarding the conduct of police would be interpreted by rank and file as implicit criticism.

*If nothing is said the media would read that the police have done something wrong.
Saying nothing creates a worse scenario.*⁶⁴

Irrespective of a legitimate need to show public support, statements made in support of members that pre-empt the investigative process undermine the integrity of the investigation into the death. Far from helping the police involved, statements exonerating police reduce public confidence in the investigative process. They remove the legitimacy of the investigative process, and with it, any chance of a public acceptance that police associated with the incident have been legitimately exonerated.

The following extract of a radio interview with a senior police officer following a death associated with police contact demonstrates the criminalisation of the deceased,

⁶³ Flemington and Kensington Community Legal Centre (2010), submission to OPI Review (endorsed by the Darebin Community Legal Centre)

⁶⁴ Working group participant

the exoneration of police and the impact pre-emptive statements can have on public confidence in the integrity of the investigation:

Interviewer – ... you spoke yesterday, you spoke at a press conference and one of the points that you seem to make, it was almost, it sounds like you formed a judgment really that police had done what they could under the circumstances.

Senior police officer – ... I have formed a judgment based on the information that was available to me last night

Interviewer – Is it a premature judgment though given there is still an investigation to go?

Senior police officer – Well ... I think it is open to me to form conclusions based on the information that was available to me, both from police witnesses and also from civilian witnesses who did actually see the full extent, we understand, of what occurred...

They've done everything they could to call on the individual concerned to cease threatening them with serious injury or indeed the threat of loss of life. That individual was armed, and our key concern is for the members who are involved in this to give an account of what they did and obviously I think it is open and due to them, that the Victoria Police, where we are able to form a view that members have acted appropriately, we do everything we can to support them.

Interviewer – Well then what is the point of the investigation? If you've got sufficient information to form that view.

Senior police officer – The point of the investigation is to understand exactly what occurred...

Interviewer – Sure but if that is going to be revealing things that you don't now know I would have thought that it's most appropriate not to come out and say that the officers did what they could in the circumstances and basically say that they were justified in their behavior until you've got that information, I mean, I don't mean to be picky about it, but that seems to be an obvious precaution to take, just to keep your powder dry at the moment.

Senior police officer – I guess ... the alternative would be to remain completely silent.

Interviewer – no, you could say, we've got an investigation, we have faith in that investigation.⁶⁵

65 'Police shoot St Kilda man dead' 774 ABC Melbourne 2 May 2011. Radio.

Suggested improvement

Police required to make statements to the media should be trained in media management and Victoria Police media protocols should be amended to:

- Clearly state who is authorised to make statements to media at critical incidents involving a death associated with police contact.
- Require that statements to media should respond to the particulars of the incident and:
 - acknowledge the tragedy
 - reassure the community as to public safety
 - express concern about the welfare of the family of the deceased
 - express concern as to the welfare of any police involved
 - stress that the matter will be subject to a Coroner's inquest
 - state that there will be a thorough police investigation and police investigators will forward a brief of evidence to the Coroner to assist with the inquest
 - state that the police investigation will be subject to active oversight by the Ethical Standards Department who may also report to the Coroner
 - state that OPI will also independently oversee the investigation
 - advise that neither the police investigation nor the oversight will pre-judge the outcome of the Coroner's inquest.

While it is a current cultural expectation that senior police will make statements in support of police, the majority of working group participants agreed that these statements should be limited to statements of concern about the welfare of police. Police should be told about changes to police media policy and the reason for this change.

Transparency of processes

The importance of transparent processes was highlighted by a working group participant:

[A] lack of accessibility to information and transparency is one of the greatest contributors to a lot of perception. More fuel to the fire of 'why they are keeping secrets'. I would like to see more access to information and data so the community can be informed.⁶⁶

Prior to this Review

At the start of this Review, OPI found it difficult to identify consistent statistical data related to deaths associated with police contact because of differences in definition. It was also difficult to identify the extent of relevant information available on key agency websites.

The key exception to this was the Coroners Court. The Coroners Court website provides readily accessible fact sheets for families as well as basic information regarding procedures for deaths in custody and reportable deaths. The *Coroners Act 2008* requires that all inquest findings and recommendations are to be published on the internet, unless otherwise ordered by a Coroner. These are readily accessible.

Since this Review

Working groups identified that an agreed 'working definition' of deaths associated with police contact that required a 'special response' should be used by key agencies to assist with data collection and to increase transparency and accountability regarding the incidence of deaths associated with police contact.

A common understanding of a death associated with police contact that required a 'special response' would also facilitate the care and support of the deceased's next of kin and further enhance the investigation.

Assessment

Working group participants agreed that consistent and clear information regarding processes should be provided by key agencies. This information should include an outline of the investigative and oversight process, coronial processes, media management, rights in relation to autopsies, funeral assistance and counselling. Working groups agreed that, where practicable, this information should be made available on multiple agency websites.

⁶⁶ Working group participant

In ensuring transparency regarding its processes, Victoria Police is currently developing an information sheet for families of the deceased with a contact number of the lead Ethical Standards officer.⁶⁷

Following discussions at OPI's second forum, Victoria Police has also agreed the Ethical Standards Department's oversight statement will accompany the investigative brief forwarded to the Coroner on completion of the primary police investigation. This will assist the Coroner with coronial processes and increase the transparency and public accountability of investigative processes.

Suggested improvement

- All agencies represented in OPI forums make information accessible to the public regarding their protocols and services in the event of a death associated with police contact and that agencies will collaborate to ensure this information is consistent. This information should include information for next of kin regarding police attendance at autopsy, their right to object to an autopsy and access to victim support.
- The Coroners Court of Victoria provide clear information regarding the phases and procedures of the investigative and oversight process on its website.

The Coroners Court of Victoria, Victoria Police, Victims Support Agency, the Department of Justice update their websites to:

- explain their agency's role in the event of a death associated with police contact
- refer viewers to the Coroners Court website for further information regarding the investigative and oversight process.

⁶⁷ Forum participant (2011)

Informing and caring for next of kin and loved ones

Prior to this Review

The OPI issues paper described issues for a deceased person's next of kin and loved ones as follows:

Some concerns expressed by families affected by police related deaths were summarised in a submission to OPI's review. It included:

- Lack of caring and civil communication about the death with families;
- The criminalisation of the deceased through the police investigation;
- Lack of family involvement in the scope and direction of the initial investigation;
- Focus on negative rather than positive aspects of the deceased's history without any attention to the histories of the police members associated with the death;
- Hostile and aggressive initial treatment of grief-struck and shocked family members;
- Failure to provide the family with access to welfare assistance, counselling or explanation during the investigation;
- Failure to enable and facilitate an independent autopsy for the family or provide a written document of rights around the autopsy;
- Police publically supporting the actions of the members associated with the death before the outcome of the inquest; and
- Police providing information to the media that is critical of the deceased.⁶⁸

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

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

⁶⁸ Flemington and Kensington Community Legal Centre (2010), submission to OPI Review (endorsed by the Darebin Community Legal Centre)

Since this Review

The working groups acknowledged that next of kin and loved ones of those who died in a death associated with police contact require a unique set of supports, depending on both the circumstances of the death and subject to the wishes of the family.

As one forum participant put it:

I hasten to say that families or victims are not a homogenous group. They're a vast array of very different people; obviously... the best way to respond is not to use any one-size-fits-all response at all. So that's immediately a huge resourcing issue. It's a very complex response we have to make.⁶⁹

Next of kin and loved ones play an important role in the investigative process providing insight and acting as advocates for the deceased. They may also contribute to enhancing the investigation through legal representation in the Coroner's inquest. In the course of the Review it became clear that one of the most significant challenges for the next of kin and loved ones of the deceased is navigating the investigative process. At the time when families are in most need of supports, they are often less able to seek out this information and to advocate for their own rights and those of the deceased.

Victoria Police presently offers support to next of kin and loved ones through the Victoria Police Victims Advisory Unit.

Assessment

At times families of the deceased can find it difficult to accept support from the agency which they feel is responsible for the death of their loved one. It was acknowledged that despite Victoria Police best efforts to provide support to families through the Victims Advisory Unit, Victoria Police is not the most appropriate agency for providing support to next of kin and loved ones in the event of a death associated with police contact.

Through the working groups, existing supports through the Victims Support Agency were identified as a potential case management option for next of kin and loved ones of those who have died in a death associated with police contact. The *Victims Charter Act 2006* provides the legislative framework for Victim Support Agency's work and defines a 'victim' as a 'victim of crime'. Next of kin and loved ones are not generally categorised as 'victims of crime'. However they are victims of a tragedy requiring a special response from the State.

The current framework allows the Victims Support Agency to provide services to those who are not victims of crime in 'exceptional circumstances'. This exception has been used to provide support to bushfire victims and victims of other tragedies that were not 'crimes'. In order to automatically facilitate access for this group to Victims Support Agency services, working groups discussed the merits of waiving eligibility

⁶⁹ Forum participant (2011)

criteria to allow agencies to provide support to next of kin and loved ones of someone who has died in a death associated with police contact.

Suggested improvement

It is acknowledged that next of kin and loved ones should be provided with access to consistent case management support until the finalisation of coronial proceedings. Facilitating access by next of kin and loved ones to the Victims Support Agency's service would assist Victoria Police to meet its obligations under the *Victims Charter Act 2006* and support an enhanced investigation by providing next of kin and loved ones with:

- accredited and accountable institutionally independent support
- flexible case management support from shortly after the incident until delivery of the coronial finding
- service providers who have 'local knowledge'
- therapeutic interventions including counselling
- practical supports including transport, childcare, accommodation, medical, accessing legal services, interpreters, community support, assistance preparing victims' impact statements.

In order for these services to be automatically accessible to next of kin and loved ones of a person who has died, the Victims Assistance and Counselling Program Guidelines would need to be updated and the 'victims of crime helpline' re-badged as the 'victims support helpline' for these incidents. Consideration will have to be given to providing 24/7 access to the Victims Support Agency referral services.

The Department of Justice and Victoria Police will need to develop protocols to ensure that next of kin and loved ones of a person who has died as a result of police contact will have access to independent victim support services.

Where the Coroner believes it is in the public interest for next of kin to have legal representation to ensure there is an enhanced investigation, it is suggested that the Coroner may request the family be provided with Legal Aid.

It is also suggested that Victoria Police:

- Identify that the agencies funded by Victims Support Agency as the preferred agencies to facilitate support services for next of kin and loved ones involved in a death associated with police contact.
- Facilitate the handover of **all** victim support functions to Victims Support Agency once a referral has been made in these cases.

- Require police to request consent from next of kin to send referrals to Victims Support Agency as soon as practicable and where consent is provided, require a referral be made to Victims Support Helpline as soon as practicable.
- Ensure where feasible that the police officer notifying a next of kin or loved one of the death of a person is accompanied by a victims support worker. Where this is not feasible, ensure that the police inform the next of kin that he or she has a right to victims' support and that police will facilitate contact with victim support services.

Police will need to be informed about changes to standard operating procedures in the event of a death associated with police contact. Police will also need to work with the Victims Support Agency to educate police about the role of the victims support worker, in incidents of death associated with police contact and the services available to the deceased's next of kin and loved ones.

Conclusion

OPI's Review of the investigation of deaths associated with police contact involved unprecedented consultation and collaboration between a diverse range of stakeholders. Together stakeholders agreed that a death associated with police contact is a unique incident that requires a special response by the State. As such, it is vital that the investigation of a death associated with police contact is conducted in such a way as to give the public confidence that the investigation will be subject to the highest levels of scrutiny, accountability and transparency.

The Coroners proceedings are public. Evidence gathering processes by Victoria Police are subject to independent scrutiny and in some instances cross-examination by the Coroner.

Victoria Police has demonstrated significant commitment to improving current processes. In particular, the Ethical Standards Department has implemented a process to improve the integrity of investigations of deaths associated with police contact. The Ethical Standards Department's report on the integrity of the investigation will be made available to the Coroner and may be subject to further public scrutiny as part of the hearing process.

Other key stakeholders have also signalled their willingness to improve support to the next of kin and loved ones and provide increased public accountability and transparency of investigative processes.

An optimal framework for Victoria

The current framework which supports the investigation of deaths associated with Victoria Police contact is underdeveloped. There is an opportunity to develop an optimal framework for the investigation and oversight of deaths associated with police contact which is consistent with the capacities and limitations of the Victorian law enforcement environment. Ultimately it is for the Victorian Government to determine if the current policy and legislative framework requires amendment and, if so, what that amendment should look like. In considering whether there is a need for legislative amendment, Government may consider the following principles upon which to base its assessment:

- Independence
- Effectiveness
- Promptness (timeliness)
- Next of kin involvement
- Sufficient public scrutiny (transparency)

Monitoring the progress of the Queensland Coronial investigation model may provide useful insight into any alternative framework.

In considering what, if anything, should be done to improve the current framework, OPI urges the Government to further consult with key stakeholders and consider the extensive contribution made by participants in this Review.

Improving current processes

The aim of an investigation into a death associated with police contact should be to 'reveal the truth' about what has happened to determine whether:

- the police action was reasonable and proportionate in the circumstances
- any inaction was not the result of a failure to discharge the duties and responsibilities of the State
- there are any lessons to be learnt that may prevent a future death.

Despite the improvements which have been introduced since the commencement of this Review, there is still more to be done in the following areas:

Investigative responsibility

In all matters warranting a special response, the Victoria Police Homicide Squad or Major Collision Investigation Group is responsible for the primary investigation and evidence gathering process.

Incident management

Victoria Police policy should ensure that as soon as practicable an investigator should seek a 'free narrative' account from the police involved regarding what has occurred. That account should be audiovisually recorded.

As soon as practicable and after the scene has been cleared an investigator should undertake a 'walk through' with the police involved. The 'walk through' should be audiovisually recorded.

Victoria Police Ethical Standards Department is responsible for the *active* oversight of the investigation, subject to no conflict of interest.

Where the Homicide Squad, Major Collision Investigation Group or Ethical Standards Department has a conflict of interest which cannot be adequately resolved or mitigated, alternate arrangements are to be agreed to in consultation with the Coroner and OPI.

Media management

OPI considers media statements made by some police shortly following a death associated with police contact as a key area in which public confidence in the integrity of the investigation is undermined. While these statements are given to support members of police at a time of great distress, statements that pre-empt investigative findings diminish public confidence in the investigative process. They remove the legitimacy of the investigative process, and with it, any chance of public acceptance that police associated with the incident have been legitimately exonerated.

Oversight and transparency of processes

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

Informing and caring for next of kin

Next of kin and loved ones play an important role in the investigative process, providing insight and acting as advocates for the deceased. They can enhance the investigation through participation in the coronial process.

Next of kin and loved ones of those who died in a death associated with police contact require a very unique set of supports, depending on both the circumstances of the death and the desires of the family. One of the most significant challenges for next of kin and loved ones of the deceased is navigating the investigative process. At the time when next of kin and loved ones are in most need of support, they are less able to seek out this information and to advocate for their own rights and those of the deceased.

As an arm of Victoria Police, the Victim Advisory Unit is not the appropriate agency to support family and loved ones of someone who has died in association with police contact. In order to assist next of kin and loved ones Victoria Police should work with the Department of Justice to develop protocols to ensure that next of kin and loved ones of a person who has died as a result of police contact will have access to the independent Victims Support Agency.

Future work

Until such time as the Government develops an alternative framework for the investigation of deaths associated with police contact, OPI considers the current arrangements are capable of satisfying the principles discussed in this report, provided the recommendations in this report are adopted.

Victoria Police should conduct statewide training about changes to policies and procedures in relation to deaths associated with police contact to ensure police understand the improvements to the current processes and to promote their confidence in the integrity of the investigative process.

If as a State we are committed to reducing the number of deaths associated with police contact a whole-of-government approach with on-going cooperation between key stakeholders is essential.

Appendix One – Terms of reference

Investigations of Deaths Associated with Police Contact

Objective

To produce a report to Parliament that considers:

1. The sufficiency and appropriateness of Victoria Police policies and procedures and relevant legislative frameworks for conducting investigations into deaths associated with police contact.
2. Options to existing law and practice regulating the conduct of such investigations.

Background

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

Scope

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

1. *Public perception*: what are the concerns or issues associated with police investigating police that are involved in deaths associated with police contact?
2. *Definition of deaths associated with police contact*: what type of deaths should be considered ‘police related’ and investigated accordingly?
3. *Current Victoria Police policy and process*: what are the strengths and weaknesses of the current process used by Victoria Police? What is the reality of the policy in practice?
4. *Investigative responsibility*: who should conduct investigations into police related deaths?
5. *Management of police officers involved in the incident*: how should police be managed in these cases – for example as witnesses or suspects? Should they be cautioned? How should police statements be recorded? Should police be treated the same as members of the public involved in a criminal investigation?
6. *Level of internal and external oversight*: what should the respective roles and responsibilities of internal and external oversight units be?

7. Human rights and independence – what satisfies the obligations under the *Victorian Charter of Human Rights and Responsibilities*? What constitutes an ‘independent and effective’ investigation into police related deaths? Does this mean a separate organisation should conduct the investigation or can independence and effectiveness be realised by other means?
8. *The relationship between Victoria Police and the State Coroner*: what is the reality of the relationship between the investigative unit and the State Coroner in police related deaths? Who is ultimately responsible for the investigation and what are the respective roles and authority of police and the State Coroner? What could/should OPI’s role be?
9. *Other models for investigating police related deaths*: what type of models are used in other jurisdictions – interstate and overseas?
10. *Options for improving the current system in Victoria*: how can the current system in Victoria be improved?

Appendix Two – Own motion determination



DIRECTOR, POLICE INTEGRITY

DETERMINATION TO CONDUCT AN INVESTIGATION PURSUANT TO SECTION 44 OF THE POLICE INTEGRITY ACT 2008

Pursuant to section 44 of the Police Integrity Act 2008, I, Michael John Strong, Director, Police Integrity have determined to conduct an investigation on my own motion into the following matters:

1. Deaths associated with police contact;
2. The independence, effectiveness, timeliness and sufficiency of the Victoria Police investigations into such deaths; and
3. The application and effectiveness of Victoria Police policies, practices or procedures that may be relevant to deaths associated with police contact.

Date: 3 September 2010

A handwritten signature in black ink that reads 'Michael John Strong'.

.....
MICHAEL JOHN STRONG
DIRECTOR, POLICE INTEGRITY

Appendix Three – Review methodology

As part of the review of investigations of deaths associated with police contact, the Review Team:

1. reviewed legislation, practices and procedures relevant to investigating deaths associated with police contact in Victoria (including OPI's own motion review of the management and investigation of recent deaths associated with police contact).
2. reviewed legislation, practices and procedures relevant to investigating deaths associated with police contact in other jurisdictions
3. called for public submissions
4. held an international forum
5. published an issues paper
6. conducted a series of working groups with key stakeholders
7. held a number of key stakeholder meetings
8. convened a second forum
9. consulted with stakeholders on the draft of this report; and
10. published this report.

Each of these phases is explained in greater detail below.

Literature and media search

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

Library, internet and media searches were also conducted to help identify the main issues associated with police investigating police and any contemporary literature in this field. This included the identification of any recent or high profile cases which precipitated increased media attention or public discussion about the investigation of police related deaths. For example, concerns about potential infringements of human rights, the involvement of police in the investigation or oversight of a matter and any

public comments or recommendations made by State and Territory Coroners about the way police conducted an investigation.

Consultations with Victoria Police

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

Victoria Police policy and guidelines

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

This included:

- Relevant sections of the Victoria Police Manual;
- the Ethical Standards Department's Discipline Investigations Manual; and
- the Ethical Standards Department's Guide for Investigators.

Since then, Victoria Police commenced its own review of these documents. The product of this work will be considered by the OPI project team during the Review.

Data and investigation files

Data from the State Coroner's Office and Victoria Police was examined as part of this Review. The State Coroner's Office conducted a search of its National Coroner's Information Service on behalf of the project team. The aim of the search was to identify a) all reported police related deaths in Victoria between 2000 and 2010 and b) any police related deaths in Australia where the presiding Coroner made any comments or recommendations about the police investigation in his or her findings. Following approval from State and Territory Coroners, transcripts of the cases identified in Part B of this request were also provided to the project team.⁷⁰

Victoria Police provided data on all deaths associated with police contact that occurred between 2000 and 2010. The dataset contains details of all Ethical Standards Department

⁷⁰ The State Coroner's office advised OPI of the following limitations with its data: the data recorded on the National Coroner's Information Service includes closed cases only, there may be inconsistencies in state and territory coding protocols and delays in closing cases on the system; the system excludes Western Australian cases which are not authorised for inclusion. The data provided may therefore underestimate the number of police related deaths

review files where the person involved in the incident was reported as 'deceased'.⁷¹ All records were sorted to remove any cases that involved the death of a sworn or unsworn member, either on or off duty. A total of 167 deaths were available for analysis.

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

Public submissions

On 5 June 2010 and 1 April 2011, OPI called for public submissions from interested parties wanting to share their knowledge, experience or opinions regarding deaths associated with police contact. In total, 17 submissions were received, addressing some or all of the terms of reference.⁷²

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

The public submissions reinforced the view that people affected by police related deaths – including family members and police officers – experience the negative effects of these incidents long after a police investigation or a coronial inquest has concluded, particularly if they felt aggrieved by the investigative process.

In one submission, a family member describes the 'disappointment and [sadness]' at hearing that 'nothing appears to have been learnt' in this area in the 80 years since a relative died in police custody. The author states that the incident is still 'distressing for family members'.⁷³

Similarly, a police officer described having had a negative experience of being the subject of an investigation following a death in custody. Contrary to views that police prefer police-led investigations, this officer called for an independent agency to take over investigations into these matters to allow for the better treatment of police. The officer recalls how they were 'treated like a criminal', 'not afforded any rights' and 'made to feel totally responsible' and 'guilty' for the death, describing the incident as having a 'serious impact' on all parts of the officer's life.⁷⁴

Naturally, all submissions to the Review suggested changes – minor and major – to the current investigative process and model. While there was some consistency in

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

72 Three submissions are confidential at the request of the authors and are not referred to in this issues paper

73 Submission to OPI Review (2010)

74 Submission to OPI Review (2010)

what these changes should be, there were also differences in the views and opinions provided on the terms of reference.

Some of the consistent themes emerging from the public submissions include that:

- the definition of a police related death should include at the very least any death arising from police action (that is, police shooting, police pursuit, or any other use of force), police inaction (ie failing to do something to control a situation or protect a person) and deaths in custody (ie deaths in police cells, police vans or while police are making an arrest).
- police officers involved in police related deaths should be treated no differently from members of the public involved in any police investigation. This includes how police are managed as suspects and witnesses, how statements are taken and recorded by police investigators, and the legal defences and rights available to police.
- investigations of police related deaths should be consistent with the five key procedural standards identified by the European Court of Human Rights as necessary for fulfilling the obligations arising from the right to life. In other words, that investigations be independent, adequate and effective, prompt, involve next of kin, and be open to public scrutiny.

On the other hand, differences of opinion were apparent on three key issues including which organisation should conduct investigations of police related deaths – Victoria Police or a separate agency? Some have suggested that the current system is essentially the ‘best’ but could be enhanced with stronger oversight and/or some procedural changes. Others, however, have called for a new independent framework given that changing policies and processes won’t address current concerns about conflict of interest. To this end, there have been calls for a new body to be established in Victoria to conduct these investigations, for OPI to be empowered and resourced to take over these investigations, and for a Federal Independent Investigation Commission to be established with capacity to act immediately in all States and Territories and the type of investigators to be used in these matters.

While some submissions supported the use of experienced specialist police investigators, other submissions suggested that any investigative body be partially or fully civilianised, that staff include people from non-policing backgrounds, and that the body not include seconded police officers; and whether some deaths should be classified as police related at all – for example those occurring in police presence or in the vicinity of police operations (ie in cases where police are not involved or engaged with the person) and those following police contact (that is, where a person is not in custody, care or control of police). These cases tend to question the inclusion of deaths that are not or do not seem to be proximate to police either in place or time.

Specific recommendations made in the public submissions about current policy, processes and the overall framework for conducting investigations of police related deaths were considered in the development of these recommendations.

A list of individuals and organisations that made submissions to the Review is at Appendix Six.

OPI Forum 1

On 29 and 30 July 2010, OPI held a forum on investigations of deaths associated with police contact (OPI forum). The aim of the forum was to discuss a range of issues associated with police investigating police, and to learn more about the experiences and models used in national and international jurisdictions. The forum brought together representatives from police services, oversight agencies, coroners' offices and community and legal groups within Australia and overseas.

Presentations delivered at the forum included those from:

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

This forum was the first national forum convened with the range of stakeholders and parties involved in the investigation and oversight of police related deaths.

There was general consensus from forum participants that the following key challenges need to be addressed:

- Maintaining public confidence in the integrity of investigations.
- Improving treatment and support for people affected (families and police officers) by police related deaths.
- Ensuring that police rights are preserved.
- Reducing the risk of police (investigators and those involved in an incident) collaborating on statements.
- Accurately capturing data and reporting on police related deaths.
- Ultimately, who should investigate these incidents?

Forum participants identified 10 key principles to underpin an investigative or oversight framework for deaths associated with police contact.⁷⁵ These were:

1. **Rigour:** ensuring efficiency and effectiveness in the process, and that agencies are adequately resourced to achieve their goals.
2. **Impartiality:** those charged with investigating and overseeing a matter are able to carry out their duties objectively and without sympathy or prejudice.

⁷⁵ Other principles identified by attendees included leadership; investigative, oversight and policy framework; and clarity of purpose and focus of an investigation

3. **Independence:** those involved in investigation and oversight are sufficiently uninvolved with those subject to an investigation.
4. **Integrity:** the public has confidence in the process and its outcomes.
5. **Accountability:** the process and its outcomes are transparent and open to public scrutiny. It is important to ensure that appropriate action is taken for any wrongs identified.
6. **Expertise/competence/professionalism:** the best-equipped people are responsible for carrying out investigations and oversight.
7. **Systemic perspective:** any conduct, policy, procedural or training issues are able to be identified and for learning and prevention to be incorporated into the goals of the model.
8. **Promptness/timeliness:** that any investigation is carried out in a reasonable time period.
9. **Inclusion of affected people:** that families and police be adequately and properly included in the investigative process and that sufficient welfare and legal support is provided where needed.
10. **Proportionality:** that the investigative and oversight response reflects the nature and circumstances of the police related death.

A number of short and long-term goals were identified by attendees to help focus these efforts. These goals were:

- OPI and Victoria Police will formalise a framework for the investigation and oversight of deaths associated with police contact.
- Improving effective communication with next of kin.
- Informing the general public about oversight and investigative processes.
- Addressing the police media response to police related deaths – for example the tendency to demonstrate support for police officers by exonerating them immediately.
- Strengthening OPI's active oversight and if necessary seeking further resources.
- Improving access for affected persons to independent and continuous support, and legal representation.
- Improving the timeliness of coronial inquests, and if necessary seeking further resources.
- Introducing national standards on training for internal investigators.
- Establishing benchmarks for evaluating or assessing the integrity of investigations.
- Regular public reporting on police related deaths and 'near miss' or serious injury incidents.

- Maintaining, at least in the short term, responsibility for investigations of police related deaths with the Homicide Squad and Major Collision Investigation Group.
- Applying learnings from investigations of police related deaths.

A list of agencies represented at Forum 1 can be found at Appendix Four.

Issues Paper and Working Groups

Following the forum, OPI published an issues paper and established a series of working groups which held 11 x 2.5 hour meetings to facilitate focused consultation between interested parties on the goals identified by forum participants and develop an action plan or potential solutions for consideration by relevant stakeholders.

Four working groups were established to address:

- Improving Current Processes
- Knowledge/Information Management
- Next of Kin Involvement
- Establishing a National Approach

Through these discussions, stakeholders identified areas where there was potential to achieve some significant outcomes for Victoria, particularly in the area of next of kin support and knowledge/information management.

Importantly, the working groups also helped establish working networks between Government and civil society.

A list of the working group objectives and participants can be found at Appendix Five.

OPI Forum 2

A second and final forum was held on 17 May 2011, at which stakeholders presented their work and recommendations to the group for discussion.

At this forum, OPI presented a work-in-progress draft of recommendations for this report and worked with forum participants to refine the recommendations and further discuss their impact.

Some of the participants' contributions at the forums and working groups are quoted, with consent, in this report.

A list of agencies represented at the forum can be found at Appendix Four.

Appendix Four – Forum participants

OPI Forum 1 Participants, 29 and 30 July 2010

Australian Human Rights Commission	Independent Police Complaints Commission, United Kingdom
Commission for Public Complaints Against the Royal Canadian Mounted Police (presentation via video link)	Mental Illness Fellowship Victoria
Commonwealth Ombudsman	Northern Territory Ombudsman
Coronial Advisory Council, Victoria	Police Complaints Authority, South Australia
Corruption and Crime Commission, Western Australia	Professor Andrew Goldsmith
Crime and Misconduct Commission, Queensland	South Australia Police
Department of Justice, Victoria	Tasmanian Integrity Commission
Dr Graham Smith (presentation via video link)	The Police Association Victoria
Dr Ian Freckelton SC	Queensland State Coroner
Federation of Community Legal Centres	Victorian Equal Opportunity and Human Rights Commission
Independent Police Conduct Authority (NZ)	Victoria Police
	Victorian State Coroner

OPI Forum 2 Participants, 17 May 2011

Australia New Zealand Policing
Advisory Agency (ANZPAA)

Centre of Excellence in Policing and
Security (CEPS), Griffith University

Commonwealth Ombudsman

Corruption and Crime Commission,
Western Australia

Crime and Misconduct Commission,
Queensland

Darebin Community Legal Centre

Department of Justice, Victoria

Dr Ian Freckelton SC

Federation of Community Legal
Centres

Human Rights Law Centre

Independent Police Conduct Authority
(NZ)

Mental Illness Fellowship Victoria

Northern Territory Ombudsman

Police Complaints Authority,
South Australia

Professor Andrew Goldsmith

Queensland State Coroner

South Australia Police

Tasmanian Integrity Commission

The Police Association Victoria

Victorian Equal Opportunity and
Human Rights Commission

Victoria Police

Victorian State Coroner

Appendix Five – The working groups

Improving Current Processes

Working group objectives

This group will be responsible for considering some of the process issues raised in the interim paper regarding the current framework – for example, strengthening oversight of investigations, conflict of interest, cautioning, recording police statements, and reducing the risk of police collaborating during the investigative process. OPI and Victoria Police have already commenced much of this work. It is proposed that more regular (and formal) meetings take place to continue and finalise current projects, with input from the Coroners Court of Victoria and the Department of Justice.

Key outcomes

- OPI and Victoria Police to formalise a framework for the investigation and oversight of deaths associated with police contact.
- Strengthen OPI's active oversight and if necessary seek further resources.
- Improve the timeliness of coronial inquests, and if necessary seek further resources.
- Maintain, at least in the short-term, responsibility for investigations of police related deaths with the Homicide Squad and Major Collision Investigation Group.

Participants

- Victoria Police
- Coroners Court of Victoria
- Department of Justice (including the Victims Support Agency)
- The Police Association
- The Office of Police Integrity

Knowledge/Information Management

Working group objectives

This group will focus on the communication and reporting of information regarding deaths associated with police contact. This includes communication with the public about incidents of police related deaths and processes used to investigate and oversight these matters, as well as communication with internal and external stakeholders regarding issues and recommendations arising from these incidents.

Key outcomes

- Inform the general public about oversight and investigative processes.
- Address the police media response to police related deaths – for example the tendency to voice support for police officers by exonerating them immediately.
- Introduce regular public reporting on police related deaths and ‘near miss’ or serious injury incidents.
- Apply lessons from investigations of police related deaths.

Participants

- Victoria Police
- Coroners Court of Victoria
- Department of Justice
- The Office of Police Integrity

Next of Kin Involvement

Working group objectives

The group will focus on improving the experience and treatment of affected parties in the investigative process, and access to welfare and legal representation. While it is recognised that police involved in police related deaths are affected by these incidents, the focus of this group will be on the family (and network) of the deceased.

Key outcomes

- Improve effective communication with next of kin.
- Improve access for affected persons to independent and continuous support, and legal representation.

Participants

- Victoria Police
- Coroners Court of Victoria
- Department of Justice (including the Victims Support Agency)
- Federation of Community Legal Centres
- Darebin Community Legal Centre
- Kensington and Flemington Community Legal Centre
- Mental Illness Fellowship Victoria
- Human Rights Law Resource Centre

- Victorian Equal Opportunity and Human Rights Commission
- The Office of Police Integrity

Establishing a National Approach

Working group objectives

This group will focus on broader issues associated with the overall framework for investigating deaths associated with police contact, including national investigative standards and training. It will also be responsible for considering the applicability of international investigative models to Victoria.

Key outcomes

- Establish benchmarks for evaluating or assessing the integrity of investigations.
- Introduce national training standards for investigators.

Participants

- Victoria Police
- Coroners Court of Victoria
- Department of Justice
- Federation of Community Legal Centres
- Darebin Community Legal Centre
- Kensington and Flemington Community Legal Centre
- Mental Illness Fellowship Victoria
- Human Rights Law Resource Centre
- Victorian Equal Opportunity and Human Rights Commission
- The Office of Police Integrity

Appendix Six – Submissions to the Review

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

Appendix Seven – Summary of relevant legislation

Police Regulation Act 1958

This Act consolidates the laws relating to the Victorian Police Service.

Police Integrity Act 2008

The *Police Integrity Act 2008* established the Office of Police Integrity, setting out the functions of the Office and of the Director, Police Integrity. It amended the *Police Regulation Act 1958*.

Coroners Act 2008

The *Coroners Act 2008* established the Coroners Court of Victoria, as a specialist inquisitorial court. It also established the Coronial Council of Victoria to provide advice and make recommendations to the Attorney-General.

This Act changed the definitions of reportable deaths, medical procedure and examination, reviewable deaths, person placed in custody or care, responsible person and senior next of kin.

Charter of Human Rights and Responsibilities Act 2006

The Charter seeks to protect and promote human rights by setting out the human rights that Parliament specifically seeks to protect and promote and ensuring that all statutory provisions, whenever enacted, are interpreted so far as is possible in a way that is compatible with human rights. It imposes obligations on all public authorities to act in a way that is compatible with human rights and requires statements of compatibility with human rights to be prepared in respect of all Bills introduced into Parliament and enabling the Scrutiny of Acts and Regulations Committee to report on such compatibility.

The Act confers jurisdiction on the Supreme Court to declare that a statutory provision cannot be interpreted consistently with a human right and requiring the relevant Minister to respond to that declaration.

In exceptional circumstances, the Charter enables Parliament to override the application of the Charter to a statutory provision. The Charter also renamed the Equal Opportunity Commission as the Victorian Equal Opportunity and Human Rights Commission and confers additional functions on it.

Victims Charter Act 2006

This Act establishes the principles governing the response to victims by police and victims' services agencies.

Appendix Eight – Research on other investigative models

The following extract from the discussion paper explores the five predominant models uses in overseas jurisdictions for investigating deaths.

There are five predominant models used in overseas jurisdictions for investigating deaths associated with police contact. These include:

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

Each of these models is briefly discussed below.³⁹

Investigation by another police service

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

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

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

The use of an external police service to investigate police-related deaths has received some criticism similar to that levelled at internal police investigations.

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

⁴⁰ Commission for Public Complaints Against the Royal Canadian Mounted Police (2009), *Police Investigating Police*, p 78.

*produce similar findings to an internal investigation and result in a low level of substantiated complaints.*⁴¹

Hybrid civilian/police model

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

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

Civilian-managed investigation

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

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

⁴¹ Commission for Public Complaints Against the Royal Canadian Mounted Police (2009), *Police Investigating Police*, p 78.

⁴² Government of Alberta Solicitor General and Public Security website https://www.solgps.alberta.ca/programs_and_services/public_security/ASIRT/Pages/default.aspx

⁴³ Commission for Public Complaints Against the Royal Canadian Mounted Police (2009), *Police Investigating Police*, p 83.

⁴⁴ The IPCC has four 'modes of investigation' available for dealing with serious complaints and allegations of misconduct against the police in England and Wales. These include independent, managed, supervised and local investigations. See http://www.ipcc.gov.uk/index/about_ipcc/investigations.htm and <http://www.ipcc.gov.uk/cy/mou.pdf>

in the early stages, to ensure the investigation is carried out in accordance with IPCC direction.

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

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

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

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

Embedded in the proposed model are a range of structural and procedural changes which require the level of investigative and oversight response to be determined by the seriousness of the incident. The Commission acknowledges that *'the [Commission's] recommended option underlines the importance of police in the process (as part of the solution) while also recognising that an enhanced degree of civilian engagement in the criminal investigation process is fundamental to ensure its impartiality and integrity.'*⁴⁵

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

Embedded civilian observer

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

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

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

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

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

Independent model

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

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

⁴⁷Final Report Review of the Independent Observer Pilot Program, CPC website, <http://www.cpc-cpp.gc.ca/prt/rep/opp/review-examen08-eng.aspx>

⁴⁸Los Angeles Police Department website: http://www.lapdonline.org/police_commission/content_basic_view/900

With the exception of the Special Investigations Unit in Ontario, all of these agencies also have one or more other functions or responsibilities. For example, to investigate or oversee investigations of a range of other matters such as serious assaults, allegations of misconduct and corruption, other serious criminal offences, public complaints and use of force issues.

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

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

Some disadvantages with the independent model include:

- tension between using current and former police officers (who have the advantages of contacts, contemporary investigative experience and an understanding of the organisational culture) and civilian investigators who are independent of any police influence but can be expensive to train and may lack the contacts, experience and respect former police officers enjoy;
- agencies that rely heavily upon former police officers may attract criticism as they may not be considered impartial;⁴⁹
- the cost involved in either establishing a stand-alone agency or making investigations of police-related deaths part of an existing oversight agency's core business;
- police members may not have any confidence in or cooperate with a system perceived to be staffed by inexperienced civilian investigators or people who lack understanding or appreciation of police culture; and
- agencies may lose the confidence of police services, the legal fraternity and wider community if it cannot attract and retain competent investigators or undertake investigations competently.

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

⁴⁹ Hopkins, T (2009), *An effective system for investigating complaints against police*, Victoria Law Foundation.