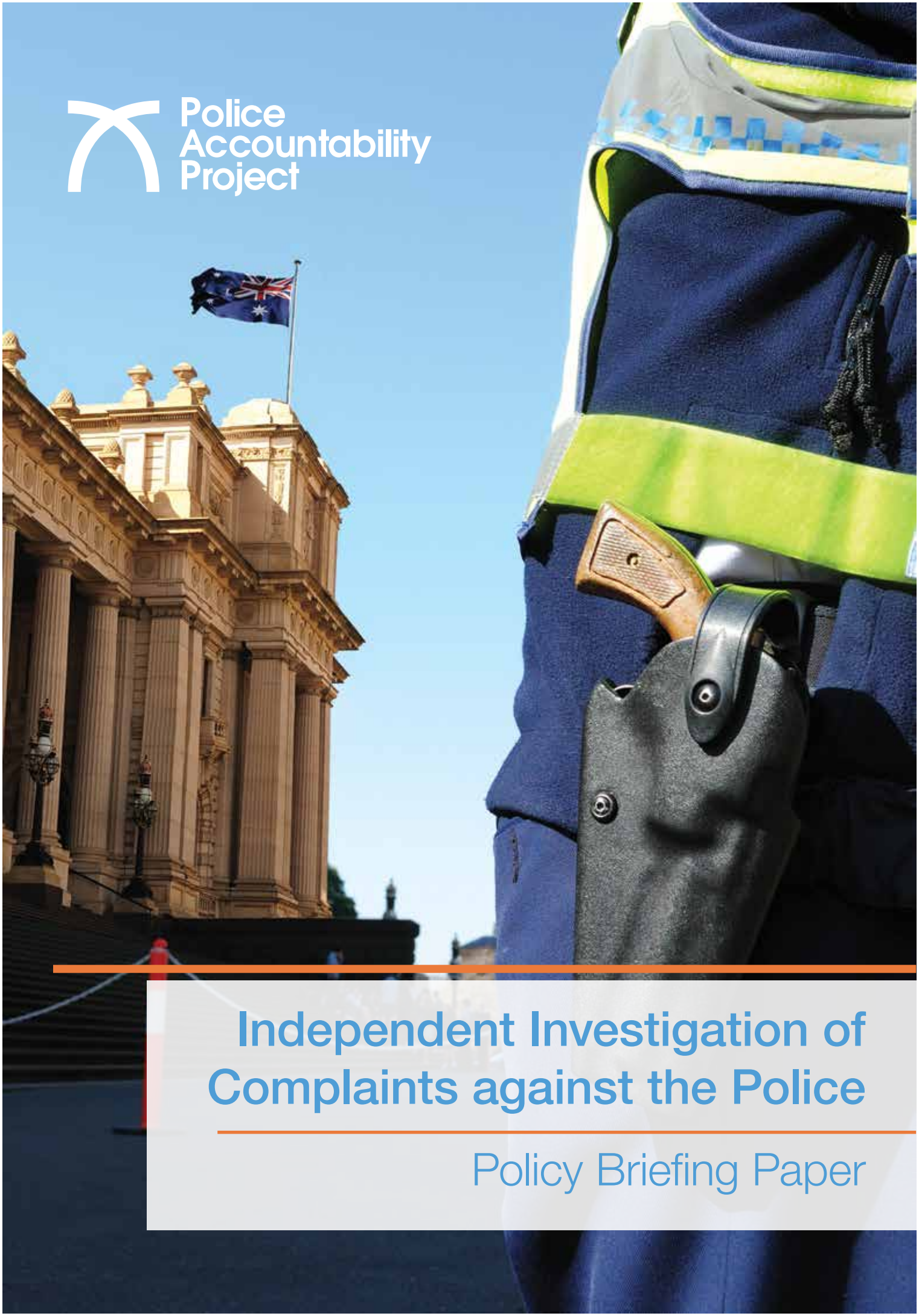
Police Accountability Project



Independent Investigation of Complaints against the Police

Policy Briefing Paper

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Endorsed by:

Introduction

All Victorians are stakeholders in ensuring a robust, effective and human rights oriented police accountability system. In this updated Briefing Paper, we seek to give a voice to the experience of many Victorians we have assisted navigate the current police oversight system.

Overwhelmingly, their collective experience is of a system that has failed to respect fundamental human rights.

Police are granted powers by the state and it is the state's responsibility to ensure that these powers are not abused. Police must be fully accountable for their every action when interacting with citizens.

The use of force, or the use of coercive and invasive powers, are a routine part of a police member's job. Police are provided with weapons including guns, Tasers, OC (pepper) spray and batons. Police arrest, detain, stop, question and search people, their cars and homes, all of which impacts on fundamental human rights and freedoms.

The abuse of force or power has a profound and detrimental impact on all those who experience and their families and entire communities. It undermines safety, self-worth and belonging and it erodes faith in the institutions of democracy and the rule of law. *Even minor excesses by Police can have a significant impact on the community.*

The abuse of police power impacts most upon the already vulnerable such as the young, the mentally ill, those from refugee and migrant backgrounds and Indigenous Australians.

Police who abuse the trust of Victorians must be held accountable. Existing accountability mechanisms in Victoria consistently fail to maintain accountability, uphold human rights, change police behaviour or improve practices.

> *"In a democracy, policing, in order to be effective must be based on consent across the community…[where the] community recognises the legitimacy of the policing task, confers authority on police personnel carrying out their role in police and actively support them. Consent is not unconditional, but depends on proper accountability."*[1] *Nowhere is this need for accountability more acute than in contexts where the State takes life through the use of deadly force or as result of serious dereliction of duty.*

Victoria does not need an independent 'review' model, under which police retain responsibility for formal investigations into misconduct complaints and deaths caused by police. Such models have consistently failed to deliver public trust and meet human rights benchmarks and is currently failing Victoria. **It needs a fully independent model for investigation of complaints against police.**

Prenzler et al note in discussing the rise in civilian review models around the world, which fall short of fully independent investigative bodies:

> *"Available performance indicators – such as public confidence, complainant satisfaction, complaint substantiation rates and police conduct indicators- suggest some achievements. A capacity to hold open inquisitorial hearings and refer matters to a public prosecutor or administrative tribunal significantly enhances the democratic accountability process, as does the ability to publish reports.*
>
> *Nonetheless, most review systems allow too much scope for police to control or subvert the process. One major problem is that civilian review holds out a false promise. Agencies look like they will investigate and adjudicate allegations against police. It is hardly surprising then, that complainants' anger and disillusionment with authorities are compounded when the oversight agency refers the complaint to the police."* [2]

1. *A New Beginning: Policing in Northern Ireland*, The Report of the Independent Commission on Policing for Northern Ireland (Independent Commission for Policing in Northern Ireland, 1999, p22), available at: http://cain.ulst.ac.uk/issues/police/patten/patten99.pdf.
2. "Scandal, Inquiry and Reform" in *Civilian oversight of Police*, Prenzler, Heyer, Garth (2015) p 6.

This paper addresses this persistent and reoccurring issue which plagues Victoria's current system of police oversight. It draws upon the direct experience of victims, solicitors from community legal centres and law firms and upon decades of international research and developing best practice approaches.

People who, in good faith, lodge a formal complaint about something that they suffered often do so with a sense of injustice. They are often motivated by an impulse that says that *"if I don't complain, what happened to me could happen to someone else."*

The current system tends to punish and dismiss complainants.

Complaints are an opportunity for positive reform. Most people who spend the time and effort it takes to make a formal complaint provide a benefit to the community. Complaints from the public allow the detection, investigation, disciplining and prosecuting of police members who have engaged in misconduct. When a person takes the time and effort to lodge a formal complaint, they create an opportunity for the reform of systemic failures in police practices.

An ineffective police complaint system has the effect of hiding or ignoring human rights abuses against members of the Victorian community. Victorian Parliament has a particular responsibility to ensure the effective and impartial investigation of complaints against police.

Beyond human rights compliance, practical benefits of an independent model for Victoria include:

For police:

- Freeing up policing resources that would otherwise be diverted from front line service delivery and primary duties;
- Minimising community concerns about the integrity of investigations, (relating to either process or outcomes);
- Improving member confidence in whistleblowing/ reporting misconduct and reducing risks of leaking confidential complaint information in the context of 'warning' colleagues that they are under investigation;
- Improving police policies and operational practices through external scrutiny;
- Avoiding police being politicised; and
- Avoiding conflicts of interest that put an investigating police officer in an unenviable position of trying to avoid bad publicity that impacts political and public trust in police, versus their obligation to uncover and prevent misconduct.

For the community:

- Increased trust for investigation processes and outcomes;
- Increased participation in investigations;
- Public safety; protection from unlawful use of lethal or non-lethal force;
- Increased public confidence in accountability mechanisms, in turn, increasing confidence in policing; and
- Increased public confidence in the administration of justice.

This briefing paper is intended for Ministers, Members of Parliament, policy makers, police command and community advocates. It makes 32 key recommendations and covers seven primary issues:

1. **Key policy recommendations /executive summary**
2. **How complaints against police are currently investigated in Victoria**
3. **What's wrong with the current system?**
4. **Getting the model right**
5. **Investigation of police-related deaths**
6. **Why the NSW Law Enforcement Conduct Commission is no model for Victoria.**
7. **Overcoming the perceived barriers to independent investigation**

3. Documented accounts of this 'leaking' occurring include Operation Styx.

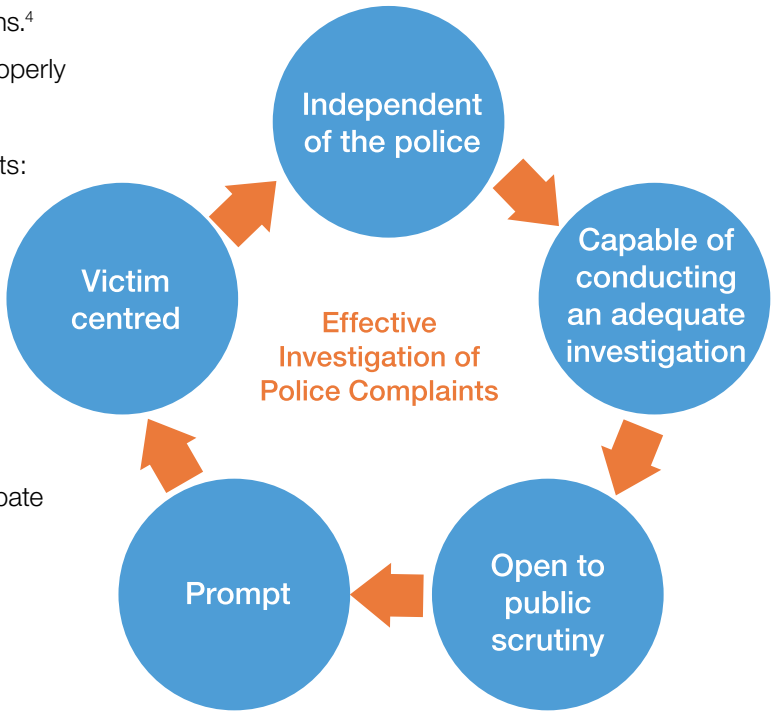
1. Key policy recommendations/executive summary

The Victorian Government must, as a matter of urgency, establish a body separate from police to independently investigate complaints made against police. The best model for such a body is the Police Ombudsman of Northern Ireland. However, the role could be conducted by IBAC with some significant legislative and cultural changes, which would include the quarantining of a dedicated specialist, police focused investigative unit, separate from teams that carry out anti-corruption investigations.[4]

Whichever model is adopted, the body must be properly resourced and empowered to meet the standards required of police oversight and accountability, established by the European Court of Human Rights:

- Independent of the police (institutionally, culturally, and politically);
- Capable of conducting an adequate investigation (i.e. an investigation leading to criminal and/or disciplinary outcomes);
- Prompt in its investigations;
- Open to public scrutiny;
- Victim centred; enabling the victim to fully participate in the investigation, including through access to information relevant to their complaint.

Necessary reforms discussed in this paper, which are critical to the above model, include:



In relation to the investigation of police misconduct complaints, generally:

1.1 Independent investigation of *all* police misconduct complaints *other than customer service complaints.* (Customer service complaints should **not** include complaints that involve allegations of discrimination or duty failure (including in relation to family violence) or complaints about breaches of human rights. To ensure transparency and consistency, what constitutes a 'customer service complaint,' should be set out in a publicly accessible and plain language policy document that is widely available online and in police stations.

1.2 Investigations of police complaints must adhere to procedural fairness in decision making (for example, complainants should be informed before a complaint is dismissed and have opportunity to comment on any adverse material which may affect the complaint outcome. For example, complainants may be able to provide further information, witnesses or evidence and correct false assumptions). [5]

1.3 Investigation decisions must be explained, recorded in writing and publicly available, subject to appropriate and necessary redactions.[6]

4. It is worth noting that IBAC does not currently consider itself to be a complaint handling body and does not consider that it is subject to the rules of natural justice or that it owes complainants transparency or explanation for its actions.
5. *Victorian police complaints investigations in the spotlight: IBAC recommendations fail the "Horvath test"* (Flemington & Kensington Community Legal Centre, 2016).
6. For example, see the Washington DC model, where the Office of Police Complaints (which conducts investigations by independent, non-police decision makers), records its decisions in writing and decisions are appealable: <http://policecomplaints.dc.gov/node/164852>.

1.4 Investigation decisions must be administratively and judicially reviewable.

1.5 Investigation files must be provided to complainants under Freedom on Information legislation, subject to lawful exemptions. To facilitate this, section 194 of the IBAC Act should be removed.

1.6 Legislative time limits need to be set for finalisation of investigations and for the gathering of critical evidence (like CCTV footage) and interviewing witnesses.

1.7 The provision of immediate access to the independent body, of police held CCTV footage;

1.8 The maintenance of an electronic database of police complaints and outcomes that is accessible and searchable by an independent body, that includes relevant demographic information about the complainant such as race/ethnicity/aboriginality and which has clear guidelines on how and what information should be recorded. Customer service complaints should also be recorded on this database. Records of complaint histories should be mandatorily reviewed by independent investigators at the commencement of each investigations so that pervasive breaches of conduct by individual officers are acted upon through appropriate disciplinary procedures.[7]

1.9 Complainants should be informed before the independent body refers a complaint to Victoria Police for investigation (which, as we argue above, should only be where the independent body considers the complaint relates to customer service).

1.10 The public should have adequate access to information about police complaint, investigation processes and review rights. This requires:

- Provision of material/information in multiple languages;
- Creation of a Complainants' Charter;
- Referral to appropriate support agencies;
- Regional offices;
- A dedicated outreach team;
- Assisting complainants to make a proper statement, and allowing support people/lawyers to be present;

1.11 The independent body should assess whether or not as a result of evidence obtained through the course of an investigation, criminal charges may be appropriate and if so, refer the matter promptly to the Office of Public Prosecutions for assessment (and /or decide to prosecute)(noting there is a one year time limit to bring charges for summary offences. Victims should be supported through this process.

1.12 Data on complaints against police, as well as disciplinary action, civil litigation and prosecutions against police should be regularly and publicly reported.

1.13 Adjudication of complaints and disciplinary proceedings should occur in public.

1.14 Specialist investigation teams should be made up of no more than 20% former police officers; any former police officers recruited should be from outside of Victoria.

1.15 Internal policies and selection /screening criteria for applicants should be developed to ensure a culture of independence is developed and recruited for and that investigative staff come from diverse backgrounds, which reflect the community.

1.16 All investigators should be trained in dealing with bereavement and trauma.

1.17 Police must be prohibited from commenting in the media about matters that are subject to investigation in a manner that pre-judges or prejudices the outcomes of the investigation.

7. 5% of sworn officers are the subjects of 20% of all police complaints, see:": Special report concerning police oversight (IBAC, 2015), p 14.

In relation to police contact death investigations, specifically:

1.18 Independent investigation of *all* police contact deaths.

1.19 Family violence deaths where the perpetrator was known to police and/or where the victim was known to police, should be subject to mandatory coronial investigation and inquest.

1.20 Deaths associated with police contact must be investigated for the Coroner by specialist, multi-disciplinary teams employed by an independent body which meets the human rights benchmarks required under Victorian and International law - whether or not that body is IBAC or the Coroner's Court (or another body).

1.21 To ensure the state meets its obligations to prevent violations of the right to life or the right to be free from cruel, inhuman or degrading treatment, where the Coroner finds there has a been a breach of human rights:

a). they must be statutorily empowered to make binding recommendations to prevent similar breaches in the future, that are required to be implemented by body at whom they are directed (such as Victoria Police);

b). the Coroner's Court /other independent body must be required to monitor and publicly report upon systemic issues arising from police contact death investigations.

1.22 The implementation of coronial recommendations should be monitored and publicly reported on and disseminated, including through the tabling of implementation reports before parliament, along with recommendations, to increase public transparency.

1.23 There must be mandatory notification to families of the implementation or non-implementation of coronial recommendations.

1.24 There must be mandatory notification to families of referrals by the Coroner's Court, to the Director of Public Prosecutions (DPP), where the Coroner has reason to believe that an indictable criminal offence has occurred.

1.25 There must be mandatory notification to families by the DPP of decisions to prosecute/not prosecute upon referral by the Coroner to the DPP and written reasons should be provided to families where there is a decision not to prosecute.

1.26 A decision not to prosecute by the DPP should be appealable, as it is in the UK.

1.27 Time limits should be imposed for police contact death investigations to ensure timeliness in investigation that meets the human rights requirement for promptness.

1.28 Specialist family liaison officers should be trained to support bereaved families with timely and relevant information before and throughout the death investigation and inquest process.

1.29 Police contact death investigation reports should be publicly available online, following the completion of investigation and inquest, with a search function as well as hyperlinks to other documents and reports and, where possible, links to videos, CCTV stills and graphics which form part of the report. [8]

1.30 Families must have timely and adequate access to Legal Aid at a level equivalent to that available to the Chief Commissioner of Police to ensure they can fully participate in the coronial investigative process and a dedicated funding stream should be made available at Victoria Legal Aid for this purpose. Victoria should also consider setting up a Victorian Coronial Inquest Unit within Legal Aid, similar to that established in NSW.

1.31 Police must be prohibited from commenting in the media about matters that are subject to, or will be subject to coronial investigation and are or will be before the Coroners Court in a manner that pre-judges or prejudices the outcomes of the investigation and inquest.

1.32 All investigators should be trained in dealing with bereavement and trauma.

8. As done by the IPCC, see: *Review of the IPCC's work in Investigating Deaths* (IPCC, March 2014), p 80 available at: https://www.ipcc.gov.uk/sites/default/files/Documents/deaths_review/Review_of_the_IPCCs_work_in_investigating_deaths_2014.pdf

2. How complaints are currently investigated in Victoria

There are three ways you can submit a complaint against police in Victoria: at a police station, to the Police Conduct Unit, or to the Independent Broad-based Anti-corruption Commission, ("IBAC").

While, in theory, IBAC can investigate complaints against police, in practice, the overwhelming majority of complaints by the public are sent back to the police for investigation or "management".

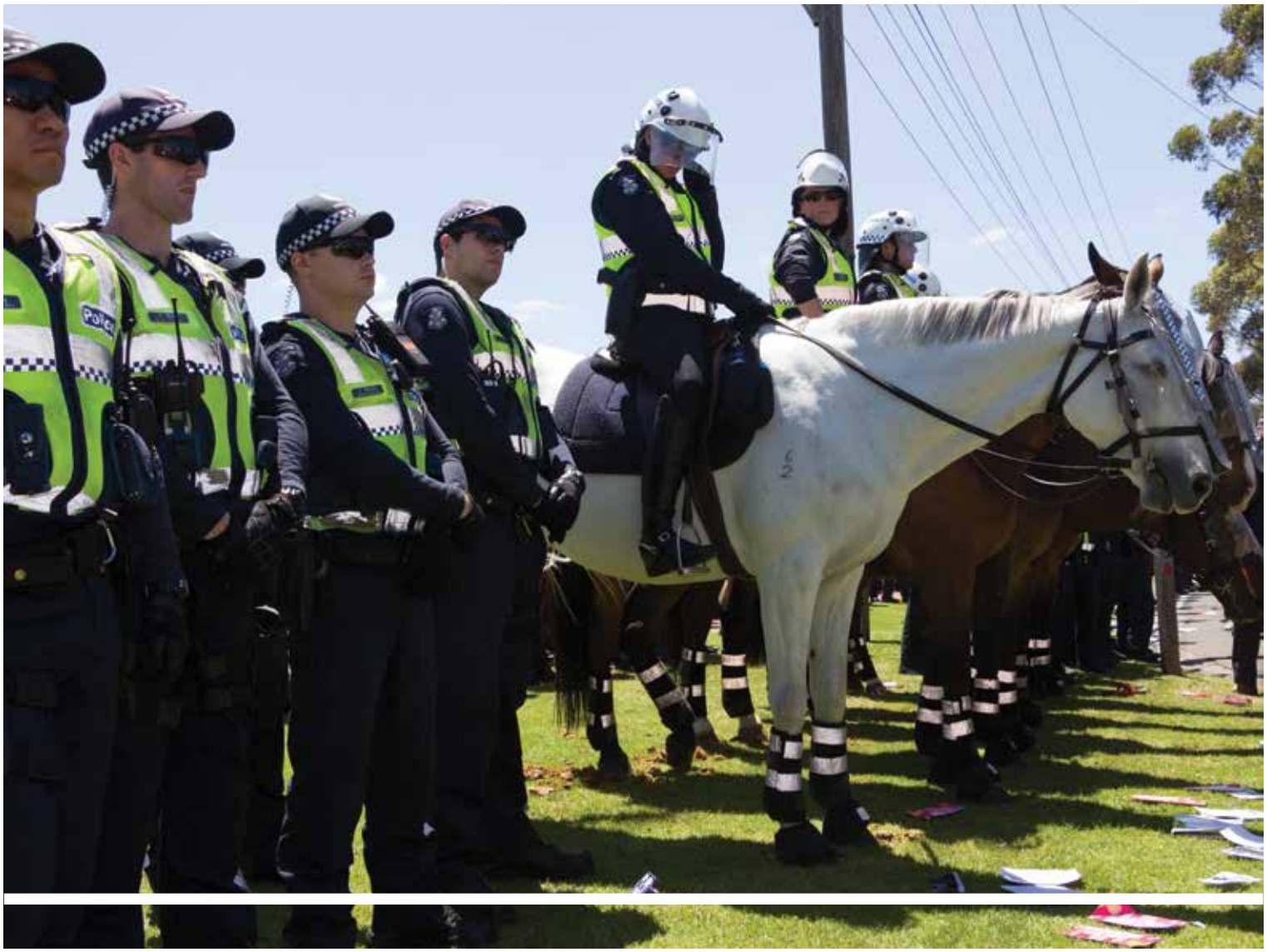
When a person dies in police custody in Victoria, although the death is subject to mandatory investigation and inquest by a Coroner, the investigation of that death and preparation of the evidence brief is in practice, carried out for the Coroner by a member of Victoria Police.

What this means for Victoria is that Police have to investigate their own colleagues when:

- there is a death in police custody; or
- there is a complaint of torture, degradation, abuse, ill-treatment, assault, racial abuse or excessive force in police custody.

Consequentially police investigate their colleagues for allegations of unlawful and/or criminal conduct, disciplinary breaches, human rights abuses and other misconduct.

For the overwhelming number of complaints concerning police, IBAC's role is limited to a complaint triage service and extremely limited desktop 'oversight' of an internal police investigation, even in serious cases of alleged police misconduct.



3. What's wrong with the current system?

In Australia police are rarely prosecuted or disciplined for the death, assault or ill-treatment of a member of the public[9]. This is not for lack of meritorious complaints. It is because the current system of accountability is not working.

3.1 Police consistently fail to find that meritorious complaints are substantiated

An analysis of police complaint substantiation rates indicates that there is something seriously wrong with our current system of handling complaints. From available data, less than 10% of all complaints to police are substantiated. Tellingly however, less than 4% of all assault complaints are substantiated.

	2000-2011[10]	2012[11]	2013[12]	2014-2015[13]	2015-2016
Assault allegations substantiated	3.6%	2.3%	3.8%	Data not reported	Data not reported
Total complaints substantiated	6.4%	7.2%	9.8%	9%	Data not reported

This is not for a lack of meritorious complaints. When courts are given the chance to assess allegations of police mistreatment, they consistently find those allegations have substance, despite being dismissed by the police complaint system.

This means that our criminal courts are currently more effective institutions in holding the police to account than police complaint investigations. The extraordinary and consistent differences in the results of criminal proceedings in criminal courts and police complaint investigations highlights the failure of the current complaint investigation system and the urgent need for reform.

Since 2006, clients of the Flemington Kensington Community Legal Centre have made 109 complaints[14] to the Office of Police Integrity, IBAC or Victoria Police about their experiences. All but three complaints made to independent bodies were referred to Victoria Police for investigation. Two of the three matters investigated independently of the police resulted in disciplinary recommendations and/or the initiation of criminal proceedings against police.

In all but 3 of the 103 complaints investigated by Victoria Police, Police investigators found in favour of the police, rather than the complainants' version of events. [15] The details of these three exceptions, where some, but not all, allegations were substantiated, are as follows:

9. See for example McCulloch & Palmer 2005 – Report to the Criminology Research Council, "Civil Litigation by citizens Against Australian Police between 1994 and 2002", Human Rights Watch 1998 "Shielded from Justice, Police Brutality and Accountability in the United States." British Columbia Civil Liberties Association Press Release dated 30/09/08 Deaths in Custody Investigation needs reform, "Torture in Chicago" 2008 Report by Peoples Law Office et al. Conversations with Imran Khan and Raju Bhatt in the UK 2008.
10. Peter Mickelburough, *Claims of Police Violence and Corruption on the Rise*, (9 July 2012, Herald Sun).
11. From FOI results released to the FKCLC by Victoria Police on 10 October 2014.
12. From FOI results released to the FKCLC by Victoria Police on 10 October 2014.
13. Audit of Victoria Police Complaints Handling Systems at Regional Level (IBAC, 2016). Per IBAC Audit of 354 files from 2014/2015 period (not a representative sample as not dispersed data – all from southwest metro region) http://www.ibac.vic.gov.au/docs/default-source/reports/summary-report-audit-of-victoria-police-complaints-handling-systems-at-regional-level.pdf, pages 6, 16.
14. Some complaints contain numerous allegations of misconduct, some complaints were made by a groups of individuals.
15. In one case the decision was partly reversed and substantiated after a court decision.

Case studies

A client made an allegation that they were placed in a freezing cold cell. In the investigation into the complaint, Victoria Police agreed that the cells were not heated but stated they were deemed suitable for custody at the time. They noted that they have since been decommissioned and substantiated this allegation. However, the more substantial part of the complaint, involving allegations of excessive force and racial profiling, were not substantiated.

Another client made an allegation of breaches to the Human Rights and Responsibilities Charter after their car was stopped twice within a period of approximately 30 minutes. A Victoria Police investigator substantiated their allegation that this was in breach of their Charter rights. Nonetheless, other significant allegations of trespass, intimidation and illegal stop and search of a motor vehicle, and an illegal search and seizure of items in the client's home, were not found to be substantiated.

A third client made an allegation that Victoria Police failed to submit a Use of Force form as required by Victoria Police policy. Victoria Police found this allegation substantiated. Notwithstanding this, the other more serious allegations in their complaint - use of excessive force and unlawful imprisonment, were not substantiated.

We consider that the extremely low substantiation rates by Victoria Police investigators (which our data suggests is less than 2%) is more likely to indicate a failure in the investigative process rather than every one of the complaints investigated by Victoria Police being without substance.[16]

In thirteen[17] criminal cases the Flemington Kensington Community Legal Centre has been involved in, judicial decision-makers contradicted the assessment made by the Victoria Police investigators. These judgements support the view that the present internal complaint system is not achieving justice.

These thirteen cases came before the criminal courts[18] because the FKCLC's clients had been charged by the police for conduct arising out of the same incident that our client complained about. Charges included assault, resist and hinder police in the execution of their duty or offensive language. The FKCLC's clients defended the charges. In four other cases, charges were dropped on the day of the hearing. It can be inferred from the decision to withdraw the charges that the Prosecutor believed it was likely that the court would dismiss the charges.

16. The inherent structural flaws in Victoria's complaint system was explored in Tamar Hopkins', 'When Police Complaints Mechanisms Fail, The use of civil litigation', (2011) Alternative Law Journal 36,101.

17. In two of the cases, the client defended the charge and also made the complaint prior to the Legal Centre's involvement. The Legal Centre acted in subsequent civil legal action against police which resolved with settlements. There are three other cases where the client declined to make a complaint due to fears that the investigation would adversely interfere with the criminal case but nevertheless successfully defended the charges.

18. These courts include Magistrates, Children's, County and Supreme Courts

Case study

A Somali youth made a complaint that a police officer had assaulted him by hitting him with a torch in the face causing his teeth to be damaged[5]. Three months after he had lodged his complaint about the police conduct, he was charged with hindering police in the execution of duty. His complaint against the police was found to be "unsubstantiated" by the police investigators. However, the Magistrate, listening to the all evidence, found that he had not hindered the police and that the police had acted unlawfully in touching him. Because the Magistrate was not hearing a charge against the police, the Magistrate did not conclude that the police officer had "assaulted" the youth. However, the obvious conclusion to draw from the Magistrate's finding was that the police officer had assaulted the youth. Any unlawful touching, including the striking of person in the face with a torch, is an assault. This conclusion of unlawfulness flatly contradicted the "unsubstantiated" assault finding by the police investigators. The youth went on to sue the police involved in assault, battery and false imprisonment. The claim settled confidentially before trial.

Case study

In 2014, a client intervened to assist a homeless person who they considered police were harassing. The client was handcuffed and taken to a nearby police station, where they were charged with offensive language and refusing to state name and address. The complaint they made to IBAC about excessive use of force and unlawful arrest was unsubstantiated after being referred to Victoria Police for investigation. The legal centre assisted the client to defend the charges and following a contested hearing in 2015, the Magistrate found the evidence of police was inadmissible because the police were acting unlawfully, having no legal basis for the arrest and that the police had breached the client's rights to privacy and freedom of movement. The charges were dismissed and costs were awarded against police.

Case study

An Eritrean taxi driver alleged that police had assaulted him. Police investigators accepted a police member's version of events that his hand had slipped to the neck of the driver who was seated in the driver's seat the taxi. The taxi driver had photos of injuries to his neck as a result of his allegation that the officer had tried to choke him. An image of the police officer's hand on the taxi driver's neck had been caught by the taxi's automatic camera system. In contrast, a Magistrate hearing the case took the view that the police officer had no right to be touching the taxi driver, let alone holding him around the neck. The logical implication is that the police assaulted the driver, although because the case was not against the police officer, the Magistrate did not directly say so. The decision of the police investigators failed to find any unlawfulness on the part of the officer.

Case study

A Magistrate found that an African youth could not be arrested for failing to give his name and address to a police officer because he was not under a legal obligation to provide his name and address to the police officer. The youth had alleged in his complaint that he had been unlawfully arrested and assaulted in the arrest.

The logical conclusion of the Magistrates decision was that he had been unlawfully arrested. In contrast, the police investigating the complaint found the complaint to be unsubstantiated. The Court's conclusion directly contracts the unsubstantiated finding.

Case study

In 2015, two African youth were stopped, questioned and capsicum sprayed by police when police mistakenly took one of them for a suspect. When they made a complaint to the local station about the police officers' conduct, including in relation to excessive use of force and racial profiling, they were charged with a range of offences. Ultimately, the offences were withdrawn, when police admitted in Court to having colluded in making their statements. The complaint was never followed up.

19. Elizabeth Porter, 'Somali youth to sue police over unprovoked attack' *The Age*, Melbourne, 21 October 2007.

Case study

A Magistrate found that the police trespassed when they searched a Sudanese boy's house in breach of their search warrant. The boy was charged with hindering police after running off to his room and locking the door after the room had been searched. The police broke down the door to his room and detained him. Amongst other things, he complained of assault, trespass and unlawful arrest. In contrast to the logical conclusion of the Magistrate, Police investigators found these aspects of his complaint unsubstantiated. Interestingly, the former Officer of Police Integrity, in monitoring the outcome of this court case, asked the police investigators to re-investigate the claim. As a result, these aspects of the complaint were subsequently substantiated.

In nine of the cases, where both complaints against police were made and police charges such as hinder, assault, obstruct or resist police followed the complaint, judicial officers reached conclusions that concurred with the complainant's view they had been assaulted and differed to findings of the police investigators into a complaint. Indeed, at this stage **all** contested hearings involving clients who made an official complaint have resulted in judgements that contradict the police complaint investigation.

Case Study

In 1993, Corinna Horvath was brutally assaulted by police who unlawfully broke down her door and trespassed into her property. While her police complaint resulted in no action being taking against police, a Magistrate dismissed the charges finding that the police had maliciously laid them against her and a County Court Judge subsequently found that she had been unlawfully assaulted following a civil claim. These independent fact finders determined the facts in ways that completely contradicted the police disciplinary process – leading the United Nations to conclude in 2014 that internal process of police investigating themselves was flawed. Today, the same internal mechanisms apply in the overwhelming majority of investigations and disciplinary processes.[20]

The fact that independent magistrates and judges are finding that police acted unlawfully in situations where the complaint investigation does not, raises questions about the effectiveness of the investigation and determination of complaints about police by police. It also underscores the importance of criminal courts as the primary means of redress against police misconduct; a role that is unfortunately undermined by the pressure on complainants to plead guilty and by cuts to legal aid and court funding for those seeking to defend charges.

The experience of the FKCLC in achieving these results is similar to other lawyers and CLCs who defend clients charged when they have or are intending to make a complaint about the police; such as Fitzroy Legal Service, Youthlaw and Robert Stary & Associates.

The success of the criminal courts in holding police to account for misconduct suggests ways in which police complaint systems may be improved. For example, it is clearly beneficial for evidence to be tested in open court and for decision makers to be independent.[21] In Washington DC, USA[22], complaints are determined by an independent (non-police) decision-maker often following a hearing and testing of evidence. Decisions are recorded in writing and are appealable. Interestingly, complaints in this system are frequently substantiated.

20. United Nations, Human Rights Committee, Horvath v Australia, 1885/2009, 24 April 2014.

21. Above n 1, 99.

22. Office of Police Complaints, <http://policecomplaints.dc.gov/node/164852>

3.2 Problems with the investigation process

Why do police investigations consistently fail to identify meritorious complaints? We believe it is because of a number of reasons to do with the internal nature of the investigative process.

Bias in the investigation

In internal police investigations evidence collection is subject to the biases, motivations and interests of the investigator.

For example, police investigators consistently:

Lack motivation to collect evidence from all witnesses or to gather available CCTV or other evidence in a timely manner;

> *In 2014, a legal centre client alleged he was assaulted by the police for failing to give his name and address. He had two independent witnesses to the assault. The police investigator failed to interview his two witnesses.*

View the complainant as criminal and motivated to lie;

> *In 2015, a complaint investigator told a lawyer at FKCLC that "After 25 years in the force, I am cynical about complainants."*

Seem entrenched in a culture that tolerates or accepts police abuses so tend to downplay or minimise unlawful conduct;

> *In 2014, a client alleged that the police slammed him face first on the ground breaking his front teeth causing bleeding and requiring dental surgery. Photos of him after the arrest show the broken teeth and swollen mouth. At least five police were present during the incident. Not one of the police statements about the incident describe that our client was forced to the ground or that he suffered serious injury.*

Interpret their job as picking holes in a complainant's story rather than picking holes in the police version of evidence;

> *In 2006, a police investigator, investigating a serious assault allegation, interrogated the three civilian witnesses. While interviewing them, the police investigation minimised the language they used (ie 'dragged' became 'escorted') and tried to get them to admit to criminal conduct. The same investigator accepted the notes made by the police in relation to the incident and statements made for the purposes of prosecuting the complainants without interviewing them.*

Tend to be uncritical of police accounts;

Actively assist the police to frame a defence to the complaint;[23]

> *In 2008 when interviewing a police officer who was alleged to have assaulted a complainant, the police investigator asked, "it looks like your hand slipped, is that right?"*

Use information obtained in complaint gathering to assist a prosecution of complainants;

> *In 2007 a complaint investigator provided a statement made by a witness to a complaint to a prosecutor who was prosecuting the complainant.*

Consistently fail to interview police, instead just accept a statement or notes from the officer;

Fail to question the police under criminal caution or for disciplinary purposes;

> *In 2011, a police officer stated in Court that he was not even aware a complaint had been made against him alleging serious assault. Through the civil claim, discovery of the police investigation revealed that none of the police officers had been questioned at all by police. investigators.*

23. See for example the investigation into the death of Adam Salter discussed in the Operation Calyx report, Police Integrity Commission, June 2013

Fail to understand the law/Charter/Victoria Police Manual requirements and instead apply police logic or police "common sense" and understandings about "the way things are done" to police conduct.

In 2015, a police investigator declined to investigate a complaint alleging that three mobile phones were taken in a police raid of a complainant's house when only one phone was listed on a warrant saying that no unlawfulness was apparent on the face of the complaint.

In 2016, a client was walking across a street with their skateboard under their arm. They saw a marked police car run a red light without their lights on. They yelled at the police car, then police did a U-turn and pulled up in front of our client. Police told our client to 'put their weapon down', referring to the skateboard. Our client dropped the skateboard behind them, away from the police. A Constable then allegedly pushed them and kept their hand on our client's chest. A Sergeant then allegedly got out of the police car and immediately sprayed our client's face with capsicum spray, unprovoked. Our client fell to the floor, convulsing and vomiting for 30 minutes. Our client's police complaints were sent to the Police Conduct Unit (PCU). Their complaint was unsubstantiated and there was no disciplinary outcome for the police. The allegations against police engaged section. 10 (protection from torture and cruel, inhuman or degrading treatment) of the Charter of Human Rights and Responsibilities Act.

Intimidate or urge complainants to drop their complaint;

In 2008, a police investigator approached a client on three occasions to get him to sign a "statement of no complaint" in relation to a complaint he made about being seriously assaulted during an arrest.

Complainants are locked out of the process

Complaints also fail because complainants are rarely given any opportunity to give feedback to an investigation before it is finalised.

Nor are complainants routinely given access to the investigation reports into their claim. Indeed, it is currently the case that copies of investigation reports where a complaint was initially made to or subsequently referred to IBAC, are now being regularly denied to complainants when they make FOI requests for them.[24]

If complainants *were* to be provided with access to the report before finalisation, they could correct false assumptions, provide further information, witnesses or ideas. (Indeed as these reports frequently make negative comment about complainants, procedural fairness suggests they ought to have the opportunity to comment.)

Lack of trust and confidence in the complaint process

We believe, based on numerous client interviews, that the numbers of formal complaints again police represents a very low proportion of actual incidents.

People who report police misconduct to community workers or solicitors frequently don't make or don't continue with a complaint because of their lack of trust in a police handling the matter.

Many lawyers themselves also distrust police investigating and commonly advise their *clients not to make complaints* to police investigators.

Even police members don't trust internal investigation and are less likely to whistle-blow, knowing that their complaint will be investigated by other police. Unfortunately much of this lack of trust has foundation.

This lack of trust in internal investigation is a major impediment to holding police to account for their wrong-doing[25].

24. This information is denied under reliance of section 194 of the IBAC Act, discussed further below.

25. For further detail, Hopkins T, "Effective System

3.3 Limitations of IBAC

We believe limitations of IBAC also contribute to the low substantiation rate of complaints in Victoria.

Regulatory capture

IBAC, (much like its predecessor, the Office of Police Integrity) is of the opinion that the vast majority of police misconduct complaints can be resolved at the station level.[26] This opinion may well have been forced on these bodies by a lack of resources, but it also underpins an attitude—that a person accused of serious professional misconduct can be investigated by their own colleagues—that is completely at odds with public opinion, international human rights standards and is indicative of regulatory capture.

Regulatory capture is the process by which the regulator fails in its role of holding the regulated body to legal standards because of inappropriate relationships:

> *Regulatory capture occurs 'when officials inappropriately identify with the interests of a client or industry'. For example, a liquor licensing inspector could, after years of contact with people in the industry, begin to favour the wishes of the industry rather than public interest. Alternatively, the inspector may be biased toward a single firm or company, motivated by a 'white knight' kind of sympathy. In such cases the regulator may fail to enforce because they believe the firm is struggling and the management team are 'nice folk' who ought to be protected.*[27]

A study by Tim Prenzler into the Queensland Criminal Justice Commission set up following the1989 Fitzgerald Inquiry into police and public sector corruption in Queensland, found evidence that the CJC was exposed to regulatory capture through its "role in facilitating police management, joint operations [with police] against organised crime and reliance on seconded police investigators."[28] He also found that the CJC had adopted an appeasement strategy towards the police and politicians. It is our contention that IBAC's acceptance that police should investigate themselves is an appeasement strategy rather than one that reflects public interests or international human rights standards[29].

The reality is that complaints alleging excessive force by police are routinely investigated by line managers within Victoria Police. If we are to ensure that police use force appropriately, excessive force complaints must be investigated independently of Victoria Police.

IBAC does not have an established process for resolving complaints and do not adhere to natural justice

In early 2015, IBAC admitted they have no real criteria for investigation of police complaints. The IBAC Act permits IBAC to investigate police in a wide range of circumstances including in situations where the alleged conduct could "bring the force into disrepute or where the officer could be dismissed." It is our contention that every time a police officer abuses his or her power, this brings the force into disrepute. Police carry and use lethal weapons. Any abuse of power raises serious doubt into a person's ongoing capacity to continue carry such weapons.

A further critical concern about IBAC is its attitude to complainants. IBAC consider that they are:

- Not a complaint resolution scheme;
- Are not required to be transparent to complainants;
- Are not required to explain the reasons for their decisions to complainants;
- Are not required to adhere to natural justice in their decision-making.

26. See for example, IBAC Annual report (205-2016), p 33, in which IBAC states "the majority of police complaints assessed by IBAC are considred appropriate for direct action by Victoria Police."
27. Gary Adams, Sharon Hayes, Stuart Weierter and John Boyd, Regulatory Capture: *Managing the Risk Australian Public Sector* Anti-Corruption Conference 24 October 2007 – Sydney, 1.
28. Prenzler T "Civilian Oversight of Police, A Test of Capture Theory," in *British Journal of Criminology* (2000) 40 at 659.
29. Hopkins T, The effective investigation of complaints against police, 2009 <http://www.communitylaw.org.au/flemingtonkensington/cb_pages/files/VLF%20REPORT%20-Effective%20Investigation.pdf>.

The Police Complaints Clinics run by the FKCLC and the Melbourne University Law School now have such little faith in the IBAC process that staff at those clinics no longer recommend that members of the public make complaints to IBAC, but instead make their complaints to the Police Conduct Unit. They do not make this recommendation because they think complaints are better investigated by the police. The reasons for the Clinic's recommendations are as follows:

1. Complaints made to IBAC will inevitability be referred to the police – even very serious assaults.
2. Complaints made to IBAC will cause significant delay in complaint investigation and resolution.
3. Complaints made to IBAC preclude complainants from accessing any information about the investigation of their complaint, even if that investigation ends up being conducted by Victoria Police, due to the operation of section 194 of the IBAC Act (discussed below).

Processes are not transparent to the public or complainants

The implication of section 194 of the IBAC Act is that any complaint investigation undertaken by Victoria Police following a referral from IBAC is not subject to the *Freedom of Information Act 1982* (the FOI Act). Section 194 provides that the FOI Act 'does not apply to any document that is in the possession of any person or body' if that document relates to (among other things), complaints, investigations, reports, or recommendations made or conducted under the IBAC Act.

This is, as IBAC itself states, a broad exclusion.[30] We believe it unreasonably removes a key avenue by which complainants can understand how their complaint was investigated.

We believe that IBAC should be subject to the FOI Act in the same way as other Victorian Government agencies. Part IV of the FOI Act already allows agencies to refuse freedom of information requests where to do so would be contrary to the broader good, including where releasing a document would prejudice law enforcement activities.[31] There is no need for a blanket exemption of the kind set out in section 194 of the IBAC Act.

30. IBAC, 'Statement 3 – Freedom of Information Arrangements' http://www.ibac.vic.gov.au/general/contact-us/freedom-of-information-requests/freedom-of-information-part-ii-statements/statement-3---freedom-of-information-arrangements
31. Section 31, FOI Act.
32. See further: *Independent Investigation of Complaints Against the Police: Policy Briefing Paper* (Flemington & Kensington Community Legal Centre, 2015), p 9.
33. *Police Accountability and Human Rights Clinic: First year Report 2015* (Flemington & Kensington Community Legal Centre, 2015), p 12.

In summary

When examined against the five principles of effective police oversight (see next section) it is our experience and observation that:

a). The IBAC is independent, institutionally and hierarchically, but practically, is connected with Victoria Police. In particular:

- IBAC suffers from regulatory capture.[32] This is evidenced by the fact that complaints alleging serious misconduct allegations like excessive use of force are routinely referred to Victoria Police for investigation.[33] It is also illustrated by the IBAC's position that it is appropriate to refer the majority of complaints it receives about police misconduct to Victoria Police for "direct action;"[34] despite international human rights law requiring independent investigations. (We acknowledge, however, that this practice is no doubt compounded by resourcing issues and also enabled by the IBAC Act, which allows for the referral of complaints from IBAC to Victoria Police when the subject matter of the complaint is relevant to Victoria Police's functions/ the exercise of its power *and IBAC considers* that it would be *more appropriate* for Victoria Police to investigate)[35]; and
- IBAC does not have a human rights and/or victim centred policy framework or culture. This is evidenced by the fact that it does not see itself as a complaint handling body and cannot adequately support complainants through the complaint/ investigation and or prosecuting process.

b). The IBAC does *not* gather evidence effectively in many matters and is therefore compromised in its ability to determine whether police conduct is unlawful and ought be punished;

c). The IBAC is *not* prompt in carrying out its investigative or oversight processes, which is exacerbated by communication delays between Victoria Police and IBAC. One client we assisted waited over 2 years for IBAC to review Victoria Police's determination of his complaint, which involved serious human right breaches;

d). The IBAC is *not* transparent. For example, complainants receive only minimal information on how complaint determinations have been made, IBAC decisions are not reviewable, and complainants to IBAC cannot obtain access to their investigation file because of the operation of section 194 of the IBAC Act, which restricts access to documents under the Freedom of Information Act that relate to a complaint made to IBAC or an investigation carried out by it.

e). The IBAC does *not* involve complainants sufficiently in the complaints process nor safeguard their interests. It is decidedly not victim-centred. Victims are not invited to respond to allegations made against them, nor adequately informed, consulted with, referred to services or supported through the complaint making process.

Although IBAC has completed some significant police oversight activities since its establishment, IBAC's fundamental focus has been on, and remains on high level corruption. This is evidenced by its allocation of resources and indeed, its name.

We also consider that many of the activities it has completed concerning police misconduct, including Operation Ross and the IBAC's *Audit of Victoria Police Complaints Handling Systems at Regional Level* have significant shortcomings that further underline the institutional issues outlined above.[56] We continue to hold serous reservations about IBAC's institutional culture and ability to properly investigate and tackle police misconduct.

34. IBAC Act, Section 73.

35. See attached papers: *Victorian police complaints investigations in the spotlight: IBAC recommendations fail the "Horvath test" (Flemington & Kensington Community Legal Centre, 2016), and How can we make human rights central to IBAC decision-making?* (Hopkins, 2016)

36. See attached papers: *Victorian police complaints investigations in the spotlight: IBAC recommendations fail the "Horvath test"* (Flemington & Kensington Community Legal Centre, 2016), and *How can we make human rights central to IBAC decision-making?* (Hopkins, 2016)

4. Getting the model right

Human rights standards and indeed, community expectations, demand that the investigation of human rights abuses and unlawful police behaviour is conducted by a body that meets the following five benchmarks:

1. Independent of the police

The investigating body must be not only institutionally independent of police but also practically, culturally and politically independent. This means that the use of former police officers should be minimal if at all[37]. The agency must be protected from the risks of agency capture through minimising collegiate working relationships with the police agency. It should be properly and securely funded, and protected from political and police union interference through separate enabling legislation and regulations as well as independent reporting to parliament. Its key positions must be long-term appointments.

On 2 April 2009 the United Nations Human Rights Committee observed that Australian police must be independently investigated where allegations of human rights abuses are made. In the 2014 decision in *Horvath* (1885/2009), a case involving the abuse of a Victorian woman by police, the UN stated at paragraph 8.4:

> In the present case, the disciplinary claims before the Police Department were dismissed for lack of evidence. In this respect, the Committee notes the author's allegations, uncontested by the State party, that neither author nor the other civilian witnesses were called to give evidence; that the author was refused access to the file; that there was no public hearing; and that once the civil proceeding finding was made, there was no opportunity to reopen or recommence disciplinary proceedings. In view of these shortcomings and *given the nature of the deciding body*, the Committee considers that the State party failed to show that the proceedings met the requirements of an effective remedy under article 2, paragraph 3 of the [International Covenant on Civil and Political Rights] [emphasis added].

The history of the reform of police complaint systems in England and Wales provides an instructive example of what results from police accountability organisations that are not truly independent. After each agency is created, a boom in complaints occurs as complainants' and their solicitors' hopes are raised that the new body will be effective. The hope is quickly dashed and complaints drop down to normal levels a short while later. Interestingly, substantiation rates also dropped after each body was created and these rates did not improve over time. A cause of complainant dissatisfaction was that each creation remained focussed on police concerns disregarding the interests of complainants.[38]

37. The Washington DC Office of Police Complaints currently employs no former police officers and yet is capable of conducting investigations. Only 25% of the investigating staff in the Northern Ireland Police Ombudsman's Office are former police officers and none of these officers previously worked in Northern Ireland.

38. Smith Graham 2005, A Most Enduring Problem; Police Complaints Reform in England and Wales, Jnl Soc. Pol. 35, 1, 121-141.

In 2008, The Guardian newspaper conducted an investigation into complaints lodged with the Independent Police Complaint Commission in the UK and found:

- A pattern of favouritism towards the police with some complaints being rejected in spite of apparently powerful evidence in their support;
- Cases of indifference and rudeness towards complainants;
- Extreme delays, with some complaints remaining unresolved after years of inaction and confusion[39]

Consequently it is incumbent on legislators to understand that the creation of "independent" investigation cannot be in name only. It must be functionally and practically independent. For instances the following are not solutions:

a). Employing current Victoria Police investigators in the new "independent" body[40];

b). Using seconded police in the independent agency;

c). Failing to address issues of cultural independence (i.e. an agency that while nominally independent is biased against complaints).[41]

Last year, the Victorian Government supported the recommendation of the 2015 Human Rights Charter Review, that IBAC, as an independent body, be given the capacity to investigate allegations of serious human rights abuses by police and protective services officers. This needs to happen as a matter of urgency. [42] However, it is our view that all complaints, other than customer service complaints, should be independently investigated, including complaints about police conduct that causes physical injury, or which breaches human rights.

This is because determining what constitutes a 'serious human right abuse' is a difficult exercise. For example, discriminatory treatment, arrest without lawful justification, conducting searches without lawful justification and treatment that leads to injury will often fall into this category, infringing upon Charter rights like freedom of movement, rights to privacy, and protection from torture and cruel, inhuman or degrading treatment. Because of this assessment challenge, an independent body should be adequately resourced to be capable of investigating all complaints excepting those relating to customer service.

CASE EXAMPLE

The Police Complaints Clinic assisted a woman with a complaint alleging repeated incidents of duty failure in the enforcement of an intervention order. These incidents included: Failure by the police to properly investigate an arson near the client's home; repeated failure to serve an intervention order on behalf of our client; and pressuring our client to not proceed with the intervention order when the client attended the police station to request that it be served. Despite the seriousness of the complaint, it was initially assessed by PSC and classified as C2-5 'Management Intervention Model' (MIM). Our office wrote to PSC to request reclassification of the incident to C3-2 'Misconduct on Duty'. We submitted that it warranted formal investigation under Victoria Police's *Discipline Investigation Guide* as it involved a 'lack of action regarding...breaches of intervention orders'. PSC decided not to change the classification.

39. Crisis at police watchdog as lawyers resign | Politics | The Guardian http://www.guardian.co.uk/politics/2008/feb/25/police.law1.

40. This was Chicago's "solution" when it created the Independent Police Review Authority. Its substantiation figures went down after the re-labelling effort. In contrast, in 2013, the Home Affairs Committee in the UK recommended that the Independent Police Complaint Commission of England and Wales cap former officers at no more than 20% of its investigative staff and improve in-house investigative capacities to restore public confidence in the institution.

41. Hopkins, The Effective Investigation of complaints against police, 2009, Chapter 3. <http://www.policeaccountability.org.au/wp-content/uploads/2014/03/VLF-REPORT-Effective-Investigation.pdf>42. From Commitment to Culture: The 2015 Review of the Charter of Human Rights and Responsibilities Act 2006, (Brett Young, 2015).

42. *From Commitment to Culture: The 2015 Review of the Charter of Human Rights and Responsibilities Act 2006*, (Brett Young, 2015).

Case Example:

Police in Victoria are wrongly identifying up to 375 women every month as perpetrators (Respondents) on Family Violence Intervention Orders (IOs),[43] which is a clear instance of duty failure (failure to protect). In one case, a perpetrator of family violence identified a woman lying unconscious in an ambulance as the aggressor: attending police standing next to the ambulance also identified her as the Respondent on the relevant IO.[44] At Women's Legal Service Victoria (WLSV), lawyers tend at the time of the initial hearing to seek a withdrawal from police, or advise their clients to cross-apply for an IO in which the perpetrator is correctly named as Respondent. WLSV lawyers have also occasionally made complaints to police stations where IOs or safety notices were issued, an approach which can succeed for individual affected family members. In general, however, women are reluctant to engage in police complaint processes that will ultimately be managed by Victoria Police. Although WLSV has made complaints to police stations on this issue, there remains no systemic redress of the issue from Victoria Police. WLSV is currently collecting evidence of instances where police have wrongfully named Affected Family Members as Respondents on IOs, through its duty lawyer and case work services, with a view to more formally engaging Victoria Police on this issue.

The naming of victims as primary aggressors is common across jurisdictions in Australia,[45] with police accountability processes largely unequal to addressing it. Compounded harmis caused to victims and their children when the victim is wrongly named as the perpetrator. For example, an IO naming the victim as the perpetrator is discoverable and can influence outcomes in other legal proceedings (including Family Law and Child Protection Matters). We urge an examination of emerging good practice in police accountability processes around this issue, locally as well as globally. The Men's Referral Service NSW, for example, seeks as a key objective to provide feedback and training guidance to NSW Police and the NSW Department of Justice on the wrongful assessment of men as victims by Police.[46] Victoria Police's Centre for Learning which provides ongoing development for officers may also have a role to play in building officers' skills in correctly identifying predominant aggressors. We consider investigation and oversight by an independent body would better facilitate the systematic redress of this issue.

43. Nathan de Guara, Policy Consultant, *No to Violence: Male Family Violence Prevention Association*, Interview, 21 August 2017.
44. Helen Matthews, Principal Legal Officer, *Women's Legal Service Victoria*, Interview, 21 August 2017.
45. A recent meeting of representatives of Women's Legal Services of Australia in Canberra (8 August 2017) shared strategies for dealing with this phenomenon, which attending lawyers noted as commonly occurring.
46. Jacqui Watt, "MRS NSW Victims Services Pilot – Final Report", 30 June 2016, pp.5-6. It also references UK research (UK Respect) that assessed the first 100 men calling their Men's Advice line identifying as victims. Through engagement, "a high proportion" of these men "were assessed to be the predominant aggressor within their relationships", p.6.

The PSC should continue to deal with customer service complaints and work with police managers at the regional level through its Management Intervention Model (MIM) to resolve customer service complaints. Victims should, however, be able to appeal to an independent body if they consider that their complaint has been inappropriately classified as a customer service complaint. For example, where a complaint about 'duty failure' has been classified as customer service complaint, despite it engaging human rights (this could encompass complaints concerning how police have responded to a victim of family violence, which may impact important Charter rights like the protection of families and children as illustrated in the case studies above).

'Active oversight' by an independent body of 'minor' human rights breaches or misconduct, cannot cure deficiencies in police investigations such as bias or failure to adequately obtain evidence. Once those deficiencies occur early in an investigation process, they undermine the integrity of the investigation going forward, reducing the ability to discipline officers or prosecute charges or to provide confidence to the complainant in the investigation outcome.

To ensure transparency and consistency, complaint classification categories including what constitutes 'customer service,' 'duty failure' and 'human rights infringements' and therefore which matters will be investigated by the PSC/Victoria Police and which by an independent body, should be set out in a publicly accessible and plain language policy document that is widely available online and in police stations.

To ensure more serious matters are not being classified as 'customer service' complaints, the independent body should also be mandated and adequately resourced to audit, annually, a sample of complaints PSC has classified as being customer service related to ensure they do not engage important human rights issues that warrant independent investigation. The need for this is demonstrated in IBAC's Audit Report, which reported 11% of audited files had complaint classification issues.[47] The Victorian Equal Opportunity and Human Rights Commission's August 2013 submission to Victoria Police's review of field contact reports and cross cultural training also found, "*complaints are not always appropriately classified. VEOHRC's view was that complaints about rudeness are routinely dealt with through the MIM process, including complaints about name calling which could occur on the basis of ethnicity, disability or other protected attributes and therefore should be treated as misconduct.*"[48]

2. Capable of conducting an adequate investigation

The investigating body must be capable of ascertaining whether the actions of the police breach legal or disciplinary standards and whether police practices are in compliance with human rights. The decision following investigation should be open to administrative review and subsequent to this judicial review.

3. Prompt

Police suspects and witnesses must be separated and interviewed immediately for both criminal and administrative purposes. Enforceable timelines for investigations are critical. Provision of documents by police agencies must be prioritised and investigators should use warrants to collect documents themselves where any delay occurs.

4. Open to public scrutiny

Data on complaints against police, as well as disciplinary action, civil litigation and prosecutions against police should be regularly and publicly reported. Investigation bodies should be subject to freedom of information law. Adjudication of complaints and disciplinary proceedings[49] should occur in public.

5. Victim-centred and enables the victim to fully participate in the investigation

Complainants need to be protected from victimisation after making a complaint and should be entitled to full and frank reasons for the decision on their complaint and be provided with the capacity to seek review of that decision. The investigating body should be accessible to all Victorians, with information provided in multiple languages. Outreach and support should be provided to ensure accessibility for vulnerable groups. Complainants must be permitted to provide evidence through an advocate.

47. IBAC's Audit report, p 20, 24.

48. Ibid.

49. QCAT decides police disciplinary processes in public in Queensland, see: http://www.qcat.qld.gov.au/matter-types/occupational-regulation-matters/prescribed-persons

These standards are mandated under International law.

In 2005, Graham Smith analysed police complaint and substantiation rate data in the UK over a 40-year period[50]. During this time four statutory reforms to complaint handling processes occurred. Each reform was precipitated in part by an inquiry or serious scandal in policing but also a build-up in dissatisfaction[51]. Noting the continued dissatisfaction of complainants and solicitors despite these reforms, Smith concludes that:

> *"the search for effective complaints systems is severely damaged by under representation of complainant's interests in the reform process and by those responsible for procedures."*

In order to devise a complaint system that will succeed where all others have failed, true reforms must take into account complainant concerns (which is in itself a human rights requirement) and *must* meet internationally defined human rights standards.

It is our position that all police oversight legislation and legislation that provides statutory examination of police contact deaths, should be reviewed against these benchmarks to ensure conformity with human rights conventions to which Australia is signatory.[52]

This would encompass the *Victoria Police Act 2013* (Vic), the *Coroners Act 2008* (Vic), the *Independent Broad-Based Anti-Corruption Commission Act 2011* (Vic), and *The Equal Opportunity Act 2010* (Vic).[53]

Currently, it is our view that the IBAC *does not* meet the five principles of effective police oversight established by the European Court of Human Rights. Rather, the IBAC falls *far short* of what is required for a police oversight body under international human rights law.

Police Ombudsman of Northern Ireland

The **Police Ombudsman for Northern Ireland** demonstrates that it is possible to design a police complaints body that meets the five principles listed above. Features of the Northern Ireland model include that:

- The Ombudsman is appointed by the Queen on a seven year fixed term and is accountable to parliament through the Minister for Justice;[54]
- It is staffed with specialist investigators who have power to secure incident scenes and seize documents and property. Police are obliged by law to provide information required in connection with an Ombudsman's investigation;[55]
- Following an investigation, the Ombudsman can recommend to the public prosecutor that an officer be prosecuted, or to the Chief Constable that an officer be disciplined.[56]
- The Ombudsman may refer a complaint to the police to handle, but only if it is 'less serious', and the complainant consents. Even then, the Ombudsman's office will check how the police have handled the complaint[57]
- The body is subject to Freedom of Information law[58] and has publicly committed to disclosure of information about the office's work.[59]

50. Graham Smith 2005, A Most Enduring Problem: Police Complaints Reform in England and Wales, Jnl Soc. Pol. 35, 1, 121-141.
51. Ibid at 136.
52. This includes the International Covenant on Civil and Political Rights (ICCPR) and the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.
53. Examples of legislative changes that we consider necessary include inserting racial profiling as a breach of discipline into section 125 of the Victoria Police Act 2013, with a reverse onus of proof; amending the Equal Opportunity Act 2010 (Vic) to explicitly define the term "service" in section 44 to clarify that Victoria Police provide services to all people including those they question, investigate, stop, or detain. This would ensure individuals or groups alleging racial profiling could bring disputes to the Victorian Equal Opportunity and Human Rights Commission or the Victorian Civil and Administrative Tribunal; and amending the Victoria Police Act to ensure police found to have committed a Police Tort under the Act are legislatively required to be disciplined and victims of serious police misconduct are provided with standing in disciplinary hearings.
54. https://www.policeombudsman.org/About-Us/Corporate-Governance
55. Office of the Police Ombudsman for Northern Ireland, The Police Complaints System in Northern Ireland, page 9. Accessed from: https://www.policeombudsman.org/getmedia/02508825-5b89-4148-9b3c-58b939261d65/The-Police-Complaints-System-in-Northern-Ireland.PDF
56. Dealing with complaints against police, p 9.
57. Police Ombudsman for Northern Ireland, Dealing with complaints against police, p 7. Accessed from: https://www.policeombudsman.org/PONI/files/e9/e9fd9c06-639f-43e7-a44c-050bf8426a5c.pdf
58. https://www.policeombudsman.org/About-Us/Access-to-Information/Requesting-Information-the-Freedom-of-Information
59. https://www.policeombudsman.org/About-Us/Access-to-Information/Policy-on-the-Public-Disclosure-of-Information

Office of Police Complaints - Washington DC

The Office of Police Complaints in Washington DC is another example of a complaint body that is independent and considers the needs of complainants:

- Complaints are made to the civilian Office of Police Complaints (OPC). The office conducts an investigation into the complaint.
- A legally trained complaint examiner will determine whether there is a factual dispute about what occurred and if there is, will hold a hearing into the complaint.
- The complainant is entitled to legal representation at the hearing.
- The examiner will make a written decision substantiating allegation or exonerating the officer. This decision is publically available on the OPC website (with names removed). The examiner will make recommendations to the Chief Commissioner about disciplinary action against the police. If the Chief Commissioner refuses to discipline the officers as recommended, a panel of three examiners will review the decision. The Chief Commissioner of Police is mandated to accept this further decision.[60]

Law Enforcement Review Agency – Manitoba, Canada

The Law Enforcement Review Agency (LERA) is required under legislation to:

- 'promote a high standard of professional conduct among police officers in Manitoba.
- guarantee each citizen in Manitoba the opportunity for an independent investigation and review of their complaints against on duty municipal police officers.
- provide a mechanism for the resolution of complaints in a manner that is fair both to the complainant and the respondent police officer(s).
- ensure that the conduct of police officers is consistent with the rule of law and the ideas of a democratic and open society.'[61]

LERA refers complaints for adjudication to a judge of the Queen's Bench for public hearing. The complainant is entitled to representation at the hearing. All decisions are appealable.

Other examples where police are investigated by a body independent of police include:

- Special Investigations Unit (Ontario, Canada)
- Civilian Complaint Review Board (New York)
- Independent Investigations Office of British Colombia (Canada)
- Independent Police Conduct Authority of New Zealand.

The Police disciplinary system

We note there are aspects to this system that warrant similar review and investigation which are beyond the scope of this Policy Briefing Paper. In particular, the current disciplinary system remains embedded within Victoria Police.

In our view, a disciplinary system and tribunal must also be separate from Victoria Police to ensure a robust police complaints system.

The victims' role in the disciplinary process also deserves greater scrutiny and is need of significant reform. For example, victims should be provided standing in disciplinary proceedings (as police officers subject to proceedings are), they should be able to cross-examine charged officers and be legally aided.

This is critical given it is the only method by which officers that repeatedly breach human rights and act contrary to law, can be dismissed. For many victims, this is a more important outcome than criminal sanction. An adequate, transparent, disciplinary system is also critical to ensure public trust in the police oversight system is restored and maintained.

Conclusion

Victoria has had a proud tradition leading improved human rights outcomes in Australia, and has the opportunity to embed into its police oversight system human rights principles that reflect the values legislated in the Charter. Critical to this, is a fully-fledged, independent body that is adequately resourced to investigate police misconduct, which has a strong culture of decision making based on human rights.

60. http://policecomplaints.dc.gov/page/complaint-examiner-decisions
61. https://www.gov.mb.ca/justice/lera/

5. Investigation of police related deaths

This section sets out global best practice, human rights compliant standards for investigating deaths that involve police.

It is our view that both the evidence of what works, coupled with Victoria's human right's obligations require a different model for how investigations of deaths which involve police, are carried out. Such a model must be practically and institutionally independent, effective and multi-disciplinary. It must also be timely and allow for sufficient and meaningful participation of victims/next of kin.

Right to Life obligations

In order to fulfil Victoria's obligations to protect the right to life under the *Victorian Charter of Human Rights and Responsibilities 2006 (Vic)* and international law, the State must ensure that investigations into deaths implicating police are carried out and that these investigations at a minimum, must be[62]:

1. Independent: Those carrying out the investigation must be independent from those implicated in the death; both institutionally and practically.

2. Effective: The investigation must be capable of leading to a determination of whether the action taken by State authorities was justified in the circumstances, to a determination of the culpability of those responsible for the death.

3. Prompt: The investigation must take place promptly and must proceed with reasonable expedition.

4. Transparent: The investigation must be open to public scrutiny to a degree sufficient to provide accountability in the circumstances of the case.

5. Inclusive of family/victim centred: The family of the deceased must be involved in the inquiry to the extent necessary to safeguard his or her legitimate interests.

We reiterate the importance of having these as central benchmarks in any new system adopted.

The current system: how police-contact deaths are currently investigated

The Victorian Coroner is currently required to investigate and hold an inquest into a limited range of 'police contact deaths.' Currently, this captures[63]:

- the death of a person *who immediately before death* was a person placed in 'custody or 'care' of: the Chief Commissioner of Police, the Secretary of the Department of Justice or a police or protective service officer;[64]
- the death of a person under the control, care or custody of the Secretary to the Department of Justice or a police officer;[65]
- the death of a person who a police officer or prison officer is attempting to take into custody or who is dying from injuries sustained when a police officer or prison officer attempted to take the person into custody (for example, a death during a police vehicle pursuit or resulting from the discharge of a police firearm);[66]
- a person in Victoria who is dying from an injury incurred while in the custody of the State (including the State's police);[67]
- The death of person held in detention /who died whilst a person authorised to take /hold that person in custody under Victorian or Commonwealth law attempted to take them into custody.[68]
- Circumstances where a member of the police force's conduct immediately preceding a death requires further investigation by the coroner under the Act.[69]

Deaths occasioned by the failure of police to discharge their duties where it is foreseeable that a failure of police to act could lead to a real and immediate risk of death caused by the actions of a third party, do not compel mandatory coronial investigation and inquest. This includes deaths of children and women who are killed by perpetrators of domestic violence by a third party whose previous criminal

62. Ibid. See also: Opinion of the Commissioner for Human Rights Concerning Independent and Effective Determination of Complaints Against Police, (Commissioner for Human Rights 2009), available at: https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806daa54.

63. There are some exceptions to this, including where a person has been charged with an indictable offence in relation to the death that would otherwise be subject to mandatory inquest.

64. See Section 4(2)(C) and 15 of the Coroners Act (Vic) 2008 and the definition of 'person place in custody or care' under s 3 of the Coroners Act.

65. Section 4(2)(e) and and 15 of the Coroners Act (Vic) 2008 and the definition of 'person place in custody or care' under s 3 of the Coroners Act

66. Section 4(2)(e) and and 15 of the Coroners Act (Vic) 2008 and the definition of 'person place in custody or care' under s 3(j) of the Coroners Act.

67. Section 4(2)(e) and and 15 of the Coroners Act (Vic) 2008 and the definition of 'person place in custody or care' under s 3(k) of the Coroners Act.

68. These are currently listed as a prescribed class of persons whose death the Coroner is required to investigate under the Coroners Regulations 2009 (see also section 4(2)(e) and and 15 of the Coroners Act (Vic) 2008 and the definition of 'person place in custody or care' under s 3(l)).

69. Coroners Court of Victoria, Practice Direction 4 of 2014, Police Contact Deaths, para 3(f).

conduct and ongoing risk to the person killed was known to police in circumstances where police have failed to discharge their duty of care and act in accordance with their training and instructions (for example under the *Victorian Police Code of Practice for the Investigation of Family Violence,* which acknowledges that "police have a duty of care to protect vulnerable persons from ongoing abuse."[70])

While there is some provision for coroners to investigate family violence deaths if the circumstances of the police force's conduct immediately preceding that death are deemed to require further investigation (under the Coroner's Court *Practice Direction 4*: *Police Contact Deaths*),[71] we consider that deaths that substantively involve police in this context of serious dereliction of duty,[72] leading to the death of a vulnerable person at risk of death by family violence, should be mandatorily investigated with inquest. The Coroners Act should be amended to reflect this.

In Victoria, the investigation of police contact deaths is in practice, typically carried out for the Coroner by a member of Victoria Police's Homicide Squad (for police shootings) or a member of the Major Collision Investigations Unit (for police pursuits). Police contact deaths can, however, be carried out by any member of Victoria Police nominated by the Chief Commissioner. The Coroner can also nominate any person to assist them in their investigation.[73] With oversight from Victoria Police's Ethical Standards Division (not IBAC), the investigating police officer prepares a brief of evidence for the Coroner and the matter proceeds to inquest. There is no requirement for the investigating police officer to be hierarchically separate from the officers who are witnesses to, and potentially, criminal suspects, in a police contact death. Nor is there a requirement that they be from a different police service area (see case study, below).

A first directions hearing is required to be held within 28 days of the police contact death being reported to the Coroner,[74] unless otherwise ordered. In practice, however, first directions hearings are often delayed and may take up to two months to be held. Even where directions hearings are held within 28 days, this elapse of time can mean critical directions regarding the timely securing of evidence and time critical lines of investigation are given too late.

Although the investigator is required to take any instructions from the Coroner directly and carry out the investigation under their direction,[75] the investigation is not independent or at arm's length from police.

In a police contact death inquest, separate to the assistance provided by the police investigator in the investigation, the Coroner can be assisted by an independent lawyer from outside of the Police Coronial Support Unit (the PCSU). In practice, independent counsel instructed by the Court's in house solicitors (or sometimes externally briefed commercial lawyers)[76] are almost always engaged. The independence of this role was embedded due to the conflict of interest in having a member of the PCSU (ie, a police lawyer) assist the Coroner at Court, in circumstances where the police's conduct associated with the death is likely to come under scrutiny (the PCSU is made up of police who are prosecutors or other experienced police advocates and who typically assist Coroners in other inquests).[77]

70. Code of Practice for the Investigation of Family Violence, Edition 3, Version 2, 2014, p 17.

71. Coroners Court of Victoria, Practice Direction 4 of 2014, Police Contact Deaths, para 3(f).

72. For example, where there has been substantive police involvement with the perpetrator/victim and there are serious questions about the adequacy of police conduct (for example, the failure of police to follow the Code of Practice for the Investigation of Family Violence).

73. Coroners Court of Victoria, Practice Direction 4 of 2014, Police Contact Deaths, para 4.

74. Ibid, para 13.

75. Ibid.

76. Where for example, the Court doesn't have resources/capacity to manage the complexity of the investigation.

77. See, Coroner's Court of Victoria Practice Handbook (State of Victoria, 2011), p 41.

This practice of ensuring that the counsel who assists the Coroner, inter alia, with 'discovering, assembling, presenting and testing evidence at the inquest,' including examining evidence and witnesses in order to ascertain the identity, cause and circumstances of the death, comes from *outside the PSCU* **is in stark contrast and is at odds with, the practice of appointing a Victorian Police officer to carry out the investigation and prepare the brief of evidence**, which fails to provide for any institutional independence. A real conflict of interest exists for investigating police officers, who stand between the competing pressures of avoiding scandal/poor press that impacts political and public trust in the police organisation they are employed sworn members of, versus uncovering and preventing misconduct that may have contributed to a civilian's death. Community distrust in the investigation carried out by the Victorian police member assigned to investigate the death frequently arises, diminishing the credibility of the investigation in the eyes of the community. This also impacts police: where inquests find officers have used lethal force lawfully and exonerate officers, community concern about conflicts of interest can cast doubt over the credibility of coronial inquests and findings.

Following an inquest, the Coroner makes findings into the cause of death, and the circumstances in which the death occurred. As part of its preventative function, a Coroner may also elect to make comments on public health and safety and the administration of justice.[79] They can also make non-binding recommendations.[80] However, there is no power to compel the organisation at whom recommendations are directed at, to take action in relation to the recommendations and frequently families are not notified of the organisation's response or action in relation to recommendations, unless they actively seek out the information.

Case study: Inquest into the death of Michael Atakelt

Michael Atakelt was a young Ethiopian- Australian man whose body was found in the Maribyrnong River on 7 July 2011. Michael's community had serious concerns about the investigation into Michael's disappearance and death, including: the Footscray police's response to Michael's mother's multiple attempts to lodge a missing person's report to raise concerns about her son's safety; the failure of police to notify Michael's family that Michael had been in police custody days before his disappearance; and the dismissal of foul play as a potential cause of death (which the Coroner, ultimately determined could not be ruled out). Despite these concerns about local police (further compounded by the community's lived experience of discriminatory policing practices over many years in the Footscray/Maribyrnong area), the police officer initially assigned to investigate Michael's death on behalf of the Coroner was from the Footscray police region. Significant shortcomings in the initial investigation, ultimately recognised in the Coronial findings into Michael's death, (including the failure to treat Michael's death as 'suspicious' and decision to exclude key lines of inquiry); only compounded the community's distrust of the investigation arising from the appointment of an investigator who was not institutionally independent from police. In this instance, it was clear an independent investigator not associated with police was required. Instead, the investigation was carried by a police investigator from the very police region that Michael's community thought had been implicated in his death and who had failed to adequately investigate his disappearance.[81]

78. Ibid.

79. Section 67, Coroners Act 2008 (Vic).

80. Section 72, Coroners Act 2008 (Vic).

81. For more information, see *Coronial Findings into Death of Michael Atakelt: A death we need to learn from* http://www.policeaccountability.org.au/racial-profiling/a-death-we-neeed-to-learn-from/ and *Coronial Findings into the Death of Michael Atakelt (amended)*, available at: http://www.policeaccountability.org.au/wp-content/uploads/2014/09/michaelatakelt_247911_amended.pdf.

How do current Victorian investigations into police contact deaths measure up to human rights benchmarks?

This section examines how the current investigation process for police contact death investigations (set out above), holds up against human rights benchmarks.

Independence

The human rights requirement for independence in police contact death investigations is supported by the Coronial function in Victoria. The preamble to the *Coroners Act 2008* (Vic) states:

> *'The coronial system of Victoria plays an important role in Victorian society. That role 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.'*

Indeed, the Coronial system's important function of independence in death investigations *is* a hallmark of the vast majority of coronial investigations carried out by police officers on behalf of the Coroner. For example, it exists where police investigate a death in a mental health facility, on behalf of the Coroner, or where the police investigate a suspicious death by fire, on behalf of the Coroner. But the vast majority of coronial investigations carried out by the Coroner do not cast question over police officer(s) conduct. Unfortunately, when the deceased subject of a coronial investigation *does* implicate police in the taking of life, and potentially criminal behaviour, the practice of engaging a police officer to carry out the investigation on the Coroner's behalf still continues. **This practice fundamentally undermines a key objective of the Coronial system and also breaches Victoria's obligation under human rights law to provide for an institutionally independent investigation where the State is involved in taking life.**[82]

A 2014 United Nations Committee against Torture report which examined police violence, deaths in custody and racism in the US summarised the obligation as follows:

> *"All instances of police brutality and excessive use of force by law enforcement officers (should be) investigated promptly, effectively and impartially by an independent mechanism with no institutional or hierarchical connection between the investigators and the alleged perpetrators."*[83]

Neither Victoria's current model, nor a model that gives IBAC 'oversight' or audit powers in relation to police contact death investigations, meet the requirement for independent investigations of police contact deaths. Rather, this is a civilian 'review' model, which cannot compensate for effective and independent civilian *investigation*. First, because it is often not possible to cure deficiencies in an investigation once it has been carried out (eg, key evidence may no longer be able to be obtained). Second, because it is very difficult to restore trust and confidence in a community that holds concerns about a police led investigation into a death caused by a police officer, through a civilian review model. Civilians must lead and carry out, the actual investigation. Police investigations, even when supervised by an independent body, have been held to be insufficient for the purposes of safeguarding investigative independence.[84]

Civilian review /oversight models of police conduct (as opposed to civilian investigative models) have a long history in the United States. Australian Academic, Tim Prenzler's research into these bodies concludes that they have undermined truly independent civilian accountability efforts. Yet such models have persisted since (and despite) the US Commission on Civil Rights' 1981 report *who is Guarding the Guardians? A Report on Police Practices,* which concluded that "while encountering some successes, (review) boards largely failed. Their basic flaw was that they were advisory only, having no power to decide cases or impose punishment."[85]

82. Ramsahai v The Netherlands (Application no. 52391/99), Judgment 15 May 2007; Bati v Turkey (Application nos. 33097/96 and 57834/00), Judgment 3 June 2004; Horvath v Australia – United Nations Human Rights Committee Communication No. 1885/2009, paragraph 10.
83. United Nations Committee Against Torture, *Concluding Observations on the Third to Fifth Periodic Reports of United States of America* (20 November 2014), p 13, available at: https://www.state.gov/documents/organization/234772.pdf.
84. Investigations of Deaths Associated with Police Contact: calling for an independent and effective investigation body FCLC, HRLC, FKCLC, DCLC, 2010), para 19, discussing *Ramsahai v The Netherlands* [2007].
85. Quoted in Prenzler, Tim "Scandal Inquiry and Reform: The evolving locus of responsibility for police integrity", in Civilian Oversight of Police (Den Heyer; Prenzler 2016), p 11.

Victoria must heed this lesson. We need to move away from review or 'oversight' bodies and toward robust, independent and effective bodies that are human rights compliant. As Prenzler notes, "the fallout from this failed reform process [in the US] is high levels of ongoing violence and corruption in US policing and a particular problem with toxic police departments that continually resist accountability agendas."[86]

In addition to institutional independence, which can be safeguarded by adequate legal frameworks (for example, by locating sole jurisdiction to investigate police contact death investigations in a body like IBAC or within an independent team at the Coroner's Court), practical independence must also be embedded by any Victoria institution that is given jurisdiction to investigate police contact deaths.[87] This is a distinct but critical issue, and requires the cultivation of a culture of independence through careful recruitment, appropriate training, the development of cultural and procedural policies and proper financing and resourcing of the institution. For practical independence to be realised, the overriding culture and decision making of an institutionally independent body's staff (including civilian investigators) cannot be dominated by police logic/deference to "common sense" policing.

Reflecting on the experience of the Independent Police Conduct Authority of New Zealand (see case study below), which is institutionally separate from New Zealand Police but which utilises multi-disciplinary teams to carry out police contact death investigations that includes some ex-police investigators from largely overseas jurisdictions (that report to non-police managers), Chair of IPCA, Judge Sir David Carruthers notes:

> *We hammer home the issue of independence every day in what we do. We have deliberately created a culture where we challenge each other all the time at every level. These are never personal or ad hominem challenges but on the issues. No one is exempt from them and at every stage of our investigations and public reports we have series of meetings involving all layers of management where we debate the issues and the conclusions. It is important to create this culture. It is really important also to hire the right people.*[88]

The Honourable Michael H. Tulloch, judge of the Court of Appeal for Ontario, tabled an independent review of the Special Investigations Unit in Ontario (SIU) in 2017.[89] The SIU employs a mix of investigators from former policing backgrounds other non-policing backgrounds, to carry out police contact death investigations. The SIU is also, institutionally independent from Ontario's police. In responding to the question of whether or not ex-police officers should be employed at all by the SIU, his views is that what is needed is the incorporation of "anti-bias measures into hiring, training, education and evaluating investigators;"[90] but that ex-police officers should not be ruled out, noting that "after all, someone who has never worked as a police officer could still be strongly biased in favour of the police, and thus make a poor civilian oversight investigator."[91] However, he nevertheless recommends that oversight bodies should recruit more high quality investigators from non- policing backgrounds as a critical part of being seen to be independent and to obtain the "benefits that come with diversifying investigation teams"; [92] which should "better reflect the diversity of the communities they serve."[93]

86. Ibid.
87. Savage, Stephen, 'Independent Minded: The Role and Status of "Independence" In the Investigation of Police Complaints,' in *Civilian Oversight of Police* (Den Heyer; Prenzler 2016), p 46
88. Correspondence with Chair of the Independent Police Conduct Authority of New Zealand, Judge Sir David Carruthers, 1 May 2017.
89. *Report of the Independent Police Oversight Review*, (Tulloch, 2017) , available at: https://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/police_oversight_review/
90. Ibid, Executive Summary, paragraph 21.
91. Above n 29, paragraph 20.
92. Ibid, para 22
93. Ibid

While some overseas jurisdictions have legislatively prescribed that police misconduct commissioners cannot be former police officers,[94] a high percentage of investigators within even these commission bodies still come from policing backgrounds. Unsurprisingly, these models report reduced public confidence,[95] including in the UK, where the high percentage of police investigators within the Independent Police Complaint Commission of England and Wales (IPCC) led the Home Affairs Committee (HAC) to report ion 2013 that the IPCC was a "second home for police officers" and public confidence needed to be restored in the IPCC by rectifying the impression that police were investigating the police. As a result, the HAC recommended that the IPCC improve its in-house investigative capabilities and cap former police officers at no more than 20% of its investigative staff "so that the number of former officers investigating the police is significantly reduced."[96] In recommending this, the HAC stated:

> *We appreciate that former officers bring investigative skills and can improve the effectiveness of the Commission. It is natural that an organisation whose principal role is to investigate the police should recruit former officers, both for their investigative skills and their familiarity with police practices and procedures, but it must make every effort to cultivate its own investigative capabilities and to avoid becoming too dependent on former police officers to fill these roles.*[97]

As a result, the IPCC has implemented a trainee investigator scheme, to train investigators from non-police backgrounds.[98]

Northern Ireland's Police Ombudsman (PONI), recognising the need for independence in its investigative staff, run sophisticated, training programs for its staff through the University of Portsmouth (see case study below). Police conduct death investigators at PONI work in mixed background teams (approximately 25% herald from PONI's Trainee programs, 20% are former police officers and 55% come from other legal enforcement/criminal enforcement roles).[99]

Victoria needs to cultivate investigative capacities within an independent body, as the PONI has done, and the IPCC is doing, to meet its human rights obligations. To achieve this, multi-disciplinary teams embedded within an institutionally independent police complaints body should be carefully considered as a reform option for Victoria (or within the Coroner's Court's Coroners Prevention Unit - which currently undertakes only secondary and tertiary analysis - they are not primary investigators) or within IBAC.[100] Initially, former officers from outside Victoria could be utilised to build expertise.[101] Numbers should be capped, however, at 20% of investigative staff. Civilians with relevant investigative background in other areas (lawyers, work safe investigators, fraud investigators etc) could also be recruited and trainee programs developed for university graduates. Partnerships could be built with universities to develop training programs to build in-house expertise, as PONI has done. In addition, internal policies and selection /screening criteria for applicants should be developed to ensure a culture of independence is developed and recruited for and that investigative staff come from diverse backgrounds, which reflect the community.

An independent multi-disciplinary team model embedded within the Coroner's Court or IBAC[102] (or other independent body) would help cultivate practical independence in death investigations, alongside institutional independence. A bank of contractors with relevant expertise could be utilised by investigative teams, for example, critical incident mental health specialists, medical experts and scientists.

The independent model was discussed in the Final Report by the Victorian Parliament's Law Reform Committee on the Coroners Act 1985. Specifically, the Committee stated that it there was a "vital need" for a Coroner to be able to

94. For example, see the Independent Complaints Commission of England and Wales.

95. Savage, Stephen, 'Independent Minded: The Role and Status of "Independence" In the Investigation of Police Complaints,' in *Civilian Oversight of Police* (Den Heyer; Prenzler 2016), p 36-37.

96. See, Home Affairs Committee - Eleventh Report: Independent Police Complaints Commission, (HC, 494 January 2013), recommendation 78, available at: https://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/49411.htm

97. Ibid, para 75.

98. Review of the IPCC's work in Investigating Deaths (IPCC, March 2014), pages 9 and 23.

99. Author's Correspondence with Paula Gillespie, Senior HR Officer, Office of the Police Ombudsman for Northern Ireland, 24 February 2017.

100. Currently, there are four investigation teams within the Coroner's Prevention Unit, including the Unintentional Death Investigation Team, the Intentional Death Investigation Team, the Health and Medical Investigation Team and the Operational Team. See: Coroner's Court of Victoria Practice Handbook, p 16

101. The new Law Enforcement Conduct Commission in NSW, has adopted a policy of not employing serving or former members of the NSW Police force or NSW Crime Commission See: https://www.lecc.nsw.gov.au/what-we-do/our-people (accessed 10 August 2017)

102. We note however, our ongoing concerns about IBAC and that our current position is that IBAC does not currently meet the requirements for independent investigations. IBAC requires significant legislative, resourcing, structural and institutional changes before jurisdiction for police contact death investigations can be located with it.

appoint an independent person to lead the investigations on the Coroner's behalf in police-related deaths "to ensure that an independent investigation takes place. It is equally important that the families of persons who have died have confidence in the investigation process. This can only be achieved by the Coroner's Office being and being seen to be independent of the police."[103]

Effectiveness

The ability of Victoria to meet its procedural obligation to adequately and effectively investigate potential breaches of the right to life in police contact death investigations in the current coronial system is also severely compromised.

The European Court of Human Rights decision, *Jordan v the UK*,[104] sets out the following requirements of an adequate and effective investigation:

- The persons responsible for carrying out the investigation must be independent from those implicated in the events; hierarchically, institutionally and practically;
- The investigation must be capable of leading to a determination of whether lethal force used was justified or not, in the circumstances;
- The investigation must be capable of leading to the identification and punishment of those responsible for unlawful use of lethal force;
- Reasonable steps must be taken, which are available to the authorities to secure the evidence concerning the incident, "including *inter alia* eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death;" and
- The investigation must take place with promptness and reasonable expedition, which is "essential in maintaining public confidence in [state authorities] adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts."

In *Jordan,* the ECHR went on to state that "any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard."[105]

When comparing current coronial practice in death investigations in Victoria against the above criteria, shortcomings that impede in the full realisation of the requirement for effectiveness include:

- **The persons responsible for carrying out the investigation must be independent from those implicated in the events; hierarchically, institutionally and practically;** *As discussed above, although the Coroner's Court carries out the inquest into a police contact death, it is a member of Victoria police that carries out the investigation on the Coroner's behalf. There is no institutional or practical independence. Inquests are not mandatory in family violence deaths were the perpetrator and/or or victim were known to police.*
- **The investigation must be capable of leading to a determination of whether lethal force used was justified or not, in the circumstances;** *In a police contact death investigation, the coroner is required to, if possible, identify the deceased and determine the cause of death. They are also required to determine the circumstances in which the death occurred. Although coroners may comment on any matter connected with the death, (including matters relating to public health and safety or the administration of justice), cost and time issues and the lack of funded representation for families means that this is routinely restricted as a field of inquiry. This in turn can reduce the adequacy of the inquiry into police conduct. Additionally, the statutorily imposed obligations on coroners do not require a finding be made into the lawfulness of any use of force used against a civilian who had died in police custody. Conversely, the Coroner's Act mandates that "[a] coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence."[106] This means that a coronial investigation is not always capable of leading to a determination of whether or not lethal force used was justified or not.*

103. Victorian Parliament Law Reform Committee, Coroners Act 1985: Final Report, 2006, Parliamentary Paper 229 of Session 2003-06, page 210, Recommendation 43, available at: https://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/final_report.pdf

104. *Jordan v United Kingdom* (2001) 37 EHRR 52 [At 104-109]('Jordan v UK'); See also, *Investigations of Deaths Associated with Police Contact: Complying with the Charter of Human Rights and Responsibilities Act 2006*, Submission to the Office of Police Integrity, (Human Rights Law Resource Centre, 18 June 2010), page 8

105. *Jordan v UK* [At 107].

106. *Coroners Act 2008* (Vic), s 69(1).

The investigation must be capable of leading to the identification and punishment of those responsible for unlawful use of lethal force; *The Coroner cannot make binding recommendations. Although The Director of Public Prosecutions is legislatively required to be notified where the Coroner believes an indictable offence (like murder) has been committed; there is no public scrutiny of the referral process to the DPP, and no ability to seek review of a DPP's decision to prosecute or not.*[107] *A coronial inquest is not, therefore, capable of leading to the punishment of a police officer that is reasonably believed to have used unlawful deadly force.*

Reasonable steps must be taken, which are available to the authorities to secure the evidence concerning the incident, "including *inter alia* eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death." *The lack of practical and institutional independence in the investigation can tarnish the investigation process itself. Examples of this include the failure to immediately separate members who are involved in, or witness to, a police contact death.*[108]

The investigation must take place with promptness and reasonable expedition, which is "essential in maintaining public confidence [State authorities] adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts." *In Victoria, inquest processes frequently take years. For example, a police contact death inquest into the deaths of two people following the police pursuit of a mentally ill man (FKCLC acted in on behalf of the family of the pursued man), took over three and a half years from the date of death for the coroner's findings to be delivered. The hearing itself, did not commence until 20 months after the collision.*[109]

"there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case. In all cases, however, the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests" *See below, further on transparency.*

In addition to the requirements set out in *Jordan v UK,* where the State is found to have committed human rights violations, including violations of the right to life through its police agencies, the state is obligated to implement non-repetition measures, to prevent similar violations from occurring in the future.[110] The Coroner's Court could play an important role in ensuring this human rights obligation is met by the State. Indeed, one of its key functions, set out in the preamble to the *Coroner's Act*, is to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of death and fires.[111]

As discussed above, however, the Coroner's preventative function is severely compromised by the absence of statutory mechanisms compelling the implementation of recommendations by receiving organisations like Victoria Police or ensuring oversight and monitoring of how recommendations are being implemented, when the receiving agency agrees to implement them.

An investigations team within the Coroners Prevention Unit (or other independent body like IBAC) set up to investigate police contact deaths should therefore be legislatively required to monitor systemic issues arising from police contact death investigations, and publicly report on the implementation of recommendations, which should be required to be implemented.[112] This would strengthen the prevention role of the Coroner's Court (tied to non-repetition requirement).

107. In Jordan v UK, the inability of the family of an unarmed man shot dead by police to obtain reasons for failure to prosecute by the DPP, was held to be a breach of the right to life in circumstances were there was no ability to seek judicial review of the public prosecutor's decision [at 122-124], see also paragraphs [80-86].

108. See for example, Findings into Death with Inquest, Court ref 2012 0265, pages 165-169, which relates to the failure to separate two members who pursued a Victorian man in a police pursuit leading to two deaths (the two members were allowed to return to the police station together immediately after the collision, unaccompanied in the same car).

109. For more information, see: http://www.policeaccountability.org.au/deaths-in-custody/media-release-police-pursuit-of-mentally-ill-man-should-have-ceased-before-pursuit-entered-off-ramp-onto-freeway-against-oncoming-traffic-coroner-finds/ ; see also Findings into Death with Inquest, Court ref 2012 0265

110. *Horvath v Australia – United Nations Human Rights Committee Communication* No. 1885/2009

111. Section 1(c) of the Coroners Court Act (Vic) 2008.

112. In a similar preventative function role that the Victorian Systemic Review of Family Violence Deaths (VSRFVD) was established with in 2009. See further: http://www.coronerscourt.vic.gov.au/home/coronial+investigation+process/family+violence+investigations/

Prompt

As noted above, police contact death investigations carried out by police, on behalf of a coroner, are not required to be completed within a set time. Delays in investigating the killing of civilians by state authorities can breach the procedural component of the right to life.[113] Victoria should consider a statutorily imposed investigation timeline, of say, 3 months. With public reporting on progress required every 60 days should this timeline not be met.[114]

Transparent

Transparency of police contact death investigations should be greatly enhanced, insuring bereaved families of victims who are interested parties are given timely information in their language, and support to participate in the investigation and inquest processes and to be able to effectively scrutinise, and at times, challenge, investigation processes and outcomes where there may be legal or process shortcomings.

Inclusive of family/Victim centred

Currently there is no dedicated funding stream to provide families with legal representation at police contact death inquests, so funding is ad-hoc and subject to the stringent means and income tests applied by Victoria Legal Aid in all its matters. Unlike the NSW Legal Aid Coronial Inquest Unit, that utilises a mix of in-house solicitor advocates and in-house and external counsel to represent families on grants of legal aid, VLA has little to no equivalent capacity to undertake representation or facilitate grants of legal aid for systemic police contact death inquest work. This also means corporate history, memory and knowledge which can help achieve systemic changes to systemic issues, is not built up. Frequently, families rely upon pro bono support or receive no support at all. With inquests running at times for months, or years, pro bono support is extremely difficult or impossible to secure.

Police involved in police contact deaths are provided with representation; so ought be the families of those who have died through the exercise of police powers.[115]

Provision of grants of legal aid to families who are interested parties in police contact death inquests, are needed to ensure equality of representation before the Coroner and to assist families to participate effectively in the investigation process. Decisions under the ECHR have made clear that the right to life encompasses the right to representation where the State has taken life.[116]

Beyond the issue of human rights compliance and ensuring equality in representation, the funding of families aids the investigative process: Families often identify lines of inquiry that might not otherwise be identified and help to test evidence, often leading to more robust findings. This has been recognised by the IPCC in England and Wales, which has committed to actively involving families in the development of terms of reference in death investigations and sharing investigation plans.[117]

More recently, in response to the recommendations of a review of the Ontario Special Investigations Unit, the Ontarian Government has implemented a policy that will provide families with funding to have their interests legally represented at a police contact death inquest.[118] In the UK, legal changes are currently being advocated for that would see bereaved interested persons provided with publicly funded legal assistance and representation at inquests and public inquires into death or serious injuries implicating public authorities, in proportion to resources provided to the public authority.[119] This is of critical importance given the public interest in examining police contact deaths.

113. Jordan v UK.

114. This has been recommended in the Report of *the Independent Police Oversight Review*, (Tulloch, 2017) https://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/police_oversight_review/ see paragraph 46.

115. Some useful case law relevant to legal aid and inquests: R (Khan) v Sec of State for Health [2003] EWCA CIV 1129 [2004] 1 WLR 971
R (Challender) v Legal Services Commissioner [2004] EWHC 925 (admin)
R (Humberstone) v Legal Services Commissioner (the Lord Chancellor Intervening) [2011] 1 WLR 1460 see also Jordan Edwards and Wright in photos attached.

116. In the UK, the obligation to ensure proper family participation has been interpreted to mean that the family must be provided with legal representation where it is likely to be necessary to ensure an effective investigation, see: *R (on the application of Amin (Imtiaz) v Secretary of State for the Home Department* [2003] UKHL 51; R *(Khan) v Health Secretary* [2003] EWCA Civ 1129; *Main (R) v Minister for Legal Aid* [2007] EWHC 742.

117. *Review of the IPCC's work in Investigating Deaths* (IPCC, March 2014), p 12, available at: https://www.ipcc.gov.uk/sites/default/files/Documents/deaths_review/Review_of_the_IPCCs_work_in_investigating_deaths_2014.pdf.

118. *Report of the Independent Police Oversight Review* (Tulloch, 2017) , Recommendation 6.17. (Family is defined as spouse, parent, child, brother, sister or personal representative of the deceased); see further: *Ontario Expanding Support for Families at Inquests*, 14 July 2017, available at: https://news.ontario.ca/mcscs/en/2017/07/ontario-expanding-support-for-families-at-inquests.html.

119. See the proposed Hillsborough law, at: http://www.thehillsboroughlaw.com/.

Families must have timely and adequate access to Legal Aid at a level equivalent to that available to the Chief Commissioner of Police to ensure they can fully participate in the coronial investigative process and a dedicated funding stream should be made available at Victoria Legal Aid for this purpose.

A system for Victoria that meets human rights benchmarks

The serious shortcomings set out above can be addressed through an adequately resourced independent body responsible for police contact death investigations. It is clear from the human rights benchmarks above, that mere oversight and audit of police led investigations, will not meet Victoria's obligations and should not be adopted as a model. Barriers exist to civilian investigation models, but these can be overcome. These are discussed below.[120]

Victoria should seize the opportunity to learn from the models around the world that are working toward meeting human rights benchmarks in the investigation of police contact deaths.

These models include PONI, the Norwegian Bureau for the Investigation of Police Affairs (see case study, below), the Special Investigations Unit of Ontario (see case study, below) the Independent Police Conduct Authority of New Zealand (see case study, below).

None of these models, we would argue, discharge human rights benchmarks completely. Some rely too heavily on former police investigators, which impact upon both the independence and public confidence in the institution. Others need to be more inclusive of families and ensure they are legally aided to ensure effective representation in investigative processes and inquests.

Of all the models, the PONI model is *the* most independent and comes closest to meeting the human rights benchmarks articulated in this briefing paper. Additionally, it has received consistently high levels of confidence from both police and civilians; it should therefore, be carefully reviewed, including its training programs for staff.

Case study: The Norwegian Bureau for the Investigation of Police Affairs

The Norwegian Bureau for the Investigation of Police Affairs was established in 2005. It is an independent investigative and prosecution body established outside the Norwegian police service and public prosecuting body and is mandated to investigate allegations of criminal conduct committed by the police in the course of duty.[121] To meet Norway's positive obligations under the ECHR's right to life, the Bureau is additionally required to immediately initiate investigations in all cases "where a person is killed or seriously injured as a result of actions carried out by the police in the performance of duty" including cases where a person dies in police custody, even if there is no grounds to suspect a criminal act.[122] Unlike the PONI model, the Bureau employs a majority of former police officers to carry out its police contact investigations. While this model meets the need for institutional independence, we do not consider this model meets the requirement for practical independence. Additionally, the Bureau has reflected that although it has four regional offices and a hotline to enable responses/deployment to critical incidents outside of office hours, there is "no standby arrangement for rapid response." This invariably means in the initial stages of a police contact death investigations, the Bureau relies upon local police to comply with directives prescribed by the Bureau, such as separating police witnesses, securing firearms and other evidence. [123] The Bureau examines officers involved in a police contact death, where their conduct involves an assessment of criminal liability, as a suspect.[124] This is to be contrasted with how officers involved in a coronial inquest into a police contact death in Victoria, are examined.

120. see also *Investigations of Deaths Associated with Police Contact: calling for an independent and effective investigation body* FCLC, HRLC, FKCLC, DCLC, 2010), which addresses additional, oft cited barriers, at paragraphs 25-50

121. http://www.spesialenheten.no/English/Mainpage.aspx . Allegations of misconduct that do not amount to criminality (unless it involves conduct leading to death or serious injury of a civilian), are, however, typically referred back to police for investigation, see: http://www.spesialenheten.no/English/Information/Reportingoffences.aspx

122. The Norwegian Bureau for the Investigation of Police Affairs Annual Report, p 8 and 34-35, available at: http://www.spesialenheten.no/Portals/0/%C3%85rsrapporter/SP_annual%20report_2015.pdf

123. Ibid, p 9.

124. The Norwegian Bureau for the Investigation of Police Affairs Annual Report, p 8 and 34-35, available at: http://www.spesialenheten.no/Portals/0/%C3%85rsrapporter/SP_annual%20report_2015.pdf

Case study: The Special Investigations Unit, Ontario

The Special investigations unit in Ontario (SIU), Canada, is an independent civilian law enforcement agency which conducts investigations of incidents involving all municipal, regional and provincial police officers across Ontario that have resulted in death, serious injury, or allegations of sexual assault. Established in 1990 under Police Services Act,[125] its stated mission is to nurture public confidence in policing by ensuring that police conduct is subject to rigorous and independent investigations.[126]

The SIU is made up of roughly 85 staff members. Under the Police Services Act, the Director of the SIU is empowered to conduct investigations into the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by police officers. [127] The Director also has power to lay criminal charges against police officers where warranted on the basis of the evidence gathered during an investigation.[128]

A person who is a police officer or former police officer cannot appointed as director of the SIU.[129] Current police officers cannot be appointed as investigators, or seconded to the SIU.[130] However, investigators come from a mix of former policing backgrounds and non-policing backgrounds such as national security and intelligence, immigration, the legal profession, workplace health and safety, and professional regulation.[131] Regionally located investigators are stationed across the province for quick deployment to secure evidence and scenes.

All investigators are mandated to carry out investigations in a credible, fair and balanced manner.[132] In the investigation of an incident, the SIU is the lead investigator and is given priority over any police force in the investigation.[133]

Case study: The Independent Police Conduct Authority of New Zealand

The Independent Police Conduct Authority of New Zealand ('Authority) independently investigates all police contact deaths. While it is not statutorily required to, it does in practice.[134] Deaths caused by police are assigned a 'category 1' status, along with complaints concerning serious bodily harm.[135] Investigations into deaths caused by police are carried out by investigators from policing backgrounds from outside of New Zealand.[136] Other investigators have training in other investigative backgrounds, such as child sexual abuse allegations in government departments. Not one investigator is allowed to take responsibility for the investigation into a police contact death. The Authority has "adopted a "team" approach and each of such events is addressed by an investigator, a legally trained report writer, sometimes an analyst or other expert and is overseen by a non police legally qualified Manager who in turn reports to the general manager (an ex Law Professor) with all public reports into police contact deaths signed off by a the Chair of the Authority, who is a judge.[137] The Authority also inspects and monitors the conditions of police detention and treatment of those in police custody to meet obligations under the Optional Protocol to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) (which Australia has indicated it will ratify in 2017; it is already signatory to the CAT). In this capacity, it can recommend measures be implemented to improve conditions of police detention and treatment of people in police custody, an important preventative function against torture, cruel and inhuman or degrading treatment. Reports of police contact death investigations are published publicly, on the Authority's website. Investigators are trained in –house and also attend police investigations training sessions.

125. Police Services Act R.S.O. 1990, c. P.15, s. 113 (1).
126. https://www.siu.on.ca/en/unit.php.
127. Police Services Act, R.S.O. 1990, c. P.15, s. 113 (5).
128. ibid, R.S.O. 1990, c. P.15, s. 113 (7).
129. Ibid, R.S.O. 1990, c. P.15, s. 113 (3).
130. Police Services Act, R.S.O. 1990, c. P.15, s. 113 (3), see also https://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/police_oversight_review/#_idParaDest-46, at 6.100.5.
131. https://www.siu.on.ca/en/org_chart.php.
132. https://www.siu.on.ca/en/investigator.php.
133. Ontario Regulation 267/10, s. 5.
134. Email correspondence with the Independent Police Conduct Authority of New Zealand Authority's Chair, Judge Sir David Carruthers, April 2017. See also section 17 of the IPCA Act, which provides that when the Authority receives a complaint it can investigate the complaint itself; refer it to the Police for investigation under the Authority's oversight (which may include direction of the Police investigation, proactive oversight, or review/audit upon completion of the Police investigation); defer action; or take no action." The action taken regarding a complaint depends upon the seriousness of the allegations; category one being most serious and typically will be investigated by the IPCA (death/serious injury). (Source: IPCA Annual Report, 2015-2016, p 7 and 59-62).
135. IPCA Annual Report, 2015-2016, p 7 and 59-62.
136. Email correspondence with Sir Judge David Carruthers, above n 97.
137. Ibid.

6. Why the NSW Law Enforcement Conduct Commission is no model for Victoria.

In New South Wales, the new Law Enforcement Conduct Commission (LECC) commenced operations in 2017. Established under the Law Enforcement Conduct Commission Act 2016 (NSW), the LECC is a civilian agency with both investigative and oversight functions in relation to misconduct within NSW police and the NSW Crime Commission. LECC is the sole body responsible for *detecting and investigating* serious misconduct *and overseeing* complaints handling by NSW Police, replacing the Police Integrity Commission (PIC), the Police Division of the Office of the Ombudsman and the Inspector of the Crime Commission in an attempt to simplify law enforcement oversight.

However, there is serious contention about whether the structural changes introduced in NSW will ensure a more effective complaints system, or merely represent an "expensive rebadging of the existing Police Integrity Commission fused with the Ombudsman".[138] It is unequivocally clear that the limitations on the LECC's investigative powers (which, in particular, preclude it form investigating critical incidents, which include police contact deaths and will also preclude it from investigating other human rights breaches such as racial profiling and police assaults that are unlikely to constitute an offence punishable by a term of imprisonment of less than 5 years) means the LECC falls short of the human rights benchmarks required for independent investigations.

No investigative powers in relation to police contact deaths

While the LECC will have stronger oversight capacity in some functions than the Ombudsman had, including enhanced monitoring capacity in relation to the police investigation process, and real-time access to information concerning critical incidents,[139] oversight cannot remedy the requirement and need for independent investigation of police contact deaths. NSW has adopted a model that embeds an outdated system in which the most serious "critical incidents" and those that result in loss of life will continue to be self-investigated by police, missing an important opportunity to have human rights benchmarks inform and enshrined in, the enabling legislation.

Preclusion of public interest investigations hinders opportunities to ensure human rights breaches are not repeated

Unlike the previous powers of the Ombudsman, the new model does not give the LECC the ability to conduct "public interest" investigations. This means that broader systemic investigations into issues with far-reaching implications for the community, such as systemic issues arising in police contact deaths, will not be possible under the new LECC model.[140] The New South Wales Council of Civil Liberties has noted concern that this preclusion of public interest investigation, together with the limitation on offences that may be investigated and other restrictions on the Commission's investigative functions will "undermine its capacity to be a driver for significant reform of day to day police culture in relation to the investigation of complaints and critical incidents." [141]

Enshrining a system in which police retain investigative power over 'critical incidents' including police contact deaths fails to guarantee independence from police and falls foul of human rights benchmarks for victim-centeredness, transparency and public scrutiny. We urge against this being a template for necessary Victorian reform.

138. http://www.smh.com.au/nsw/new-police-watchdog-will-be-old-watchdog-rebadged-says-pic-commissioner-20160304-gnb2dz.html.

139. All complaints are required to be registered on the NSWPF complaints system, with details of the allegation and the outcome of any inquiries. The Law Enforcement Conduct Commission is able to access the NSWPF complaints information system, see: https://www.lecc.nsw.gov.au/reporting-serious-misconduct/guidance-on-reporting-serious-misconduct-and-serious-maladministration/faqs.

140. An example of a systemic report undertaken by the Ombudsman was the Ombudsman's landmark 2012 report on Taser use by NSW Police.

141. New South Wales Civil Liberties Council 'Oversight of NSW Police - reform or rebadging?' February 6, 2017 http://www.nswccl.org.au/law_enforcement_conduct_commission (see though, s 10(1) of the Act).

7. Overcoming the perceived barriers to independent investigations

There a number of reasons that have been offered over many years as reasons for not independently investigating police.

1. Expense. An independent investigative body is too expensive;
2. Civilians can't investigate police, it takes police officers with the technical skills and expertise to investigate;
3. Independent investigation of police complaints takes resources away from corruption investigations;
4. You need a rapid response team, only the police are resourced to respond rapidly to the "golden hours";
5. The police will shut down and refuse to co-operate with civilian investigators; you need police so that they can develop the relationships needed;
6. The Police Association will be unsupportive;
7. The police need to retain responsibility for integrity management.

It is vital that policy makers understand that each of these purported barriers have been overcome in other jurisdictions and that many are based upon myths or inaccurate understandings. We will go through each in turn.

7.1 Expense

A thorough and adequate investigation of police complaints is a time consuming and resource intensive job. However someone has to be resourced to do it. An effective, independent complaint system that has systemic impact on improving policing practices, should see large reductions in complaints and litigation against police over time, providing costs benefits the justice system. Northern Ireland (Police Ombudsman of Northern Ireland) and the New York Civilian Complaint Review Board are two examples of independent civilian bodies that investigate complaints against police.

Using figures obtained from the Annual Reports of each organisation we can observe the following:

Region	Police expenses	Independent investigation annual expenditure	Cost of independent investigation as % of cost of police	Total population of region	Expenditure per capita
Northern Ireland	725 million pounds in 2015-16[142]	£8,557, 000 in 2016/17[143]	1.18%	1.87 million (2017)	£4.57 ($6.8 Aus dollar) spent on independent investigation per person £387.7 spent on police per person ($631 A$)
New York's Civilian Complaint Review Board	$5.2 billion in 2016[144]	$15, 076, 755 in 2016[145]	0.03%	8.5 million (2016)	$1.8 spent on independent investigation per person $612 spent on police per person
Victoria, Australia	2,607.8 million dollars 2015-2016[146]	No independent investigation of the overwhelming majority of police complaints 2015/2016 Annual Report reveals IBAC annual expenses at $31.9 million.[147] Unknown how much of IBAC's resources are on police investigations	Unknown how much of IBAC's resources are on police investigations given the majority of police complaints are referred back to Victoria Police to investigate	6.1 million (2016)	Unknown how much is spent on independent investigation per person. $427.50 spent on police per person.

From these figures, we can see that in Northern Ireland independent investigation costs 1.18% of the total budget for police.

In New York, independent investigation is 0.03% of the total budget for the police. In Victoria, then, if we took a figure somewhere in between these two figures, we would expect to need to pay $16 million a year for independent investigations. (0.7% of the total police budget.) This is a very modest price to pay for the size of the police force in Victoria and the importance of the issue. Furthermore, Victoria Police currently pay for internal investigation. The money spent on police internal investigation could be re-directed back into the overall police budget.

142. https://www.psni.police.uk/globalassets/inside-the-psni/our-departments/finance-and-support-services/documents/AnnualStatementofaccounts15-16.

143. Police Ombudsman for Northern Ireland, Annual Report to March 2017: https://policeombudsman.org/PONI/files/59/59a07a61-6d31-4190-b639-6d4333ca7dd0.pdf p 34.

144. https://council.nyc.gov/budget/wp-content/uploads/sites/54/2016/06/nypd.pdf, page 1.

145. https://www1.nyc.gov/site/ccrb/about/frequently-asked-questions-faq.page.

146. Victoria Police Annual Report, 2016-2016, Table 1.4, p 11.

147 IBAC Annual Report 2015-2016, p 8, http://www.ibac.vic.gov.au/docs/default-source/reports/ibac-annual-report-2015-16.pdf.

7.2 Only police can investigate police

There are clear examples from other parts of the world of resourced civilian agencies that investigate complaints involving police.

The Police Ombudsman of Northern Ireland, a fully civilian agency, investigates all complaints against police. [148] Civilian agencies such as the Independent Police Complaints Commission in the UK and the Special Investigations Unit in Ontario, investigate deaths in police custody while others such as the Office of Police Complaints in Washington DC and the Law Enforcement Review Agency in Manitoba, Canada investigate non-lethal complaints. Non-police investigators can include Worksafe investigators, Centrelink investigators, lawyers, former judges etc. In Ireland and Ontario investigators attend a few units at a police academy on investigations, however, they quickly develop expertise in these investigations give that is all they do. Indeed, very quickly, civilian investigators become far more expert at investigating police than police.[149]

In British Columbia, Canada, in June 2010, a police chief argued for increasing the mandate of civilian investigations bodies:

> *"Vancouver Police Chief Jim Chu says a planned new civilian-led provincial unit should cover all complaints against police and not just in-custody deaths and serious incidents as proposed by the B.C. government. Few incidents meet this threshold, Mr. Chu told a news conference Wednesday, suggesting only an average of four incidents in Vancouver meet this standard each year.*
>
> *"By allowing the civilian investigators to investigate a broader range of incidents, they would develop more experience and expertise," he said.*

He noted that broadening the role of the new unit would also save money for BC municipal police forces, which are spending more on professional standards units.

Giving an example, Mr. Chu said that since the introduction of a new police act this March, professional standards investigations for his own force have risen 46 per cent or $803,000 on an annual basis.

> *"Extending the mandate of the [new unit] would not only improve public confidence in the investigation of allegations against police officers but allow every police agency to concentrate more resources on investigating crime," he said.[150]"*

Civilians can and do investigate police contact deaths

Resistance to civilian lead investigations into police contact deaths often rests on the premise that only police are equipped and adequately skilled to carry out effective homicide investigations. However, the reality is that police were civilians once too. Civilians can be trained to investigate deaths, whether they are trained within the police or through practical, external, independent courses (as they are in Northern Ireland).

In fact, we consider that the investigation of deaths where police may be implicated in that death, is a specialist area which should require specialist training. Currently, this is not provided for in Victoria: There is no specialist training unit within Victoria Police to train police in conducting police contact death investigations; rather, the investigative responsibility for such deaths is randomly assigned to police members according to the Victoria Police Manual Police Rules and Guidelines (which is the only formal guidance provided to assigned members).

Victoria could look to models overseas, like the PONI, or to related jurisdictions in Australia, including Work Safe Victoria and The Australian Safety and Transport Bureau for how training programs can be developed for civilians investigating deaths, including in investigations where criminal culpability may be in question. These models evidence the fact that deaths do not need to be investigated exclusively by police and are, both in Australia and overseas, effectively investigated by civilian bodies.

148. Hopkins, Tamar 2009, *An Effective system for investigating complaints against the police*, Flemington & Kensington Community Legal Centre.

149. Specialist bodies such as the PONI and SIU become experts in these investigations.

150. http://www.theglobeandmail.com/news/national/british-columbia/vancouver-police-chief-calls-for-greater-powers-for-complaints-unit/article1746253/.

Case study: The Police Ombudsman for Northern Ireland – PONI's investigative staff (recruitment baselines for all investigative staff)

PONI require its civilian investigative staff to have 'a degree level qualification and a minimum of 2 years experience of managing criminal or other legal enforcement investigations at all stages in the past eight years or four years experience managing criminal or other legal enforcement investigations at all stages in the last eight years.'[157] *Civilians recruited into investigation roles at PONI that meet these selection criteria typically come from other criminal investigation bodies, such as fraud investigators, civil investigative backgrounds, such as revenue and customs investigators or social security fraud investigative agencies, or have been trained through PONI's Trainee programs.*[158] *All recruits undertake and complete an Accredited Investigation Course, run by Portsmouth University specifically for PONI staff; which takes up to two years to complete. Modules include: social psychology and the behavioural context of policing, civilian oversight and responsibility, critical incident management, gathering evidence, statement taking and report writing, conducting serious and high profile investigations and presenting and giving evidence. Portsmouth University also provides other bespoke training courses in different areas, for example, advanced interviewing techniques for witnesses and suspects and interview advisor courses (advisors create and document a specific interview strategy when dealing with particularly complex or serious cases).*[159] *The accreditation process is ratified by a joint training and standards board made up of representatives from the Independent Police Complaints Commission (England and Wales), Police Independent Review Commission (Scotland), Garda Siochana Ombudsman Commission (Republic of Ireland) and [the PONI.]"*[160] *To ensure the training for civilian staff is current, and of best practice standards, PONI also work with the Forensic Service of Northern Ireland, the Police Service of Northern Ireland and police force training bodies in the UK. This ensures it is "abreast of changes in practice, policy, legislation and technology."*[161] *Some staff, including its current Director of Current Investigations, Brian Doherty, herald from legal backgrounds (a former barrister), and after recruitment train through the University of Portsmouth's bespoke investigation courses.*[162]

PONI's investigative staff (additional recruitment baselines for death investigation staff)

Investigators in PONI's Historical Directorate, which deals with complaints alleging murder or attempted murder during the period known as the 'Troubles', typically have experience investigating serious crimes, including homicide. Staff in this directorate cannot have previously worked for the Royal Ulster Constabulary or any associated bodies involved in the death, which is a right the life requirement under the European Convention on Human Rights.[163] *As a result, PONI typically recruit ex police officers from other police departments in the UK into investigative roles in this directorate.*

Investigators in the Current Directorate who investigate current complaints about police across a broad spectrum of alleged misconduct, also investigate deaths of civilians by police. In investigating deaths, the requirement of independence is also enshrined through a policy which requires that 'all investigators or those directing or managing investigations are fit to carry out those investigations and present no conflict of interest in terms of independence by virtue of previous working experience or connections to the matter through [a] Conflict of Interest Policy.'[164] *Investigators in this Directorate work in mixed background teams (approximately 25% from PONI's Trainee programs, 20% former police officers and 55% from other legal enforcement/criminal enforcement roles).*[165]

Whilst initially following its establishment in 2000, some investigation officers were seconded to PONI from other police forces in the UK to bring expertise from their experience in their specific force, PONI has now 'built up a resilience of talent and staff' and only has one seconded officer.[166]

151. Correspondence with Paula Gillespie, Senior HR Officer, Office of the Police Ombudsman for Northern Ireland, February 2017.
152. Correspondence with Paula Gillespie, Senior HR Officer, Office of the Police Ombudsman for Northern Ireland, February 2017.
153. Correspondence with Karen Ritchie, Learning and Development Officer, Office of the Police Ombudsman for Northern Ireland, March 2017.
154. Correspondence with Karen Ritchie, Learning and Development Officer, Office of the Police Ombudsman for Northern Ireland, March 2017.
155. Correspondence with Karen Ritchie, Learning and Development Officer, Office of the Police Ombudsman for Northern Ireland, March 2017.
156. See course descriptions available at: http://www.port.ac.uk/courses/law-and-criminology/bsc-hons-policing-and-investigation/ and http://www.port.ac.uk/courses/law-and-criminology/msc-crime-science-investigation-and-intelligence/ . Brian Doherty's profile is available at: https://policeombudsman.org/About-Us/Staff-Profiles/Director-of-Investigations-(Current).
157. Article 2 Policy: Investigation of State Related Deaths by the Office of the Police Ombudsman (PONI, 2017), available at: https://policeombudsman.org/PONI/files/e5/e55c7f1c-6458-4d54-b9d9-408c838e99ea.pdf.
158. Correspondence with Paula Gillespie, Senior HR Officer, Office of the Police Ombudsman for Northern Ireland, February 2017.
159. Correspondence with Karen Ritchie, Learning and Development Officer, Office of the Police Ombudsman for Northern Ireland, March 2017.
160. Correspondence with Karen Ritchie, Learning and Development Officer, Office of the Police Ombudsman for Northern Ireland, March 2017.
161. Correspondence with Karen Ritchie, Learning and Development Officer, Office of the Police Ombudsman for Northern Ireland, March 2017.
162. See course descriptions available at: http://www.port.ac.uk/courses/law-and-criminology/bsc-hons-policing-and-investigation/ and http://www.port.ac.uk/courses/law-and-criminology/msc-crime-science-investigation-and-intelligence/ . Brian Doherty's profile is available at: https://policeombudsman.org/About-Us/Staff-Profiles/Director-of-Investigations-(Current).
163. Article 2 Policy: Investigation of State Related Deaths by the Office of the Police Ombudsman (PONI, 2017), available at: https://policeombudsman.org/PONI/files/e5/e55c7f1c-6458-4d54-b9d9-408c838e99ea.pdf.
164. Article 2 Policy: Investigation of State Related Deaths by the Office of the Police Ombudsman (PONI, 2017), available at: https://policeombudsman.org/PONI/files/e5/e55c7f1c-6458-4d54-b9d9-408c838e99ea.pdf.
165. Correspondence with Paula Gillespie, Senior HR Officer, Office of the Police Ombudsman for Northern Ireland, February 2017.
166. Correspondence with Paula Gillespie, Senior HR Officer, Office of the Police Ombudsman for Northern Ireland, February 2017.

7.3 Independent investigation of complaints takes resources away from corruption investigations

Independent Investigation of human rights abuses requires resources. In Victoria, these resources are currently given to Victoria Police.

By re-directing these resources to an independent body, both corruption and investigation of deaths and human rights abuses are possible. The independent investigation of human rights abuses must be a priority for the Victoria Government.

7.4 You need a rapid response team, only the police are resourced to respond rapidly to the "golden hours"

The Police Ombudsman of Northern Ireland prides itself on getting to police involved incidents within the "golden" hour—that is, the time immediately after an incident occurs. The Special Investigation Unit (SIU) in Ontario, which covers a huge geographical area, has mobile rapid response vehicles and mobile buses. They also fly to further destinations.

The rapid response vehicles cost about $85,000 are set up with all the necessary equipment. The mobile bus is very large and contains interview rooms fully equipped with video-recording equipment, a meeting room, computer terminal, power generators, internet access, evidence collection requirements etc.

The SIU have two people on duty 24/7 to receive calls and assess whether the SIU will activate a response. They also tell the police how to control the scene before the SIU arrives. Police are required under legislation to co-operate with the civilian investigation.

Both SIU and Police Ombudsman require the police at the scene to cordon and contain the scene and separate witnesses until they arrive. Both SIU and Police Ombudsman report strong civilian response and co-operation to their arrival on the scene.

24 hour on-call rapid response is a requirement of an independent investigation agency investigating deaths in custody and critical incidents and both SIU and Police Ombudsman of Northern Ireland demonstrate this is not only possible but preferable to having the police do this work.

7.5 The police will shut down and refuse to co-operate with civilian investigators;

There are currently in Victoria, police officers who refuse to make complaints because of their lack of faith in the impartially of PSC investigations/station based investigations. Independence will actually increase the confidence and co-operation of police members.

The Police Ombudsman of Northern Ireland annually records survey responses of officers who had dealings with the Ombudsman. In 2016-2017:

- The majority of police officers who had spoken to an Investigating Officer from the Police Ombudsman's Office had positive perceptions of staff.
- 89% of police officers thought that they were treated with respect by the Police Ombudsman's Office.
- Fiftyeight per cent were satisfied with the manner in which they were treated.
- 76% considered the complaint was dealt with independently.[167]

167. Police Ombudsman of Northern Ireland, ""Annual Report (2016-2017), p 13., available at: https://policeombudsman.org/PONI/files/59/59a07a61-6d31-4190-b639-6d4333ca7dd0.pdf.

7.6 Police will be unsupportive

In 2015, the Victorian Equal Opportunity and Human Rights Commission issued the first report into its "*Independent Review into Sex Discrimination and Sexual Harassment including predatory behaviour into Victoria Police*". The Commission's investigation, conducted at the invitation of Victoria Police, concerned allegations by Victoria Police members about police conduct.

The Commission was able to investigate in a way that led to a record number of Victoria Police members coming forward to give evidence. Indeed the Commission reports that it is the largest inquiry into sexual harassment and discrimination of an organisation outside the US Army in any part of the world.**[41]**

The Victoria Police's Chief Commissioner openly acknowledged, "We could have undertaken an internal review but that wouldn't have led to systemic change. We need change more quickly. Sunlight is the best disinfectant.*"***[45]**

The comment from the Chief Commissioner is illuminating. And his views are not alone within Victoria Police:

"It is not just about sexual or predatory behaviour. Police should NOT investigate police (male survey respondent)."

*"Stop internal investigations against those with a badge looking like a cover up (i.e.: nothing is ever thoroughly investigated against a sworn member when it is conducted by another sworn member) (male survey respondent)."***[46]**

Concerns about the lack of independence of police decision makers in relation to complaints against police raised by respondents to the Commission's inquiry reflect similar concerns consistently raised elsewhere.**[47]**

The Commission inquiry is revealing for a number of reasons. Unlike the Victoria Ombudsman when investigating sexual assault allegations against police officers by members of the public in 1997**[48]**, the Commission's inquiry was able to maintain the trust and confidence of large numbers of the targets of ill-treatment and police members who had witnessed this ill-treatment. This has much to do with its independence from Victoria Police. But it is equally due its victim-centred approach to investigation.

Internal police resistance to the idea of non-police investigation is often more emotional than reasoned. Independent investigation has the following benefits for serving police members:

1. Increases police member confidence in making complaints and the impartiality of the complaint systems;
2. Focuses police attention and resources back on the job of effective policing rather than dealing with complaints;
3. Removes the focus on police investigative biases in inquests and other complaint matters as investigations will now be conducted independently;
4. Enhances accountability and public perception of accountability, so increasing public confidence in policing.

Research shows police are not, as commonly thought, opposed to independent investigations. For example, in Northern Ireland, police report consistently high levels of satisfaction in independent investigations carried out by the Police Ombudsman.[168]

168. Police Ombudsman for Northern Ireland, Annual Report 2015-2016, p 11.

Police Unions too, consider that independent investigations are critical. The Police Union of England and Wales policy on independent investigations, for example, explicitly states:

> *"it is also vitally important that [police] help maintain a culture where complaints are fully investigated and there are procedures in place to protect whistleblowers.* ***A fully independent system must be in place*** *to investigate complaints made. This is in the interest of the public but also helps protect the rights of those under investigation. It is vital that investigations are seen to be fair and impartial. Whilst the IPCC enables some cases to be investigated independently, we do not believe its creation has led to a totally independent system."* [169]

Police recognise the benefits of speedy and transparent independent investigations. "It is in the interests of police who have acted appropriately to be cleared by an independent, effective process which the public has confidence in."[170]

Beyond police, research of public opinion surveys demonstrates strong support amongst the public for the view that the more serious the allegation levelled against police, "the more important it is that impartiality is underwritten by intuitional separation between the accused and the investigator".[171]

Surveys conducted by the Police Ombudsman of Northern Ireland demonstrate that an independent system for the investigation of police contact deaths, in which both the public and police have trust is possible.

7.7 The Police need to retain responsibility for integrity management

A frequent argument against external investigation is that police will lose responsibility for integrity management. But although the external agency will be responsible for assessing complaints and what action ought be taken, police will still have a critical role in integrity management, for example, through appropriate recruitment, early intervention, and training of their staff.

This Policy Briefing has been produced by the Police Accountability Project, a project of the Flemington Kensington Community Legal Centre.

169. Policy Document: 'Police Accountability, Version 2', (Police Federation , 2016) available at: http://www.polfed.org/documents/PFEW_Policy_-_Police_accountability_-_September_2016_v2.pdf.

170. A better system to investigate police related deaths: (Smart Justice, 2015), available at: http://www.smartjustice.org.au/cb_pages/files/SMART_PRDeaths.pdf.

171. "Democratic Policing, Public Opinion and External Oversight" in *Civilian oversight of Police* (Prenzler, Heyer, Garth (2015), p 70.

About the Police Accountability Project

The Police Accountability Project is a specialist, innovative, public interest not-for-profit legal practice located within the Flemington and Kensington Community Legal Centre taking the lead in police accountability law and strategies within Victoria, Australia.

Our casework, advocacy and law reform work is informed by our experience, by comprehensive research and by human rights principles and practises.

The Police Accountability Project provides tailored client support for young and vulnerable clients, a full suite of highly specialist legal advice, and assistance from the complaint stage to the potential of litigation along with ongoing systemic advocacy on the core accountability issues.

The Police Accountability Project is a combination of individual and community based work, combining the Walking Alongside Program, expert and strategic legal casework, Victoria's first Police Complaints Clinic and strategic law reform and advocacy work.

The Flemington Kensington Community Legal Centre (FKCLC) is a non-profit and independent community organisation, incorporated in Victoria in 1980.

171168. Police Ombudsman for Northern Ireland, Annual Report 2015-2016, p 11.

169. Policy Document: 'Police Accountability, Version 2', (Police Federation , 2016) available at: http://www.polfed.org/documents/PFEW_Policy_-_Police_accountability_-_September_2016_v2.pdf.

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