Discussion Paper

Independent Oversight of Police Critical Incidents

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September 2023

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Introduction

I have prepared this discussion paper as a consequence of my observations arising from action taken following the death of Kumanjayi Walker in November 2019.

As is known publicly, I am investigating matters arising between the time of the shooting of Mr Walker and the arrest of then Constable Zachary Rolfe. I have already completed one investigation report. A second report will not be finalised until the conclusion of the current coronial inquest into Mr Walker's death.

In advance of the finalisation of that report, I have decided to publish this discussion paper. The content of this paper is intended to provide an overview of current arrangements for oversight of police critical incidents[1] in the Northern Territory, to summarise the arrangements in other jurisdictions, and to set out what I consider to be some policy matters that would benefit from further discussion and debate.

I have intentionally avoided expressing any firm view on these matters. I do not wish to stifle debate and, as I have said publicly in the past, a statutory office holder ought tread carefully when expressing firm views about matters of policy. Instead, this paper is designed to stimulate and support considered discussion.

The reader will notice that the role of the Coroner does not figure prominently in this paper. That is intentional. The Coroner is currently undertaking an inquest where matters relating to police critical incidents has been, and will no doubt continue to be, the subject of evidence. In those circumstances it is not appropriate for me to speak to the Coroner about these matters. Of course the role of the Coroner and her insights will be of particular importance to the issues addressed in this paper, but that is a matter for discussion following the current coronial inquest.

I have decided to publish this document now for four reasons.

First, I am satisfied that the content of this discussion paper does not, and will not, impact upon my investigative activities or the coronial inquest I have already mentioned.

Second, it may be some time before the coronial inquest is finalised and her Honour's reasons are published. In the meantime, the role to be played by my office, and that of the Ombudsman, in respect of police critical incidents, remains unclear to many.

Third, while police critical incidents of the kind the subject of the current coronial inquest are rare, one cannot predict when such an incident will occur again. For that reason, it is prudent that the role to be played by each oversight agency be clarified, and that policy discussion at least begin on these matters.

Finally, given the recent appointment of Mr Michael Murphy PSM as the Commissioner of Police, and the Government's announcement of a review into aspects of NT Police, it seems to be an appropriate time to raise other matters of relevance to NT Police.

The role played by my office in respect of the investigation that followed Mr Walker's death remains unclear to many. This paper is not intended to be the forum for detailed clarification. The particulars of the role played by my office will figure in my final investigation report which, as I have stated, will not be finalised until after the conclusion of the current coronial inquest.

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[1] I will describe what I mean by a police critical incident later in this paper.

For now I need only make one comment. It is clear to me that there was confusion and misunderstanding as to the role played by my office in respect of that matter. That confusion manifested into a misapprehension as to the nature and extent of oversight by this office of the criminal investigation that followed Mr Walker's death.

Clarification is needed to avoid misunderstandings in the future.

I hope that this discussion paper advances discourse about this very important topic.

I have consulted with both the Police Commissioner and the Ombudsman in respect of this paper, and I am grateful for their input and support.

What is a police critical incident?

In the Northern Territory what is meant by a police critical incident is not defined in legislation. As I understand it, existing police general orders do not define police critical incidents. Nor do I understand there to be a policy operating within the Northern Territory Police that provides a definition.

As I will explain later, another jurisdiction does provide a statutory definition.

For present purposes, I will define a police critical incident as an incident involving the death or serious injury of one or more persons that is connected to a police activity. For example, a police critical incident arises when a person is killed or seriously injured:

- after being shot by a police officer;
- during or as a consequence of a police pursuit;
- as a result of physical force or restraint applied by police;
- as a result of the deployment of defensive equipment (eg baton, electronic control device); or
- during the course of attempting to escape police custody.[2]

The essential element is that a police activity can be linked directly to a person's death or serious injury.

The legislative scheme in the Northern Territory

Unlike most other jurisdictions, there are two separate statutory office holders who have a role in the oversight of police conduct matters. The first is the Northern Territory Ombudsman (Ombudsman). The second is the Independent Commissioner Against Corruption (ICAC).

The Northern Territory Ombudsman

The primary body responsible for the oversight of management of police misconduct is the Ombudsman.

Part 7 of the *Ombudsman Act 2009* deals exclusively with police conduct. The Ombudsman is empowered to oversee the manner in which police deal with complaints about its members, and is empowered to conduct his own investigations in respect of police. Indeed, the Ombudsman's

[2] These examples ought not be taken to be an exhaustive list of categories of police critical incidents.

important role is apparent from the fact that if the ICAC refers a matter to the Police Commissioner, the Police Commissioner is obliged to notify the Ombudsman of that referral.[3]

The action to be taken on a police complaint (as that term is defined in the *Ombudsman Act 2009*) is a matter for the Ombudsman. The Ombudsman can cause that complaint to be dealt by way of:

- taking no further action
- conciliation[4]
- the 'police complaints resolution process'
- investigation conducted by the NT Police Professional Standards Command with oversight by the Ombudsman.
- investigating the complaint himself.[5]

Where police are tasked with investigating a police complaint, the Ombudsman may request that that investigation be conducted in a particular way.[6]

The Ombudsman can prepare reports on police complaints, and can make his own findings.[7] Importantly, all of the various functions and powers given to the Ombudsman, at least in respect of police, rely upon the existence of an allegation of impropriety[8].

There presently exists a Memorandum of Understanding (MoU) between the Ombudsman and the Police Commissioner that addresses a range of procedural matters associated with the management of police complaints. That MoU is published by the Ombudsman and is annexed to his annual reports.

However, the MoU does not specifically deal with the role to be played by the Ombudsman in respect of police critical incidents.

Similarly, the *Ombudsman Act 2009* does not directly address the oversight of police critical incidents.

The ICAC

The ICAC is empowered to conduct an investigation into potential improper conduct.[9]

The ICAC is also empowered to refer a matter that may involve improper conduct to a *referral entity*.[10] In the case of a police officer (other than the Police Commissioner), a referral entity includes the Police Commissioner. As I have said, where such a referral is made to the Police Commissioner, the Police Commissioner is obliged to notify the Ombudsman.[11]

In some cases, the ICAC is empowered to give directions in respect of the referral. Section 28 provides that:

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[3] ICAC Act, ss 25(7).
[4] I understand that while available, conciliation is not utilised.
[5] See *Ombudsman Act 2009*, s 66(2).
[6] Ibid, s 84.
[7] Ibid, s 99 and s 100.
[8] Whether as a result of a complaint, report or from concerns expressed by an individual(s).
[9] ICAC Act, s 31.
[10] Ibid, ss 25(1).
[11] Ibid, ss 25(7).

(1) Subject to this section, the ICAC may give directions to a referral entity in relation to the referral, including directions as to:

(a) how the referral entity is to deal with the matter; and

(b) reporting requirements of the referral entity in relation to the matter.

(2) Except as provided by subsection (3), the ICAC cannot give directions under subsection (1) to an independent entity.

(3) The ICAC may give directions to an independent entity, other than the Speaker, Deputy Speaker, Judicial Commission or a judicial officer, requiring the entity to report to the ICAC on the actions taken by the entity on the referral and the outcome of those actions.

(4) A referral entity is not obliged to comply with a direction of the ICAC to the extent that compliance is beyond the power, or incompatible with the functions, of the referral entity.

Where a matter is referred to the Police Commissioner, care must be taken to ensure that the nature of the matter is not of a kind that would engage the Commissioner's status as an independent entity. The Police Commissioner is, by virtue of the definition of *independent entity* in section 4, an independent entity if:

(i) the matter referred does not involve an allegation of corrupt conduct of a police officer or a person employed or engaged by the Commissioner of Police; or

(ii) the matter referred involves an allegation of improper conduct of a police officer or a person employed or engaged by the Commissioner of Police and the ICAC considers the ICAC has no good reason to maintain oversight of the matter.

If the ICAC were to refer a matter to the Police Commissioner and, in light of the subject matter of the referral, the Police Commissioner had the status of an independent entity, then the only directions that can be issued under section 28 are those specified in sub-section (3).

On the other hand, if the ICAC were to refer to the Police Commissioner:

- a matter in which there is alleged corrupt conduct by a police officer, or a person employed or engaged by the Police Commissioner; **or**
- a matter of alleged improper conduct of a police officer, or a person employed or engaged by the Police Commissioner, and the ICAC decides to maintain oversight of the matter,

then the ICAC can issue directions as contemplated by sub-section (1).

The nature of the directions that can be issued in accordance with section 28 are not prescribed in any detail. Of course the directions would have to be focused towards the referral and directions given would have to be considered in light of sub-section (4).

I do not read section 28 as creating a temporal limit on the giving of directions. In other words, I do not read section 28 as only permitting the ICAC to issue a direction at the time of the making of the referral. However, given the matter has been referred to another entity for action, as opposed to being retained by the ICAC for investigation, consideration must be given to the extent to which ongoing directions would be appropriate. The question of what is meant by *oversight* becomes relevant. I will talk about *oversight* as a concept later in this paper.

The giving of directions in accordance with section 28 is contingent upon the making of a referral in accordance with section 25. A referral under section 25 is, in turn, contingent upon there being a matter that has come to the ICAC's attention that may involve improper conduct.

As is the case for the Ombudsman, the investigative and referral functions given to the ICAC presuppose the existence of alleged impropriety or, more specifically under the ICAC Act, improper conduct.

At present there is no MoU between the Police and the ICAC in respect of police critical incidents. The ICAC Act does not specifically address the role to be played by the ICAC in respect of police critical incidents.

Accordingly, where a police critical incident arises, neither the Ombudsman nor the ICAC have legislative power to oversee any investigation by police, unless there exists information known to the Ombudsman or the ICAC that might suggest improper conduct or, in the case of the Ombudsman, police misconduct.

The practice in the Northern Territory

The Northern Territory Police General Order entitled *Crime (Homicide and Serious) Investigation* (the General Order) touches upon police critical incidents.

The General Order makes no reference to either the Ombudsman or the ICAC. There is no mechanism to declare an incident to be a critical or significant incident. Rather, the General Order provides for the Assistant Commissioner of the Crime Portfolio to declare a matter a major investigation (referred to as a DI – Declared Investigation). A DI is subject to oversight by a Joint Management Committee, which is comprised of NTPFES members and other invitees determined by the Chair.

There is no specific requirement in the General Order to notify the ICAC or the Ombudsman of a DI where the matter involves a death in custody or police related death or serious injury.

Nevertheless, I understand that there is an unwritten practice of notifying the Ombudsman and the ICAC of a police related death or serious injury.

Neither the Ombudsman, nor the ICAC, have statutory powers or functions expressly directed towards the oversight or investigation of police critical incidents. Statutory powers are only enlivened upon there being a notification of some alleged improper conduct. In the absence of such notification, there is unlikely to be oversight of a DI by an independent body, or oversight would only occur as a consequence of mutual agreement.

Other jurisdictions

It is appropriate to explain what occurs in other jurisdictions. For reasons that will become clear, I have paid particular attention to Queensland and New South Wales.

Queensland

In recent times two significant reports have been delivered to the Queensland Government. If the recommendations made in those reports are implemented, it would represent a massive change to traditional methods of police oversight and investigation.

To understand the enormity of the proposed changes it is first necessary to understand the current arrangements in Queensland.

The Queensland Crime and Corruption Commission (Qld CCC) is the sole body responsible for the independent investigation and oversight of Queensland Police.

There exists a MoU between Queensland Police, the Queensland Coroner and the Qld CCC. In accordance with that MoU, the Queensland Police must notify and brief the Qld CCC in respect of any police significant incident, such as a death in custody or death arising during a police operation. The Qld CCC can decide to attend the scene of the incident to ascertain the

circumstances that led to the incident. If the Qld CCC forms the view that the incident may involve corruption by a police officer, the Qld CCC can commence an investigation or oversee the conduct of the police investigation.[12]

The Qld CCC's empowering legislation does not specifically address oversight or investigation of police critical or significant incidents.

In January 2021 the Queensland Coroner recommended that the Queensland Government consider commissioning an independent review of the current arrangements for the investigation of police-related deaths on behalf of the Coroner and the oversight of those investigations.[13] The Queensland Government commissioned that review.

On 12 July 2022, Professor Lorraine Mazerolle delivered the review report.[14]

On the topic of police related deaths, the authors said (at page 7):

> *… the primary concern raised is whether police should investigate the actions and conduct of other police. Current practice is that police-related deaths are investigated by the Queensland Police Service's (QPS) Ethical Standards Command (ESC), with the Crime and Corruption Commission (CCC) adopting an oversight role to monitor the integrity of these investigations. The State Coroner lacks the resources or investigative skills or powers to undertake his own investigations.*
>
> *Our interviews with stakeholders and thematic review of coronial reports show that people generally view the ESC investigation to be of a high standard. But the perception of 'police investigating police' is regarded as not acceptable to the community. We also found that the separate roles of the ESC, CCC and Coroner are not well understood even by those who participate regularly in these matters.*

The Mazerolle Report included seven recommendations in relation to deaths in custody and in the course of police operations.

Given the significance of the recommendations, I set them out in full:

1. *Amend section 33 of the Crime and Corruption Act 2001 (Qld) to vest in the Crime and Corruption Commission a function to lead and coordinate the investigation of deaths in police custody and deaths in the course of police operations.*

2. *Ensure that the Crime and Corruption Commission appoints a multi-disciplinary, multi-skilled investigative teams for each death in custody and death in the course of police operations that takes into account the geographic and cultural circumstances of the death and comprises a diversity of team membership which includes, in addition to sworn police investigators, at least one member from each of the following: First Nations/cultural expert, cultural safety and trauma-informed communication specialist and an investigator who is not a serving or sworn Queensland Police Service officer which may include former police from other jurisdictions, investigators from other agencies, or former Queensland Police Service personnel whose employment with the service ceased at least two years prior to their appointment to the Crime and Corruption Commission.*

3. *Provide sufficient resources to the Crime and Corruption Commission to establish and lead multi-disciplinary, multi-skilled teams to investigate deaths in custody and deaths in the course of police operations with specific resources to recruit a First*

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[12] https://www.ccc.qld.gov.au/corruption/police-oversight/oversight-serious-police-related-incidents

[13] https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/663468/cif-miller-c-20210122.pdf - recommendation 2 at page 24.

[14] Mazerolle, L., Ransley, J., Marchetti, E., Crowley, L., Colbert, P., & Gilmour, J. (2022). Independent review into investigations of police-related deaths, and domestic and family violence deaths in Queensland.

Nations/cultural expert, a cultural safety and trauma-informed communication specialists and non-sworn investigators.

4. *Replace the current Memorandum of Understanding between the Queensland Police Service, Crime and Corruption Commission and Coroner with a new agreement that reflects these recommendations. It should set out:*

    a) *principles for cooperation between the parties with the Crime and Corruption Commission taking over from Ethical Standards Command the responsibility to lead and coordinate investigations into police-related deaths.*

    b) *that the Crime and Corruption Commission is to be notified of any police-related death as soon as Ethical Standards Command becomes aware of it, and that the Crime and Corruption Commission then assumes responsibility to coordinate attendance at the scene in consultation with the Coroner and Ethical Standards Command.*

    c) *that the Crime and Corruption Commission investigative reports are to be submitted to the Coroner within 6 months, and coronial inquiries (if held) are to be completed within a further 6 months, except in exceptional circumstances.*

5. *Amend section 11(7) of the Coroners Act 2003 (Qld) to authorise all coroners across the State of Queensland to investigate deaths in police custody and deaths in the course of police operations, with the allocation of investigations to be determined by the State Coroner.*

6. *Amend the Coroners Act 2003 (Qld) to insert a new Part establishing a Police-Related Deaths Advisory Board modelled on Part 4A of the Act which establishes the Domestic and Family Violence Death Review and Advisory Board. The Police-Related Deaths Advisory Board should:*

    a) *have purposes including: to build public trust and confidence in the independence and transparency of investigations of police-related deaths; identify systemic conditions and issues leading to police-related deaths and preventative measures that could reduce the occurrence of such deaths; monitor and review the investigation and coronial processes relating to such deaths including their timeliness and appropriateness; review the extent of implementation of coronial recommendations relating to such deaths particularly those related to the functions of the Crime and Corruption Commission, Queensland Police Service and Coroner's office; and make recommendations to the relevant Minister/s for implementation to prevent and reduce the likelihood of police-related deaths.*

    b) *prepare an annual report which is made public and which reviews system issues including trends in police-related deaths, recommendations made and whether they have been implemented, and other relevant matters, but the Board should not have any function to investigate individual deaths.*

    c) *be co-chaired by the Coroner and a prominent First Nations person and also include community expert representation.*

7. *Provide sufficient resources to the Coroner's Office to establish the Police-Related Deaths Advisory Board including establishing a separate secretariat to support its functions, and appropriate remuneration for the Board co-chair and members.* [15]

Soon after that report, a further report was published that called for even more sweeping changes.

The *Independent Commission of Inquiry into Queensland Police Service responses to domestic and family violence,* was delivered by the Commissioner, Her Honour Judge Deborah Richards, in November 2022.

In her report, Commissioner Richards made 78 recommendations. Of particular relevance are the recommendations made in respect of the management of complaints and investigations into police conduct.

If those recommendations are implemented, it would signify a fundamental shift in the way police conduct matters are addressed in Australia.

In brief terms, Commissioner Richards recommended the establishment of a separate Police Integrity Unit within the Qld CCC. That Police Integrity Unit would have sole responsibility for receiving, assessing and investigating alleged improper conduct by police. In other words, Queensland Police would have no role to play in of assessing, investigating or otherwise deciding upon what course of action to take in relation to alleged improper conduct within police.

As I understand it, the Queensland Government is presently considering the recommendations made in both reports.

New South Wales

New South Wales is unique in that it is the only jurisdiction in Australia that has legislation directly addressing the oversight of police critical incidents.

The Law Enforcement Conduct Commission (LECC) provides independent oversight, review and investigation of matters relating to the New South Wales Police Force and the New South Wales Crime Commission. Its jurisdiction is confined to those two entities.

The LECC operates in accordance with the *Law Enforcement Conduct Commission Act 2016* (LECC Act). Part 8 of the LECC Act is entitled ***Oversight of critical incident investigations***. That Part is dedicated to the LECC's role in respect of declared critical incidents. As I have said, it is the only agency in the country to have a legislated role in respect of overseeing the investigation of such incidents.

There are some aspects of that legislative scheme worth highlighting.

First, while the declaration of a critical incident rests with the Commissioner of Police,[16] the LECC Act defines the features of a critical incident. Section 110 provides that:

> *[t]he features of a critical incident are –*
>
> *(a) it is an incident involving a police officer or other member of the NSW Police Force that results in the death of, or serious injury to, a person (including another police officer), and*
>
> *(b) the death or serious injury-*
>
> *(i) arises from a discharge of a firearm by the member involved, or*

[15] Ibid, page 8.
[16] LECC Act, s 111.

(ii) arises from the use or operation of defensive equipment by the member involved, or

(iii) arises from the application of physical force by the member involved while exercising any function as a police officer, or

(iv) arises from the use of a police vehicle by the member involved (including its use as a passenger), or

(v) arises while the person is in custody or while escaping or attempting to escape custody, or

(vi) appears to be likely to have resulted from any police operation.

Having declared an incident to be a critical incident, the Commissioner of Police is obliged to immediately notify the LECC.[17] The LECC has rostering arrangements to ensure such notification can be received at any time of the day or night.

Having been notified of the critical incident, the LECC can then determine whether the ensuing police investigation ought to be overseen by that body.

In accordance with its legislation, the LECC can:

- *attend the scene of a critical incident 'for the purpose of observing the exercise by police officers of any investigatory powers at or in relation to the place'*[18]
- *be present and observe interviews (subject to the consent of person being interviewed and the senior critical incident investigator)*[19]
- *require the provision, within a nominated timeframe, of access to documents relevant to the investigation.*[20]

There are two other important provisions. First, section 115(1) provides that:

> *it is the duty of the Commissioner of Police and police officers involved in investigating a critical incident under section 113, and the Commission in monitoring an investigation under section 114, to work co-operatively in the exercise of their respective functions to ensure the critical incident is investigated in a competent, thorough and objective manner.*

Second, section 115(4) provides that:

> *[t]he Commission cannot control, supervise, direct or interfere with the carrying out by the police officers of their function of investigating a critical incident.*

In other words, while the LECC is empowered to oversee a police critical incident investigation, it has no power to intervene and direct that certain actions occur.

Rather, it is empowered to provide advice to the Commissioner of Police, the nominated police contact officer and to the Coroner.[21]

In May 2023, the LECC delivered a report to the NSW Parliament in respect of the independent monitoring of police critical incidents.

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[17] Ibid, ss 112(1).
[18] Ibid, ss 114(3)(a).
[19] Ibid, ss 114(3)(c).
[20] Ibid ss 114(3)(d).
[21] Ibid, s 116 and s 117.

According to that report, between 1 July 2017 and 30 June 2022, there were 157 police critical incidents declared by NSW Police. During that period the LECC has undertaken some form of oversight in respect of all declared police critical incidents.

Three observations made in the LECC report are worth noting.

First, the report highlighted the fact that not all police critical incidents involve police misconduct. Prior to the establishment of the LECC, an oversight agency would only become involved upon the making of a complaint or report alleging some impropriety by police.

The Commission said (at page 2):

> *.... The reality is that from time to time, police are faced with a difficult situation and are required to make unenviable split-second decisions. Sometimes the outcome is tragic and results in the death of, or serious injury to, a person. In such cases, the outcome alone justifies scrutiny of police actions at the time of, and leading to, a person's death or serious injury.*
>
> *In addition, if there are concerns about possible misconduct, the family members of deceased or seriously injured persons do not usually have sufficient knowledge or information, on which to make allegations of misconduct. In addition, if misconduct is raised in the course of related court proceedings, the issues may not be able to be identified for several months or years after the incident.*
>
> *…*
>
> *The need for external independent oversight of [the NSW Police Force] critical incident investigations did not stem from a concern that police would deliberately cover up the wrongdoing of other police. Instead, it arose from a concern that investigating police may have 'understandable empathy' towards officers involved in a critical incident, which has the potential to affect the impartiality of police investigators and internal review officers from the Professional Standards Command (PSC).*
>
> *The impartiality of police investigators and internal review officers is further complicated by the fact that police have an inherent conflict of interest in the outcome of a critical incident investigation. Whether a real or perceived conflict of interest, this conflict arises because the outcome of a critical incident investigation has the potential to tarnish the reputation of the police force and/or result in legal or financial liability for the NSWPF.*

Second, the report addressed the conduct of separate investigations, one in respect of the critical incident, and the second in respect of any misconduct. The Commission said (at page 31):

> *The Commission has several concerns with the separation of critical incident and misconduct matter investigations:*
>
> - *Since a misconduct matter investigation is almost always suspended pending the finalisation of coronial and criminal proceedings, there is likely to be a long delay in taking evidence on the misconduct matter from involved police officers. Those officers may have already given evidence on those events in coronial or criminal proceedings. These factors risk impacting the officer's evidence in relation to the misconduct investigation.*
> - *The misconduct investigator tends to conduct a fresh investigation to test the allegations, which is duplicitous and a waste of resources.*

- *The findings made in the related misconduct matter investigation are not always congruent with findings that may have been warranted on the basis of all available evidence arising in the critical incident investigation[22];*
- *Any management action may be significantly delayed and will not mitigate risks of similar misconduct occurring in the interim.*
- *The delay may also affect the fairness of taking management action and therefore the type of management action that is taken. Indeed, given the passage of time, it may be too late to take management action[23].*

Other jurisdictions

In most other jurisdictions there is a single civilian police oversight body:

- South Australia – Office for Public Integrity
- Western Australia – Corruption and Crime Commission
- Victoria – Independent Broad-based Anti-Corruption Commission
- Australian Capital Territory – ACT Integrity Commission
- Commonwealth – National Anti-Corruption Commission

There are no express statutory provisions governing the independent oversight of police critical incidents in Western Australia.

In 2016 the South Australian Parliament enacted the *Police Complaints and Discipline Act 2016*. Prior to the commencement of that Act there were two bodies that could oversee or investigate police conduct matters: the Police Ombudsman and the SA ICAC. The new Act abolished the Police Ombudsman and vested the role of overseeing police conduct matters with the Office for Public Integrity, which was at the time responsible to the ICAC for the performance of its functions.

There are no express statutory provisions governing the independent oversight of police critical incidents in South Australia.

In Tasmania police complaints can be made to Police, the Ombudsman or the Integrity Commission. Complaints about police are generally dealt with by police. Pursuant to a Letter of Understanding, the Tasmania Police and the Integrity Commission have an arrangement that the Tasmania Police will notify the Commission of all complaints and internally raised matters involving serious misconduct or a designated public officer.[24]

There are no express statutory provisions governing the independent oversight of police critical incidents in Tasmania.

The Independent Broad-based Anti-Corruption Commission in Victoria (IBAC) has functions including to receive, assess, investigate or refer and oversee allegations of police misconduct.

It does not have statutory powers or functions directed towards police critical incidents.

In 2018 the IBAC conducted a review of the Victoria Police's oversight of serious incidents involving death or serious injury resulting from contact with police, deaths in custody, escapes from custody, attempted suicides while in police custody, discharge of a firearm by police or a serious

[22] Reference omitted.
[23] Reference omitted.
[24] See the Tasmanian Integrity Commission website: www.integrity.tas.gov.au.

vehicle collision involving police. The IBAC found that there were aspects of the police oversight process that were concerning and which could be improved.

The review, which included considering 140 oversight files closed by Victoria Police in the 2015/16 financial year, found that conflicts of interest were poorly managed, relevant evidence had not been considered in more than half of files reviewed, around one third of matters were not subject to adequate supervision, and that while Victoria Police had notified the IBAC of the majority of serious incidents that were examined in the review, there was no statutory requirement to do so (in the absence of a complaint about police).

The IBAC made a number of recommendations to address the identified shortcomings.

The need for clarity

There is a clear need for clarity as to the role to be played by Northern Territory oversight bodies in respect of police critical incidents. To that end both the newly appointed Police Commissioner, the Ombudsman and I have agreed to commence work on a tripartite Memorandum of Understanding that will provide clarity on the respective roles, responsibilities and expectations of the NT Police, the Ombudsman and the ICAC. For reasons already explained, there is a need to put in place such an agreement with reasonable expediency. The Memorandum of Understanding will be reconsidered in light of any findings and recommendations made by the Coroner.

Once the Memorandum of Understanding has been approved, it will be published, in order that the public can be informed of its content.

The policy questions

While a MoU is an important step to bring about clarity in the short term, such a document ought not be seen as the panacea to existing confusion. A broader policy discussion ought to occur. In my view, the following questions might be a useful starting point. I acknowledge that within each question are a plethora of detailed issues that would require consideration, and that such matters will take time to consider.

Is independent oversight of police critical incidents required in the Northern Territory?

First and foremost, there must be a consideration as to whether oversight of police critical incidents is required in the Northern Territory and, if so, who is responsible for that oversight and what oversight means.

We must exercise care and not immediately embrace, or immediately discount, arrangements in other jurisdictions. Experiences in other jurisdictions are invaluable in understanding the effectiveness (or otherwise) of oversight regimes, but they must be assessed against the particular needs of the Northern Territory and its population.

If oversight is required, what does that mean in practice?

In order to meet policy and community expectations, there should be clarity as to the role to be played (if any) by independent oversight bodies. That, in turn, relies upon a clear understanding of what is meant by *oversight.* No doubt readers of this paper will have different ideas as to what this means.

On the one hand, some may view oversight as passive monitoring, with little input.

On the other hand, others may view oversight as requiring real time review and intervention in respect of any identified error, omission or departure from appropriate process.

Oversight may involve live, real time monitoring of an activity and the power to give directions during the course of the activity. Oversight could equally involve awaiting the provision of a final report, and determining at that time whether actions have been appropriately undertaken.

There are a multitude of variations in between.

Agreement on what form of oversight (if any) is essential to ensuring clarity. Of course, the extent to which a body can engage in oversight (in whatever form is considered appropriate) will depend upon its empowering legislation and its resources.

More generally, should there continue to be two civilian bodies who have a role in investigating and/or overseeing police?

This is a question of legislation and one that is for the Government and, ultimately, the Parliament. Beyond expressing the view that more than one oversight body may lead to duplication, inconsistent approaches and confusion, I do not think it necessary or appropriate to comment further. These are significant and challenging issues that require fulsome and careful consideration.

Conclusion

As I said in the introduction, this discussion paper is not designed to urge a particular policy outcome. In the end, policy is a matter for Government and, if legislative intervention is considered necessary, the Parliament. The purpose of this discussion paper is to promote and advance constructive dialogue about these important issues, in the hope that it may support considered and effective policy debate.

I trust that this paper serves that purpose.

Michael Riches

Commissioner

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