Independent review into investigations of police-related deaths, and domestic and family violence deaths in Queensland

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Acknowledgements

We wish to acknowledge Ms Peta Colbert and Dr John Gilmour for their significant contributions to the review: Ms Colbert project managed the review and undertook the collection, coding and analysis of the Coroner reports. Dr Gilmour undertook analysis of the DIC and DIPO cases and the DFV cases. We also acknowledge the contributions of all key stakeholders who gave their time generously for meetings, preparation of data, and formal interview. Our review is richer for the involvement of these people and their insight into police-related deaths.

Citation

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

The dots within the image of the State of Queensland on the cover of this report represent the number of cases considered within the review with the blue dots representing the deaths in custody and during police operations and the orange dots representing the number of domestic and family violence incidents (cover design by Alexander Chen, Hsiaoi Group).

THE UNIVERSITY OF QUEENSLAND
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School of Social Science

12 July 2022

The Honourable Annastacia Palaszczuk MP
Premier of Queensland and Minister for the Olympics
1 William Street
Brisbane QLD 4000
Email: the.premier@premiers.qld.gov.au

RE: Independent review into investigations into police-related deaths

Dear Premier,

It is my pleasure to provide you with the Final Report for the *Independent Review and Recommendations in Relation to Police-Related Deaths and Prior Police Involvement in Domestic and Family Violence Deaths*.

The review was undertaken from 26th November 2021 to 12th July 2022. Myself, Janet Ransley and Elena Marchetti from Griffith University co-authored the report with Lincoln Crowley QC.

We are pleased to provide you with this review and our recommendations that we hope will work to build community confidence in the thoroughness, transparency and independence of investigations and oversight of police-related deaths and domestic family violence deaths where there has been prior police contact.

Yours sincerely,

L A Mazerolle

Professor Lorraine Mazerolle
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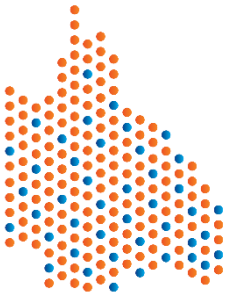
Acronyms

AI	Artificial Intelligence
AIC	Australian Institute of Criminology
CALD	Culturally and Linguistically Diverse
CCC	Crime and Corruption Commission
CCMS	Coroner Case Management System
CIB	Criminal Investigation Branch
DDFVC	District Domestic and Family Violence Coordinators
DFV	Domestic and Family Violence
DFV-VPU	Domestic, Family Violence and Vulnerable Persons Unit
DIC	Death in Custody
DIPO	Death in Police Operations
ESC	Ethical Standards Command
HRA	Human Rights Act 2019
IIG	Internal Investigations Group, Ethical Standards Command
IPCC	Independent Police Complaints Commission
IRDSIPC	Independent Review of Deaths and Serious Incidents in Police Custody
MOU	Memorandum of Understanding
NCIS	National Coronial Information System
PCC	Police Communications Centre
PPRA	Police Powers and Responsibilities Act 2000
QCAT	Queensland Civil and Administrative Tribunal
QPS	Queensland Police Service
RCIADIC	Royal Commission into Aboriginal Deaths in Custody

EXECUTIVE SUMMARY



This independent review was ordered in response to the State Coroner's recommendation that current arrangements for investigating deaths in police custody (DIC) or deaths in the course of police operations (DIPO) should be reviewed. A second focus was included in the review that tasked the review team to consider mechanisms for investigating domestic and family violence deaths where there had been prior police contact. We dealt with these two focal issues separately given the very different nature of these two types of investigation and the different concerns they raise. We confined ourselves strictly to our own terms of reference recognising two other commissions of inquiry (The Honourable Tony Fitzgerald and The Honourable Alan Wilson, *Commission of Inquiry relating to the Crime and Corruption Commission*; her Honour Judge Deborah Richards, *Independent Commission of Inquiry into Queensland Police Service Responses to Domestic and Family Violence*) with intersecting terms of reference, extensive resources and coercive powers announced and underway shortly after our review started.

Our review was informed by a broad methodology combining quantitative and qualitative social science approaches and legal and policy analysis. Data gathered and analysed included relevant policies, procedures, coronial reports, inquiry reports, stakeholder interviews and analysis of all in scope death investigations including those with prior police contacts where relevant.

For **police-related deaths (both DIC and DIPO)**, the primary concern raised is whether police should investigate the actions and conduct of other police. Current practice is that police-related deaths are investigated by the Queensland Police Service's (QPS) Ethical Standards Command (ESC), with the Crime and Corruption Commission (CCC) adopting an oversight role to monitor the integrity of these investigations. The State Coroner lacks the resources or investigative skills or powers to undertake his own investigations.

Our interviews with stakeholders and thematic review of coronial reports show that people generally view the ESC investigations to be of a high standard. But the perception of 'police investigating police' is regarded as not acceptable to the community. We also found that the separate roles of the ESC, CCC and Coroner are not well understood even by those who participate regularly in these matters. A common view expressed by our interviewees was that there is inadequate or poor communication and liaison with the families of deceased people that fuels a lack of public confidence and trust, particularly in First Nations communities. Queensland's *Human Rights Act 2019* is also relevant in the obligation it now creates for due process and fairness in legal proceedings.

To improve perceptions of fairness and public trust our recommendations include a shift in primary responsibility for DIC and DIPO investigations from the ESC to the CCC, and that the multi-disciplinary teams established to conduct the investigations be sufficiently resourced to

include cultural and communications specialists, with less reliance on seconded police. This would increase the workload of the CCC but decrease that of ESC. We estimate the DIC and DIPO investigations to be led by the CCC will involve an average of 14 investigations per year.

We also recommend a Police-Related Deaths Advisory Board modelled on the existing Domestic and Family Violence Death Review and Advisory Board. Embedded in the Coroner's Office, this new Board would provide system-level monitoring and transparency on the investigation of police-related deaths. Government should provide formal responses to the recommendations of both Boards.

For **domestic and family violence (DFV) deaths with prior police contact**, our review identified that QPS mostly takes a restricted view of prior police contacts limited to prior DFV contacts. Our analysis suggests the need to consider a broader range of prior police contacts especially including public nuisance, drug and traffic violations because these types of prior contacts with police have greater predictive power for DFV homicides than prior contact with police for DFV incidents. We understand that the new QPS DFV command is already deeply involved in implementing a DFV risk dashboard which will better facilitate police being alert to DFV at risk cases. A further issue repeatedly brought to our attention was that police called to DFV incidents sometimes choose to record them as something else (such as a street check or public order matter). While this may be because of more onerous administrative requirements for DFV matters, the result is that DFV is under-recorded and police attending incidents lack important history about DFV matters. We draw this matter to the attention of the *Commission of Inquiry into QPS Responses to Domestic and Family Violence* conducted by her Honour Judge Deborah Richards).

The principal concern identified in our review pertaining to investigative mechanisms of DFV deaths with prior police contact is the need to ensure that investigations examine not just individual officer lapses, but also systemic issues. These systemic issues might include training and workload needs, but also lessons learned in terms of missed points for intervention that might have prevented the death. The evidence suggests these investigations are currently dispersed across the QPS primarily because investigations are undertaken by the local Criminal Investigation Branch (CIB), unless evidence of police misconduct sees the ESC stepping in. Identifying system issues will be assisted if that investigative function is centralised. Stakeholders told us that DFV homicide investigations conducted by ESC are generally of a high standard, and that the ESC is a suitably centralised unit that should be responsible for all DFV death investigations where there has been prior police contact. We estimate there are about 14 investigations per year of DFV deaths where the offender has had contact with police in the five years before the homicide. If our recommendation is adopted for the ESC to lead these DFV deaths with prior police contact it will offset the suggested removal from the ESC of DIC and DIPO investigations to the CCC.

RECOMMENDATIONS

Recommendations Related to Investigative Mechanisms for Deaths in Custody and in the Course of Police Operations

1. Amend section 33 of the *Crime and Corruption Act 2001* (Qld) to vest in the Crime and Corruption Commission a function to lead and coordinate the investigation of deaths in police custody and deaths in the course of police operations.
2. Ensure that the Crime and Corruption Commission appoints multi-disciplinary, multi-skilled investigative teams for each death in custody and death in the course of police operations that takes into account the geographic and cultural circumstances of the death and comprises a diversity of team membership which includes, in addition to sworn police investigators, at least one member from each of the following: First Nations/cultural expert, cultural safety and trauma-informed communication specialist and an investigator who is not a serving or sworn Queensland Police Service officer which may include former police from other jurisdictions, investigators from other agencies, or former Queensland Police Service personnel whose employment with the service ceased at least two years prior to their appointment to the Crime and Corruption Commission.
3. Provide sufficient resources to the Crime and Corruption Commission to establish and lead multi-disciplinary, multi-skilled teams to investigate deaths in custody and deaths in the course of police operations with specific resources to recruit a First Nations/cultural expert, a cultural safety and trauma-informed communication specialist and non-sworn investigators.
4. Replace the current Memorandum of Understanding between the Queensland Police Service, Crime and Corruption Commission and Coroner with a new agreement that reflects these recommendations. It should set out:
    a) principles for cooperation between the parties with the Crime and Corruption Commission taking over from Ethical Standards Command the responsibility to lead and coordinate investigations into police-related deaths.
    b) that the Crime and Corruption Commission is to be notified of any police-related death as soon as Ethical Standards Command becomes aware of it, and that the Crime and Corruption Commission then assumes responsibility to coordinate attendance at the scene in consultation with the Coroner and Ethical Standards Command.

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

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

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

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

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

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

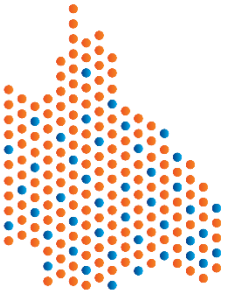
7. Provide sufficient resources to the Coroner's Office to establish the Police-Related Deaths Advisory Board including establishing a separate secretariat to support its functions, and appropriate remuneration for the Board co-chair and members.

Recommendations Related to Investigative Mechanisms for Domestic and Family Violence Deaths with Prior Police Contact

8. Ensure that the Queensland Police Service re-define 'prior police contact' in domestic and family violence deaths to include all prior contact with police (including traffic incidents and street checks) in the five years prior to the death.
9. Provide sufficient training resources to the Queensland Police Service to embed cultural safety and trauma-informed communication with families into all levels of investigative training for all investigators across the state (including regular refresher training).
10. Require the Queensland Police Service to assign all domestic and family violence homicide investigations with prior police contact (excluding those that occur in the course of a police operation which should be referred to the Crime and Corruption Commission) to the Ethical Standards Command ensuring that the investigative team draws together a multi-skilled, multi-disciplinary team that includes a specialist First Nations/cultural expert and a family liaison person skilled in cultural safety and trauma-informed communication.
11. Provide sufficient resources to the Queensland Police Service Ethical Services Command to recruit First Nations/cultural experts and cultural safety and trauma-informed communication specialists to partake in multi-skilled, multi-disciplinary teams to investigate Domestic and Family Violence Deaths with prior police contact.
12. Amend the *Coroners Act 2003* (Qld) so that the relevant Minister is required to provide a formal response to any recommendations for government action contained in reports from both the Domestic and Family Violence Death Review and Advisory Board and the Police-Related Deaths Advisory Board. Ministerial responses should be made public alongside the report on the relevant Board's website.

ABOUT THE INDEPENDENT REVIEW

Background



On 22nd January 2021, in making findings with respect to the Inquest into the death of Cindy Leigh Miller, Mr Terry Ryan, State Coroner, recommended the Government consider commissioning an independent review of the current arrangements for the investigation of police-related deaths on behalf of the Coroner and the oversight of those investigations (Recommendation 2). Although the State Coroner made no adverse comment against any police officer or member of the watchhouse staff in relation to the conduct of the police investigation into Ms Miller's death, it was acknowledged that community confidence in the independent investigation of police-related deaths is a matter of significant public interest.

The background provided for the review stated that: 'the Palaszczuk Government is committed to ensuring public confidence in the thoroughness, transparency and independence of investigations into police-related deaths. Similar to police-related deaths, the Palaszczuk Government recognises the public interest in ensuring that prior police involvement in domestic and family violence deaths should be subject to independent review in a transparent and timely manner.'

There are already a number of mechanisms to investigate and review police-related deaths and, domestic and family violence deaths with prior police involvement, including but not limited to:

a) primary responsibility for the investigation of all suspected criminal acts, including those leading to death, rests with the police (under the *Police Service Administration Act 1990* (Qld));

b) coroners oversee the investigation of all reportable deaths including those that are unnatural, suspicious or which occurred in police care or operations (under the *Coroners Act 2003* (Qld));

c) the Crime and Corruption Commission monitors and can assume responsibility for investigations of police misconduct including those involving deaths in police care or operations, and those relating to domestic and family violence deaths where there was prior police contact (under the *Crime and Corruption Act 2001* (Qld));

d) the Domestic and Family Violence Death Review and Advisory Board conducts systemic reviews and makes recommendations for system improvements (under the *Coroners Act 2003* (Qld)); and

e) the Child Death Review Board conducts system reviews after the death of a child connected to the child protection system (under the *Family and Child Commission Act 2014* (Qld)).

Investigations of police-related deaths are coordinated by a 2019 Memorandum of Understanding (MOU) between the QPS, the CCC, and the Coroner which sees the QPS Ethical Standards Branch lead most investigations, subject to monitoring by the CCC and direction by the Coroner.

The Palasczcuk Government accepted Recommendation 2 of the State Coroner's Findings of Inquest into the death of Cindy Leigh Miller and appointed an independent reviewer.

Terms of Reference

The Terms of Reference for this review implement Recommendation 2. The independent review sought to examine and make recommendations in relation to deaths in police custody (DIC) or in the course of, or as a result of, police operations (DIPO). The review was also required to examine the mechanisms for undertaking and overseeing reviews of prior police involvement in domestic and family violence (DFV) deaths.

Having regard to the current arrangements for the investigation and oversight of police-related deaths, the review was expected to make recommendations providing for the most effective mechanism for the investigation and oversight of police-related deaths.

While remaining mindful of the relationship with existing oversight mechanisms that have similar review functions, such as the Domestic and Family Violence Death Review and Advisory Board, the review was to make recommendations providing for the most appropriate mechanism to ensure that prior police involvement in domestic and family violence deaths is subject to independent, timely and transparent review.

The review was to consider:

a) the public interest in ensuring that investigations into police-related deaths and domestic and family violence deaths with prior police involvement are independent, transparent, and undertaken in a timely manner;

b) the most appropriate agency or independent body to conduct investigations into police-related deaths;

c) the most appropriate agency or independent body to provide oversight of investigations into police-related deaths and, the most appropriate mechanism to conduct reviews of police involvement into domestic and family violence deaths with prior police involvement;

d) the extent to which any recommended investigative and oversight framework, including associated investigative powers, should be provided for in legislation;

e) the approach taken when investigating and reviewing police-related deaths and domestic and family violence deaths with prior police involvement in other jurisdictions;

f) the appropriate reporting requirements for investigations into police-related deaths and reviews of prior police involvement in domestic and family violence deaths, including minimum timeframes;

g) the resourcing impacts of any proposed recommendations, particularly in regional areas;

h) the need to ensure any related proceedings are not prejudiced; and

i) any other related matters.

With respect to any recommendations made, the review was to consider the need to protect and promote human rights, including the rights protected under the *Human Rights Act 2019* (Qld).

Scope of Review

This independent review broadly examines and make recommendations with respect to the following:

1. current arrangements for the investigation and oversight of police-related deaths; and
2. the most appropriate mechanism to ensure that prior police involvement in domestic and family violence deaths is subject to timely, independent and transparent review.

Definitions

Police-related death refers to reportable deaths that are, consistent with terminology in the *Coroners Act*, either:

1. a death that has happened in the course of, or as a result of, police operations; or
2. a death in custody, to the extent the deceased was in the custody of the Queensland Police Service.

Domestic and family violence death with prior police involvement refers to a domestic and family violence death where police had been involved prior to the death. For the purposes of the review, a ***domestic and family violence death*** is defined consistently with section 91B of the Coroners Act.

Consultation

As specified in the Terms of Reference, the review team undertook targeted consultation with a range of relevant Government agency representatives, legal and community stakeholders from the following areas:

- Queensland Police Service including the Executive, Ethical Standards Command, and Domestic Family Violence & Vulnerable Persons Command
- Department of Justice and Attorney-General including State Coroner's Office, Director of Public Prosecutions, Domestic and Family Violence Death Review and Advisory Board, and Women's Safety and Justice Taskforce
- Crime and Corruption Commission
- Aboriginal and Torres Strait Islander Corporation Murri Watch
- Aboriginal and Torres Strait Islander Legal Service
- Deaths in Custody Project, The University of Queensland
- Legal Advocates
- Community.

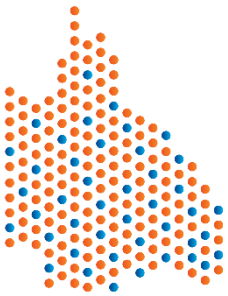
Consultation to inform the examination and recommendations of the independent review was undertaken by the Chief Investigators between 1st February 2022 to 21st June 2022.

Review Timeline

The independent review commissioned by the Palaszczuk government was announced as being led by Professor Lorraine Mazerolle on 23rd August 2021. The contract was subsequently signed including Co-Chief Investigators Professors Janet Ransley, Elena Marchetti (Griffith University) and Lincoln Crowley QC who was, at the time, with 8 Petrie Terrace Chambers. The review commenced 26th November 2021 and ended 12th July 2022.

The final report on the findings and recommendations of the review was delivered to the Premier and Minister for Trade, the Attorney-General and Minister for Justice and Minister for the Prevention of Domestic and Family Violence, and Minister for Police and Corrective Services and Minister for Fire and Emergency Services on 12th July 2022.

PART A: DEATHS IN CUSTODY (DIC) AND DEATHS IN POLICE OPERATION (DIPO)



DIC and DIPO Current Legislative and Policy Framework

Responsibility for investigating police-related deaths in Queensland is currently shared across the Queensland Police Service, Coroner's office and Crime and Corruption Commission (CCC), regulated by three main legislative schemes, a formal memorandum of understanding, and various informal or internal policies and practices. Current roles for each agency are as follows.

Police: under section 2.3 of the *Police Service Administration Act 1990* (Qld), police have functions to prevent and investigate crime, detect offenders and uphold the law. This extends to investigating all potentially wrongful deaths including those related to the actions or conduct of police officers. Section 3.2 specifically preserves in officers the powers, obligations and liabilities of constables at common law. These powers are supplemented by comprehensive investigative powers under the *Police Powers and Responsibilities Act* (PPRA) *2000* (Qld).

Police are also obligated under section 794 of the PPRA to assist the coroner to investigate deaths and conduct inquests. Under the *Crime and Corruption Act 2001* (Qld) police are also obligated to assist the CCC in any review or investigation of possible police misconduct or corruption.

Coroner: under section 11 of the *Coroners Act 2003* (Qld) coroners are required to investigate all reportable deaths that occur in Queensland. A reportable death is defined as those that are: violent or unnatural (e.g., accidents, homicides or suicides); sudden or suspicious; health care related; or which occurred in custody (e.g., in detention under arrest, court order or authority of an Act) or as a result of police operations (e.g., in a police pursuit or evacuation). Coroners are required under section 43 of the Act to determine the identity of the deceased person, and when, where and how they died. To do this they can order medical examinations and tests, and issue search warrants under the PPRA.

Inquests are held in relation to some deaths but are mandatory for DIC. Inquests must also be held for DIPO unless the Coroner is satisfied this not merited. Inquests may also be directed by the Attorney General, courts, or on the Coroner's initiative. Inquests into DIC or DIPO, under section 11(7), may only be investigated by the State Coroner, Deputy State Coroner, or an appointed or local Coroner approved by the Governor in Council.

Crime and Corruption Commission: under section 33 of the *Crime and Corruption Act* the CCC's functions include maintaining public integrity and investigating corrupt conduct,

subject to the principles set out in section 34. The principle of devolution sets out that, subject to the levels of agency cooperation and capacity and the public interest, action to prevent and deal with corruption should generally happen in the unit of public administration where it occurred. Section 41 specifies that for the police, this responsibility vests in the Commissioner of Police. Section 15 defines corrupt conduct as including conduct that does or could adversely affect the performance or function or the exercise of powers of a unit of public administration (including police) and which is not honest or impartial or involves a breach of trust or misuse of information that would constitute a criminal offence or disciplinary breach providing grounds for termination of employment.

Section 47 provides that the CCC may issue guidelines for the investigation of police misconduct, review or audit such investigations, or assume responsibility for them and that the Commissioner of Police must give reasonable help for those purposes. Schedule 2 of the Act defines police misconduct as conduct that while not corrupt is disgraceful, improper, or unbecoming, and does not meet appropriate standards.

Police-related deaths could sometimes involve conduct that is misconduct: officers involved in the incident, for example, failed to comply with relevant use of force principles or other internal policies. There could also be corrupt conduct, for example, if officers are not honest in their accounts of the events that led to the death or acted in a discriminatory fashion in the lead-up to the death.

Coordination of investigations of police-related deaths: police, coroners and the CCC all have responsibilities in relation to police-related deaths. This overlapping jurisdiction requires coordination.

In the *Inquest into the Death of Mulrunji (2010)*, Deputy Chief Magistrate Hine recommended that all such deaths should be investigated solely or primarily by the then CMC (now CCC) and that it should be resourced and empowered to undertake that role. In the Cindy Leigh Miller inquest, State Coroner Ryan noted that the government at the time had agreed with that recommendation but regarded it as implemented via the CCC's oversight role. The State Coroner found that in practice the CCC's role is focused on 'the sufficiency and probity of the initial investigative response' and making preliminary determinations about police conduct (p. 23), rather than any active involvement in investigations.

In practice, the investigation of police-related deaths is coordinated by a MOU first entered into in 2006 and revised in 2019 by the State Coroner, Commissioner of Police, and CCC Chairperson, and also given effect to in the QPS Operational Procedures Manual. The purpose of the MOU is expressed to be to outline agreed principles of cooperation between the parties to facilitate a coordinated response to the investigation of police-related deaths. The MOU specifically confirms that it has no legal effect and is to be read in conjunction with other relevant policies and legislation.

The MOU sets out the operational provisions for investigations including that:

- the QPS ESC, State Coroner and CCC are all to be notified of all relevant cases, although who has that responsibility, or the form or timeframe for notification, is not specified.
- Attendance at the scene is to be coordinated by ESC in consultation with the Coroner and CCC.
- The investigation is to be conducted by the ESC, subject to the CCC exercising its power to assume that responsibility.
- ESC is to appoint an experienced lead investigator and consult with the Coroner as to which QPS units are appropriate to assist with the investigation. The investigation of any suspected misconduct will be coordinated by ESC and CCC in accordance with existing protocols.
- QPS is to provide, except in exceptional circumstances, completed investigation reports to the Coroner within six months of the death. The Coroner, except in exceptional circumstances, will conduct an inquest and deliver findings within six months of receiving the completed investigation report.

The MOU also makes provision for information sharing, the making of public comment, and dispute resolution.

The effect of the MOU is to vest the investigative function for police-related deaths with the ESC, subject to CCC monitoring the nature of which is not specified, and the overall direction of the coroner. Day-to-day liaison with the Coroner's Office is via the QPS Detective Inspector leading the Coronial Support Unit. CCC teams involved in monitoring also include seconded QPS officers, usually as a majority of the relevant team. To a lay observer it could well appear that the investigation process is dominated by police, whether they be situated in ESC, the Coronial Support Unit, or the CCC.

The State Coroner observed in the Miller inquest that 'the CCC performs its oversight functions diligently and effectively' (p. 23) and that the Coroner is not bound to adopt the recommendations or conclusions of the QPS investigation report. Nevertheless, he added that 'community confidence in the independent investigation of police-related deaths is a matter of significant public interest' (p. 24).

This situation is now also affected by Queensland's *Human Rights Act 2019* (HRA). The HRA is expressed to be intended to protect and promote human rights and build culture and dialogue about the meaning and scope of rights. Public entities are required, under section 4, to act and make decisions in a way that is compatible with human rights. Section 9(1)(c) specifically defines the QPS as a public entity. Part 2 of the HRA sets out what constitutes human rights, including rights to:

- equality before the law (section 15)
- not be arbitrarily deprived of life (section 16)

- enjoy culture, religion and language (section 27)
- for Aboriginal and Torres Strait Islander peoples, specific rights to cultural heritage and identity, language, kinship, and in relation to land, waters and resources (section 28)
- due process, humane treatment and fair criminal and civil hearings (sections 29-35) with specific provision for children in the criminal process (section 33).

The HRA also sets up processes to achieve these rights, including parliamentary scrutiny of all legislation and providing for the Queensland Human Rights Commission to deal with human rights complaints, review public entities' operations and policies, and promote human rights. In addition to generally imposing obligations on public agencies to act in ways that are not incompatible with human rights, the HRA may be relevant to the investigation of police-related deaths, especially considering the rights related to equality, life, due process, and those rights specific to Aboriginal and Torres Strait Islander peoples.

In particular, the right to a fair hearing under section 31 stipulates that legal proceedings should be 'decided by a competent, independent and impartial court after a fair and public hearing'. It is important to note that this provision is expressed as relating to parties in criminal and civil proceedings and may not extend to Coronial inquests. Nevertheless section 31 sets a benchmark requiring independence in legal processes. That independence may be argued to apply not just to the determinative stage of cases, but also in the investigative processes leading up to that stage because of their impact on ultimate decisions. The HRA clearly expects public entities affecting rights to act in ways that are fair, independent and impartial. For those investigating police-related deaths, this may require not just fairness and independence, but also being seen by the public to be fair and independent.

Additionally, the HRA requires public entities to be cognisant of culture generally (section 27), and the distinct cultural rights of First Nations people specifically (section 28). This may extend to requiring public entities to ensure that their policies and procedures respect and accommodate First Nations cultural practices, kinship ties, and language rights. For those investigating police-related deaths of First Nations peoples, this may require them to take positive steps to determine, understand and meet those cultural needs.

In summary, in view of the HRA, all agencies involved in investigating police-related deaths should maximise the independence and impartiality of their investigative and review processes and enhance public perceptions of their fairness. Further, there is a need for positive steps to be taken to ensure that any impact on First Nations peoples is sensitive to and respectful of their cultural, kinship and language rights.

DIC and DIPO Notification and Investigative Processes

One of the first tasks of our review was to gain a thorough understanding of the DIC and DIPO notification and investigative processes. Consultation with relevant personnel was undertaken throughout the first quarter of 2022 to map the current notification and investigative processes for DIPOs and DICs, mindful of the MOU described in the section above. DIC and DIPO incidents include deaths from suicide, police-related shootings, deaths during siege type incidents, deaths following arrests, deaths during police pursuits, and deaths during operations or whilst in custody from sudden/unexplained circumstances (such as overdoses whilst in custody). Figure 1 provides a graphic representation of the process. The process was reviewed by the ESC and feedback incorporated to ensure it was an accurate reflection of the process for such investigations.

As Figure 1 shows, upon notification and confirmation of a police-related death, ESC's Internal Investigation Group (IIG) assigns an investigative team consisting typically of three to five investigators though they can assign up to six. A team of this size allows for one or two interview teams and the Senior Investigating Officer who will undertake a coordination role, and one member assigned as the Family Liaison Officer. The Family Liaison Officer will not be directly involved in the investigation. Rather, the role of the Family Liaison Officer is to demystify the investigative process and provide a link to the Coronial Support Unit and to other agency services as needed by the family. This liaison is viewed as a critical role for supporting the family during this process.

The Senior Investigating Officer oversees the investigation and team and is responsible for coordinating communications with key stakeholders throughout the investigation including:

- Briefing the Detective Superintendent Internal Investigations Group (IIG) who in turn briefs the Chief Superintendent IIG, who in turn briefs the Assistant Commissioner ESC.
- Notifying the State Coroner of a police-related death.
- Advising the CCC by phone or email. The CCC may or may not form an investigative team. Our understanding is that the CCC will always form an investigative team if the death relates to a First Nations person.
- Advising the Police Union by phone who provides support and advice to the police officers involved.

ESC investigates police-related deaths on behalf of the Coroner[1] and they communicate directly with the Coroner's Office through a Liaison Inspector who sits within the Coronial Support Unit. The State Coroner's direction formalises the investigation parameters (targeted or full investigation) and specifies if the police-related death is a DIC or a DIPO, or neither. The formal mechanisms for notifying and updating the State Coroner on the initial death and subsequent investigation is:

[1] Deaths in Custody can also be overseen by the Deputy State Coroner (Coroners Act 2003 (S11(7)).

- Form 1 Police Report of Death to A Coroner (Queensland Coroners Act 2003, Section 7(3)) – within 24 hours of a police-related death incident and can be completed by police located in the region or branch where the death occurred.
- Supplementary Form 1 Police Report of Death to A Coroner (Queensland Coroners Act 2003, Section 7(3)) – every 28 days.
- QPS Investigative Report – upon completion of the ESC IIG investigation.

The investigation by ESC comprises the coronial investigation and may also include criminal and discipline investigations where necessary. Whilst oversight function is through the CCC related to decisions on any disciplinary or corrupt conduct, the practical application is for the ESC to investigate the death. At any stage of the investigation, misconduct may be identified in which case a complaint file is generated and processed similar to the process for all other complaints. If a case is assessed by the ESC as misconduct, it is then formally referred to the CCC. At that point, the CCC would complete their own assessment through their investigative team. Options available include the CCC taking on the discipline investigation, returning it to the ESC to deal with which may or may not seek involve further CCC oversight. The ESC only reports to the CCC every three months if the CCC places oversight on the discipline investigation. However, the CCC (that may already have attended an incident), can initiate a complaint if they choose.

The model described in Figure 1 captures the investigative process but is silent on the practice of the ESC relative to the reiterative communication processes that occur throughout police-related death investigations. The investigation is completed on behalf on the Coroner by ESC, with communication and sharing of information guided by the Memorandum of Understanding (QPS, State Coroner and CCC).

Further reporting requirements and sharing of information on police-related deaths is guided by Section 16.23.5 of the QPS Operation Procedures Manual, which requires notification to the Australian Institute of Criminology (AIC) for the purposes of the National Deaths In Custody Program and the First Nations Unit through the Assistant Commissioner, ESC. In August 2021, the State Coroner provided blanket approval to QPS for the release of the information to the AIC to fulfil this new reporting requirement[2]. The flowchart for reporting to the AIC appears in Figure 2. A key consideration across all of the communications and reporting functions required of police-related deaths is accuracy and timeliness of information (see Coroner Report Analysis where investigation length and accuracy in recording is discussed).

[2] In 2021, the Honourable Ken Wyatt AM MP, Minister for Indigenous Australians (C'wealth) and The Honourable Michaela Cash, Attorney General (C'wealth) wrote to the Minister for Police and Commissioner advising they are co-leading the justice targets under the National Agreement on Closing the Gap (National Agreement) at a federal level. The Australian Government is seeking to work constructively with states and territories to assess the contributing factors to Indigenous Australian incarceration rates, acknowledging that levers to change are at a state and territory level. One of the strategies is to improve the timeliness of notifying the AIC of a DIC or DIPO.

Figure 1: DIC and DIPO investigative process

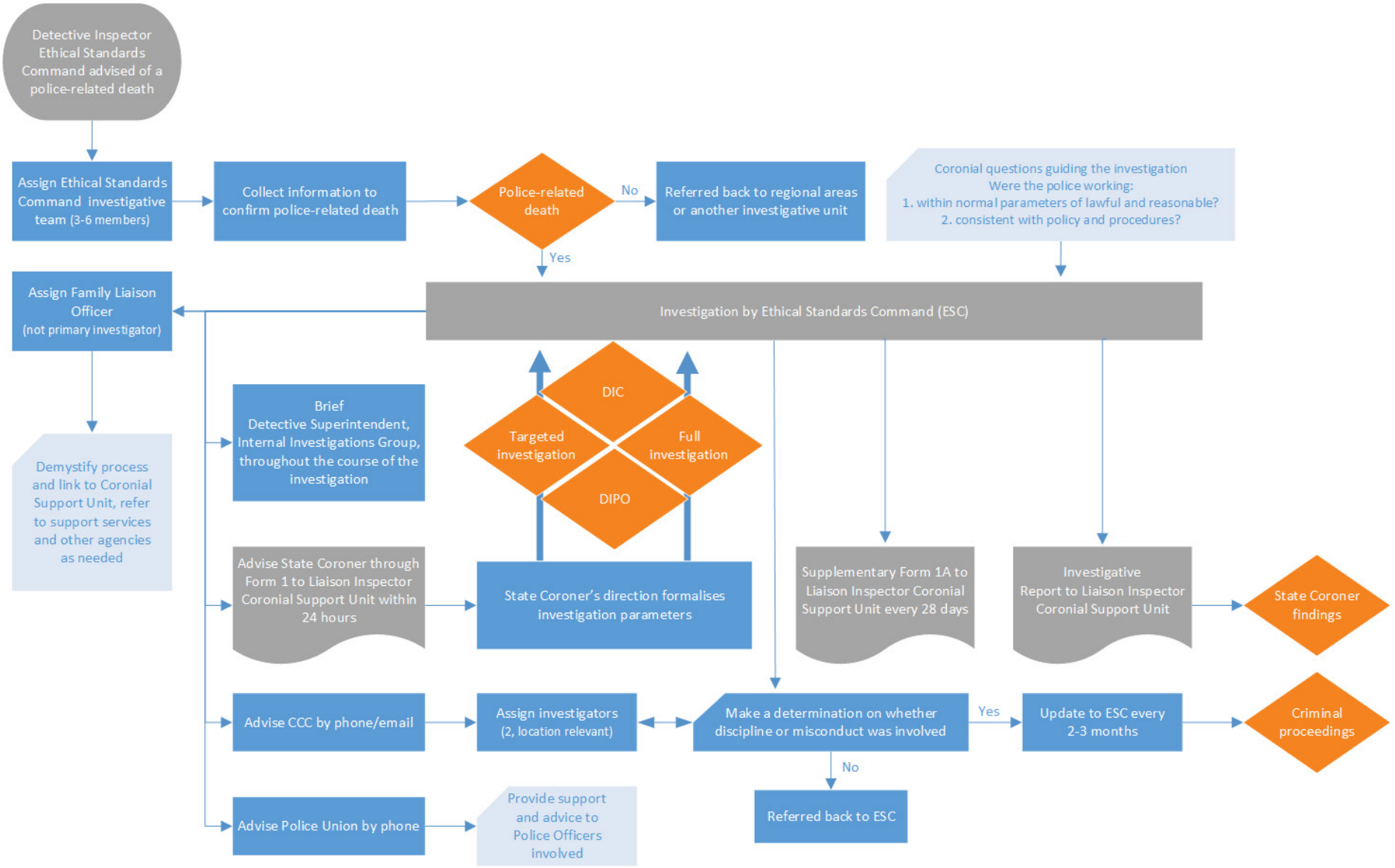
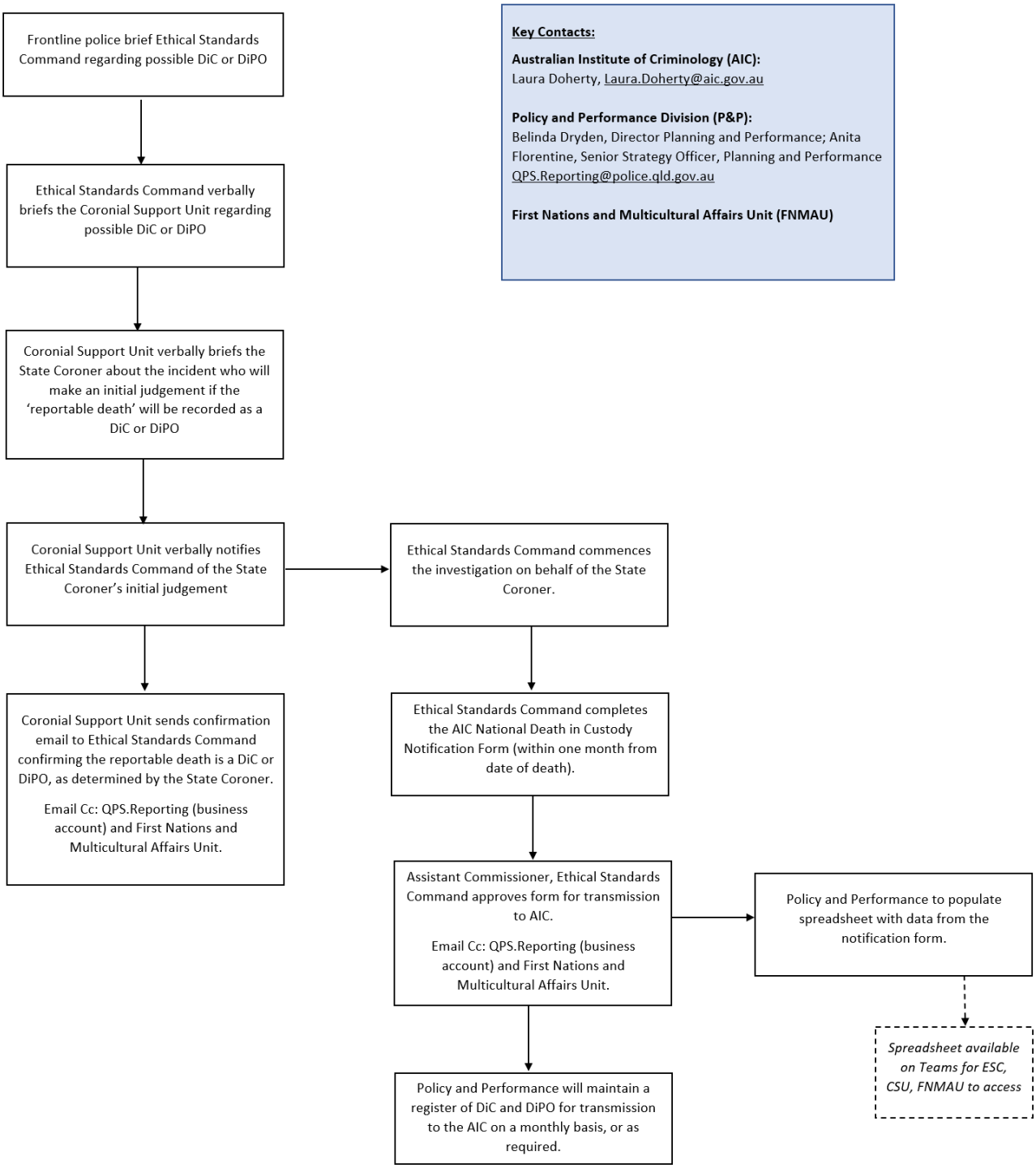


Figure 2: Deaths in custody reporting to AIC



DIC and DIPO Cases Within Scope

To better understand the workload and investigative processes with DIC and DIPO investigations, our review team examined the numbers of DIC and DIPO cases over time. The QPS provided data on the number of DIC and DIPO per year over an eleven-year span (2011 to 2021 inclusive). As Table 1 shows, the police recorded a total of 112 deaths of which N = 34 (30.4%) were DIC and N = 78 (69.6%) were DIPO. These data show an increase in deaths in police operations since 2011, peaking in 2020 (N = 15) and 2021 (N =16).

Table 1: QPS record of DIC and DIPO cases by incident year from 2011-2022

Year of death	DIC	DIPO	N
2011	3	2	5
2012	6		6
2013	4	5	9
2014		4	4
2015		5	5
2016	2	7	9
2017	1	8	9
2018	4	8	12
2019	4	8	12
2020	6	15	21
2021	4	16	20
Total	**34**	**78**	**112**

The review team sought to explore in more detail a corpus of closed/finalised DIC and DIPO cases to gain further insight into the strengths and weaknesses of the existing investigative arrangements. We sought to examine cases that were closed from 2015 to 2019. Information on these closed cases was gathered from a variety of sources including the QPS, Coroners Court of Queensland, the Coroners Court of Queensland website, Deaths in Custody Project (the University of Queensland), and through online searches. We followed a very detailed process to identify a full dataset of in scope closed DIC and DIPO cases that is described as follows:

Step 1: The Coroner's Court provided a report from the National Coronial Information System (NCIS) and raised a report in April 2022 from the Coroner Case Management System (CCMS) of cases classified as closed since 2015 (N = 60). These could include cases where the death occurred earlier (See Table 2 below) but were closed in 2015. We also examined the list of all DIC and DIPO cases identified in the University of Queensland Deaths in Custody Project and the list of cases by year identified by the QPS (see Table 1).

Step 2: An audit across all sources was undertaken to examine the reasons for variation in reporting across the different data sources. Following the audit, we identified a range of reasons for the inconsistent lists of closed cases. These reasons included:

- Online and website searches only revealed cases where findings were publicly available. We also note that some inquest findings can be selected to remain out of the public domain by direction of the Coroner.
- NCIS and CCMS data inconsistencies related to data entry gaps in coding upon entry as well as listing of cases that actually fell outside of our specific scope (N = 12).
- Circumstances surrounding the cases meant inclusion on some of the lists provided to our team yet on further examination they were deemed not within our scope. Two cases that were ultimately excluded from our review included one case that was not classified as a police-related death by the State Coroner although originally classified as one. In the other case, the death occurred in NSW and then the person was transported to the Gold Coast Hospital. This case was subsequently overseen by the NSW Coroner.
- One case was identified as a closed case but upon inspection it remained open.
- In two cases, data were unable to be provided in time for inclusion in analyses[3] so these two additional cases were also excluded from the dataset.

Step 3: The closed/finalised case dataset was eventually established with an N of 43 cases (see Table 2 below). All of the files for these 43 cases were provided by the Coroners Court (1St-15th June 2022). A summary of the cases in our dataset is shown in Table 2. As this table shows, we considered a total of 43 closed DIC (15; 34.9%) and DIPO (28; 65.1%) cases in our review scope with incident dates occurring from 2012-2019, peaking in 2015 (N = 9).

Table 2: Frequency of closed DIC and DIPO cases by incident year

Incident Year	DIC	DIPO	Total N
2012		2	2
2013	3	2	5
2014	5	3	8
2015	1	8	9
2016	1	4	5
2017		4	4
2018	5	2	7
2019		3	3
Total	**15**	**28**	**43**

[3] In the two cases there is a record of the Coroner ordering QPS to conduct a full investigation. However, we found that there was no eventual inquest, the report was never made, and a digital copy was never entered onto the Coroners Court of Queensland's system.

Tables 1 and 2 show some explainable variations in the captured data of incidents of DICs and DIPOs and alignment to closed cases on record from the Coroners files. For instance, 2014 and 2015 have an overall frequency of four and five DIC and DIPO incidents occurring respectively (Table 1), however, closed cases from the same period number eight and nine respectively (Table 2). The total N of deaths occurring in a year will only be in alignment once cases are closed: this will not occur until all cases are closed for deaths occurring during a year, which can take several years – see time lapse calculations in Coroner Report Analysis. Inconsistencies also occur when the initial record of the incident is coded as a DIC, which later the Coroner may classify as a DIPO.

Coroner Report Analysis

The Review Team undertook a comprehensive coding exercise and analysis of all Coroner's findings into closed DIC and DIPO during the reference time period that included all 43 closed cases from January 2015 to April 2022. This included a range of cases with an incident date from 11th April 2012 to 11th December 2019 (see DIC and DIPO Cases Within Scope). The purpose of this data collection was to identify the age, gender, race, location, circumstances as well as Coronial views about the post incident investigative process. We note that it was out of the scope of our review to examine Coronial views on operational police actions during the course of the DIC or DIPO incident. Rather, our review was limited to an examination of the post incident DIC and DIPO investigative processes and mechanisms (see Terms of Reference).

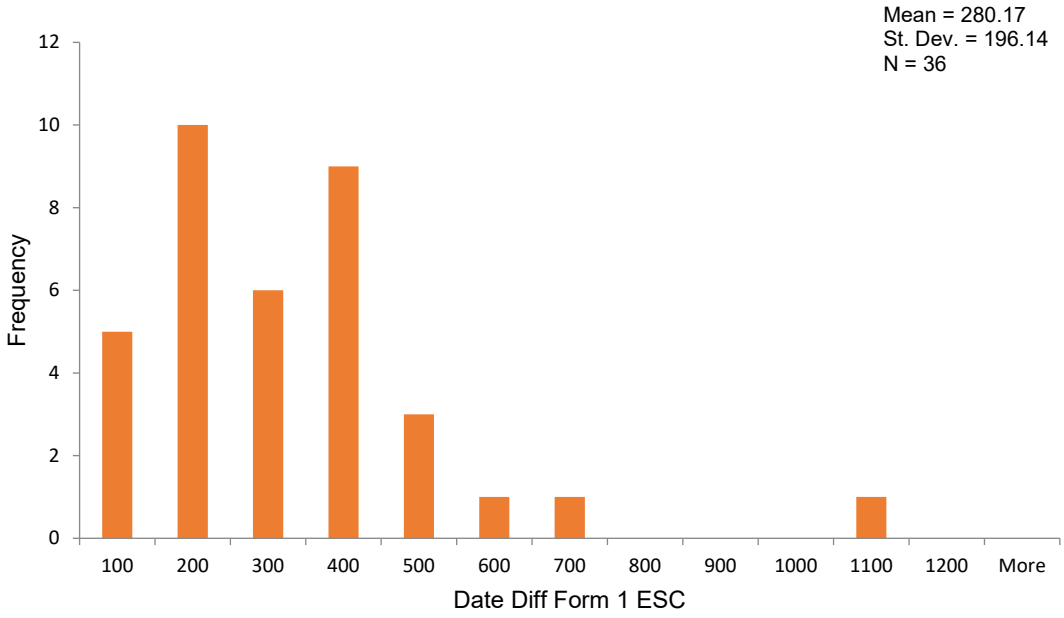
In total, there were 43 closed DIC and DIPO cases that were in our review scope. Of these, 15 were DIC and 28 were DIPO incidents. Over two-thirds (67.4%; N = 29) went to inquest and 14 were non-inquest cases. The 14 cases that did not go to inquest were deemed to have investigations that 'revealed sufficient information to enable' the Coroner to make findings and there did 'not appear to be any prospect of making recommendations that would reduce the likelihood of similar deaths occurring in future or otherwise contributing to public health and safety or the administration of justice' (Form 20A Coroner's findings, 26th April 2017, pp. 2-3). Over 70 percent (N = 31; 72.1%) of all DIC and DIPO cases were dealt with in the Brisbane District, 3 in Townsville, 2 in Cairns, 2 in Maroochydore, one each in 5 other jurisdictions. There was a mean of 3.14 hearing days (range 1-8 days) for the 29 inquest cases. The inquest cases were presided over by State Coroner Terry Ryan in 26 of the cases, Deputy State Coroner John Lock in 2 cases and 1 case by Deputy State Coroner Jane Bentley. The data show that 18 of the total number of police investigations (41.9%) were led by a Detective Sergeant.

Analysis of the DIC and DIPO cases in our scope reveal that 88.4% of the people who died during a police operation or in custody were males (N = 38) and 65.7% (N = 25) of these males died in custody (not during a police operation). The age of the person who died during a DIC or DIPO ranged from 13 years to 72 years, with a mean age of 40.6 years. We also

found that seven (16.3% of all deaths) were Aboriginal people[4]. All seven of these Aboriginal people died during a police operation (DIPO) and not in custody. One of the seven Aboriginal deaths during police operations did not go to inquest. This was a forensic crash incident. The data also show that in nearly 70% of incidents (N = 30), the police had an activated Body Worn Camera (BWC). A BWC was not activated in seven of the incidents and a BWC was not applicable in six of the incidents.

Analyses were undertaken to examine the length of time that it took to close a DIC or DIPO case (see Figure 3). We examined the time lapse from the incident date (as recorded on Form 1) to the ESC report date (also referred to as Supplementary Form 1[5]). Of the 43 cases, the Form 1 in 32 of the closed cases was undated. As such, for our analyses, we adopted the day after the incident as a reasonable estimation of submission for the Form 1 as it is required to be submitted within 24 hours of incident. Similarly, there were seven cases (16.3%) where there was no date on the ESC report submitted. No estimation was included for these reports, they were recorded as missing data and not included in our time-lapse analyses.

Figure 3: Time taken from incident to close a DIC/DIPO case



[4] Form 1 captures the 'culture' of the person who has died. In all seven cases, the person was identified as Aboriginal in Form 1 and/or in the Coroner findings. These cases did not identify any Torres Strait Islander peoples.
[5] If there was no titled ESC Report in files but a Supplementary Form 1, it was taken to be the final ESC Investigative Report. In all but one instance, these were substantial reports that referred to numerous appendices/annexures/exhibits. Analyses were only able to include data provided by the Coroners Court of Queensland. In two cases, the ESC Report was dated by month and year. In these two instances, the middle of the month was selected (15th) as the estimation of the submission date.

As Figure 3 shows, tracking of the dates of submission of Form 1 (notification to Coroner of a death) to submission of the ESC report showed a mean of 280 days (just over 9 months). One of the cases took 1032 days to close (nearly 3 years).

One of the items that we coded from the Coroner's reports was the Coroner's comments about the police DIC or DIPO investigation. We found that the Coroner made particular note that the police investigation into the DIC or DIPO was thorough, comprehensive or very detailed in 25 of the 43 Coroner reports (58.1%). In the other reports the Coroner either made no comment at all about the police investigation after the death (N = 14 reports) or simply noted that the investigation provided 'some detail' in 4 cases. We examined whether the ESC investigating police officer's total length of police service (a proxy for policing experience) had any impact on the Coroner's comments about the quality of the police report. We found that the longer length of police service of an ESC officer, the more likely it was that the Coroner would comment that the report was comprehensive or very detailed. The Coroner also had some very specific insights about DIC and DIPO investigations in the formal reports that are worth noting here. First, whilst ESC investigator reports are very detailed and procedurally thorough, the Coroner has periodically made comments in the coronial reports that the investigations tend to lack a broader contextual perspective on the circumstances of the DIC or DIPO. Second, the Coroner reports make particular commendations to the investigations when there is evidence of exemplary cross agency teamwork. This was particularly the case when the QPS and QAS have co-responded to DIC or DIPO incidents. Third, there were several cases where the coronial inquiry report made specific recommendations for cultural training particularly for DIC and DIPO cases occurring in rural and regional areas. We picked up on these matters again in our stakeholder interviews (see Stakeholder Interview Analyses Pertaining to DIC and DIPO Investigations).

Investigative Capability for DIC and DIPO

One of the requirements of this review was to consider the resourcing impacts of our recommendations. To better understand the personnel resources required to undertake DIC and DIPO investigations we examined data obtained from QPS on the strength, rank and years of service of the sworn officer staff within the ESC from 1st January 2015 to the 30th April 2022[6]. In total, N = 163 unique officers have worked within the ESC during this reference period with a mean length of service in the QPS of 28.1 years and a mean length of time spent in the ESC of 5.2 years. The majority of officers who have served within the ESC during this reference period are male (63.8%) and about half of the officers have served at the Senior Sergeant rank. About one third (N = 57) of the total population of N = 163 officers serving within the ESC during our reference period are designated as investigators who can, at any time, be tasked to investigate a DIC or DIPO. These 57 investigative officers

[6] A number of ESC investigators were in acting positions so were not captured in the ESC investigator data as it drew on level of command in report generation.

had a similar mean length of service in the QPS as all of the ESC officers (28.2 years) and had slightly less years of service (3.4 years) as an investigator within the ESC. Nearly three-quarters of all the investigators that were assigned to DIC and DIPO investigations during this reference period are male (73.7%).

We also took a census snapshot and examined the profile of investigators within the ESC as of 30th April 2022. This analysis shows that there were N = 12 investigators and N = 12 senior investigators for a total of N = 24 investigators available to work on DIC and DIPO investigations as of the census date of 22nd April 2022. The average length of service within the QPS of these 24 investigators is 28.3 years and the mean length of time spent in the ESC is 4.8 years. The majority of the DIPO/DIC available investigative officers in the ESC are male (64.3%) but it appears more females are being appointed into these investigative roles within the ESC in recent years: the average number of female investigators over the entire reference period was 26.3% whereas on our census date of 22nd April 2022, 35.7% of the investigators available for DIC and DIPO investigations were female.

The QPS estimates that, on average, 40% of the ESC investigators' time is spent on DIC/DIPO work and the other 60% is typically dedicated to other ESC investigations (noting variances where sometimes it could be 25% spent on DIC/DIPO and the remainder on other ESC business). We also understand that an ESC DIC/DIPO investigation comprises approximately 6 team members responding at the time of the incident.

From these analyses we offer three insights about the level of sufficient resources required to appropriately conduct DIC and DIPO investigations:

First, the eleven-year average is 10.2 DIC and DIPO incidents for which investigations are undertaken per year[7]. We note that 36.6% of these (N = 41) occurred in just two years (2020 and 2021) prior to this review. Taking into account the steady increasing numbers of DIC and DIPO in recent years, we used the average for the five years 2017 to 2021 (inclusive) to estimate that a DIC/DIPO investigating team would work on about 14.8 deaths DIC/DIPO per year. We estimate that currently 24 ESC investigators are working on about 1.2 DIC/DIPO per month. If 6 officers are allocated per DIC/DIPO, it is reasonable to estimate that 4 teams of 6 investigators (interchangeable personnel) work on about 3.7 DIC/DIPO per year.

Second, based on our examination of ESC investigation officer salaries (taking the mean of the range of rank-based salaries that includes the detective loading) that match the profiles of the ESC investigators), we find that $3,347,979 is spent each year on salaries on ESC investigators. If we assume that 40% of these salaries represents the amount of time dedicated to DIC and DIPO investigations, we estimate that there is about a $1,339,192

[7] The investigator data spanned the period from January 2015 through to April 2022. In the Coroner's files, three closed cases relate to ESC investigations that occurred during 2012 and 2013. These three investigations are therefore not included in our averaging of the N of investigations per year for the period 2015 to April 2022.

spend per year on police officer salaries investigating DIC and DIPO. This does not account for a range of other resourcing issues including office expenses, vehicle and travel, training as well as access to the myriad of investigation resources such as forensic analysis. Taking account of these other (and significant) resourcing matters goes well beyond the scope of this review.

Third, an investigative unit working on DIC and DIPO investigations would need to draw from a pool of at least 9-10 highly experienced, sworn police officers to conduct an average of 14.8 investigations per year, working in teams of 6 investigators and taking into account leave arrangements and rosters. Gender and race/ethnicity balance should be a consideration. Investigative experience is also clearly of great importance particularly given that the average length of service within policing for the ESC investigators is over 28 years of police service. This level of investigative expertise cannot be gained easily or quickly and is therefore a major factor in considering the staffing of an investigative DIC/DIPO team.

Stakeholder Interview Analyses Pertaining to DIC and DIPO Investigations

The Review Team undertook a total of 18 in-depth interviews with 19 stakeholders[8] from a range of government, legal and community contexts to explore perceptions and attitudes towards police investigations of DIC and DIPO. The interviews took place either face-to-face or online using Microsoft Teams. All interviews were recorded and transcribed. The Review Team members asked respondents to answer questions about their perceptions about the current investigative arrangements pertaining to deaths in custody/deaths during police operations including what they saw about the strengths and weaknesses of the investigative arrangements. We specifically asked respondents to comment on their views about police investigating police actions and what they saw about the strengths and weaknesses of the oversight and monitoring of current investigative arrangements. We asked questions about what respondents thought about community views about the current investigative arrangements, particularly across First Nations communities as well as what victim's families think about the current investigative arrangements. We focused a lot of attention in the interviews on issues of public trust in the investigative and oversight processes, asking the stakeholder views on trust in the independence, thoroughness and effectiveness of the current investigative approaches. Finally, we asked respondents for their ideas for improving current approaches to DIC and DIPO investigations, oversight and monitoring. We asked what they thought was best practice for undertaking DIC and DIPO investigations, with reference to practices in other jurisdictions.

[8] All respondents interviewed were randomly ordered and then deidentified by assigning each a number from 1-19.

Our analysis of the depth interviews leads us to identify four key themes: public trust and perceived bias; investigative capabilities; family and cultural engagement and communication; and transparent and streamlined processes and coordination. We provide an analysis around each of these themes below.

Public trust and perceived bias

One focus of our interviews was whether the public (particularly families of the deceased) trusted the investigative process of the ESC or the oversight and monitoring functions of the CCC when there had been a DIC or DIPO. The majority of respondents thought that 'police investigating police' did not engender public trust in the process of investigating a DIC and DIPO, despite many acknowledging that police officers (as serving members of the ESC) were best equipped to carry out such investigations. One of the respondents noted:

> For my part … there is always going to be a perception issue where you have police investigating police. … I think people are always going to have a degree of discomfort with the optics of police or former police being involved in investigations of police officers. On the flip side of that police have extensive investigative expertise. There is a deep pool of investigation, talent and resources that's available through the police service. … There's always going to be a degree, I think, of mistrust generally in police and certainly in those circumstances where police are both the people or some of the people involved in the investigation as well as the death. (Respondent 1)

'Police investigating their own actions' results in families deciding that there is a lack of independence (Respondent 2), which is difficult to correct when the investigation not only informs the Commissioner of Police in deciding whether to take any disciplinary action, but also the coroner's office in conducting its inquiry. This is particularly the case in rural and remote areas, where ensuring that investigations are conducted independently becomes even more difficult. Another respondent noted that while the ESC is really an agent of the coroner, they noticed that the ESC investigators align their work as being for the police and coroner at the same time. While prefacing the following comment as not being a criticism of the police, this respondent said that when 'police are investigating police', there's 'a lot of back patting' and comments such as 'I know it is very traumatic for you mate. You did your best. Don't worry about it. Nothing is going to happen to you' (Respondent 3). Having said all that, this respondent did not think that the ESC is biased in their investigations.

One of the main reasons for the lack of trust in ESC investigations and CCC oversight is that the public were not familiar with their different roles or functions. Many of the respondents made mention of the fact that there needed to be better communication about what the two investigative bodies did, how they conducted investigations and how they were limited by law in carrying out their investigations, particularly to families of the deceased. When it comes to the CCC, one of the respondents said that 'it would be better if they were more openly involved somehow or there could be some understanding of how they were reviewing the investigation or overseeing the investigation' (Respondent 2). This is related to our theme of family and cultural engagement and communication, but it is important to note that

respondents were of the view that community perceptions were linked to their knowledge and awareness of ESC and CCC functions and processes, with one of the respondents noting that 'when they [the families] actually see the process and they even get to hear from the coroner … some of them really see that it is quite fair, there are these checks and balances' (Respondent 4). This can be contrasted with another respondent who commented that even when families follow the coronial inquests and become more familiar with the events leading up to the DIC or DIPO, they are 'ropeable' when they realise that police officers are protected from self-incrimination when giving evidence at an inquest (Respondent 5). One of the respondents noted that some families thought that the withholding of information was deliberate rather than understanding that it was part of the investigative process, which did not help with building trust.

Although there are opportunities for the CCC to provide an independent oversight function for the ESC's investigation of a DIC or DIPO, the CCC in fact was noted as possibly having a closer relationship with police and the ESC than with the Coroner's Office. This close working relationship, which is necessary under the current structure, does not assist in alleviating perceptions of bias and distrust amongst family members. Additionally, the CCC's investigative team is made up of a mix of civilian investigators who may have been former police officers from Queensland or other states or countries, and serving police officers, which does not encourage families or other members of the community to view the CCC's oversight function as being independent to that of the police. The CCC's oversight or monitoring of an investigation can also be protracted, particularly when the matter goes before a Coroner, further entrenching perceptions of mistrust when families are left waiting for answers regarding what caused the death of their family member.

The CCC does, however, have an important function by making police officers accountable for conduct that is considered corrupt or falls within the category of misconduct. The CCC can take matters to the Queensland Civil and Administrative Tribunal (QCAT) to seek an order for police officers to be disciplined. In doing so, the CCC will 'stand in the shoes of community expectations' and ask whether it 'just doesn't pass muster' (Respondent 1). One respondent, however, thought that the CCC was a 'toothless tiger' because they often don't prepare reports and the threshold in getting the CCC involved in an investigation is very high (Respondent 6). This issue further compounds suspicion in the community.

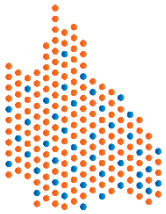
BWC have been a 'God send for the QPS and for investigative processes...and for members of the public' according to one of the respondents (Respondent 7). Others agreed that BWC footage has assisted in ensuring that there is an accurate reporting of events, which improves public confidence in the investigation, but that footage is only available when the body worn camera has been turned on.

Community distrust and perceptions of bias was noted as being particularly relevant for First Nations and Muslim communities by many of the respondents. One suggested it was because of the 'cultural barrier, as well as a language barrier' (Respondent 4). Unless there

is a ‘good liaison or good systems to explain how its [the investigation] is being done’ the ESC or CCC will be ‘on the back foot’ (Respondent 4). For First Nations families and communities, the distrust stems from historical traumas, with one respondent noting that ‘when it comes to Indigenous deaths in custody there will probably always be some suspicion there’ (Respondent 7) and another explaining that First Nations families think that ‘police are covering for police’ (Respondent 6). For Muslim families and communities, however, the distrust relates to a perception that the deceased may have been wrongly associated with terrorist activities by police.

The overwhelming consensus from our interviews was the need for a separate team (independent from the QPS) to carry out the investigations of DIC and DIPO to improve public perception and trust in the investigative process. The CCC was viewed as the best and most cost-effective option for conducting the average of 14.8 DIC and DIPO investigations each year. The CCC taking the lead in these investigations would also align with Queensland’s HRA. As is discussed below, expanding the skill-set and cultural knowledge of the investigative team to also include ‘lawyers, police and First Nations people’ was also considered necessary (Respondent 8).

However, many respondents also stressed the need for those undertaking these investigations to have excellent investigative skills and knowledge of police operational practices and procedures (Respondents 2, 8, 12). A common suggestion from those outside of policing was that the CCC is best placed to lead these investigations, provided that investigative teams were not dominated by seconded police officers (Respondents 2, 5, 8, 15).



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

Family and cultural engagement and communication

Related to the issue of trust and perceptions of bias, is how families of the deceased are kept informed throughout an investigation. A concern that was repeatedly raised by several respondents was that both the ESC and CCC do not regularly nor fully keep families informed of the progress of an investigation. It does, however, depend on each case, with one of the respondents noting that ‘some of them [families] have a lot of contact. I suppose

it's just human nature isn't it, that some relatives, you feel closer to. Some are obviously quite anti police, especially if their loved one has died in custody, or they blame the police for something that's happened' (Respondent 3).

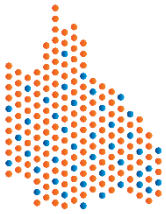
A non-QPS or CCC respondent was cognisant of the fact that investigations took time, and that certain information couldn't be provided to families at particular points in time, but that in their experience,

> no-one really explains to anybody, any client, the process or the interaction between ESC and the coroner, for example, or what the ESC are tasked to do, or that they're looking at whether there's been any failure to follow police procedure which might be a disciplinary investigation. I don't think there's … there's not a good explanation about any of that to the families. … If there was more transparent communication from the outset, that might assist to build trust because people feel like they, people feel like information is being deliberately withheld because they're hiding something, and I can understand why that might be the case, why people might get that impression. From my experience, that's not what ESC are doing at all. But that's certainly the impression that families get, particularly where they feel the police have done the wrong thing, even if the use of force was justifiable. They always think that with police shootings, we commonly get asked by families, 'why couldn't they have shot him in the leg?' for example. (Respondent 2)

Although under the OPM there is a requirement for police to provide the family with updates of an investigation, it doesn't necessarily happen. Most people just want to know that something is happening with the investigation and that 'their loved ones haven't been forgotten and isn't in a pile of crap on someone's desk where nothing is happening' (Respondent 2). The point was made that if an officer is shot or injured while doing their job, there is a wrap-around support system in place for the officer and their family, but that does not happen with the family of a person who dies in police custody or during police operations. The family in that case, may be provided with the contact details of a counselling service, but there is no support offered at the scene for witnesses of the traumatic event or to families and/or witnesses subsequent to the death. One of the respondents thought that a DIPO might lead to a different communication protocol than a DIC, because the DIPO would have resulted from a police pursuit of someone they considered to be an offender, that would then make it difficult, upon that person's death, to regard that person as a victim. This respondent thought that it would put 'officers in a very different mindset for how to deal with the victim's family' (Respondent 1).

Workloads and 'competing interests' may preclude the ESC from discussing an investigation with family members, but it was acknowledged that the ESC 'could be better, there's no doubt about that' and that they could be 'a little more empathetic across the board' (Respondent 7). They have 'really great' investigators, photographers and computer operators' but they are 'trying to wear too many hats' which can often be unhelpful, 'particularly around managing family grief' (Respondent 7). Training, according to this particular respondent, would not make any difference because 'they are not meant for those roles' (Respondent 7).

There is a clear need for liaison people with cultural knowledge to be located within the team that investigates a DIPO or DIC and within the coroner's officer. Currently the role falls with ESC investigators who are busy conducting the investigation and are not necessarily equipped or have the capacity to also undertake a liaison role. 'There should be a person who can help, or people who can help bridge that gap' (Respondent 2) and who have the necessary trauma-informed and culturally safe skill set to support the families of the deceased. Having someone on the independent investigative team who specialised in liaising with First Nations communities 'might go a long way towards solving the problem' (Respondent 6) of how best to support families and communities when there is a DIC or DIPO. It is important to follow First Nations cultural protocols when there is a First Nations DIC or DIPO, which is only possible if people conducting the investigations are aware of what is required to respect those protocols and if they are skilled communicators. One of the respondents noted that 'in Indigenous communities, it really needs to be someone that has a standing within that community, that has an established relationship so that they've got a level of credibility with the people that they're dealing with' (Respondent 9). In the past, when there have been issues with communicating with First Nations family members, it has been because officers haven't 'communicated in a timely manner', meaning they haven't 'got to key people straight away and conveyed the circumstances' (Respondent 9). Most respondents agreed that following cultural protocols would assist in improving perceptions of trust for First Nations family members and the community.



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

Investigative capabilities

The investigative and legislative skills and knowledge needed for undertaking DIC and DIPO investigations was one of the major talking points in our interviews. Most of the respondents were very complimentary about the experience and skills of the current team of police investigators within ESC and made specific comments about the sorts of investigative skills that were required in undertaking DIC and DIPO investigations. Respondent 10, for example, stated that '…the Ethical Standards Command investigations …have been quite good. Most lines of inquiry have been extensively investigated. The particular detectives involved …[more so recently] have been quite exceptional at dealing with – well, doing a thorough investigation of the issues.' Respondent 6 stated that the ESC police had the skills to '…collect evidence to the point that it reaches court standard to sustain a conviction.' Respondent 11 commented that 'investigative expertise takes years to develop [and that]…experiential learning is the biggest base of learning.' Respondent 1 said that '…police have extensive investigative expertise. There is a deep pool of investigation, talent and resources that's available through the police service.' Yet another respondent (7) noted that 'the QPS I think has matured considerably in their service delivery in comparison say to health education, other agency processes. They've got a very strong ethical standards background; they've got good skillsets.'

Respondents were also clear about being careful around any recommendation to shift the responsibility for investigating DIC and DIPO away from police. One respondent said that '…if they're not either attached to something close to the [police] organisation or in the organisation, methods changes, technology changes, legislation changes, and policy changes. So, if you're not in that system… you can't keep up with it' (Respondent 4). Another non- police respondent (3) stated: 'I have seen how non-police departments investigate matters and they're not very good at it. My view is that police are the best investigators. I've worked for investigative bodies, so I think that you run the risk of having a lower quality investigation carried out. Also, I don't know if it's fair to police to have them investigated by people who aren't police, who don't understand police. I mean these are police who have a lot of experience who are in the ESC.' Respondent 7 was concerned about our recommendation to shift the responsibility of DIC and DIPO investigations to the CCC stating that '…the day they started at the CCC…they [the police] become deskilled, because they are losing those core skills that they've adapted over the years.' Another respondent (11) commented that 'in Victoria, police had to wait a minimum of two years before they could serve in the oversight agency.' A rotation of no more than three years for police seconded to the CCC was flagged as the best approach for a model of DIC and DIPO investigations in Queensland[9].

[9] Exploring the appropriateness of the practice of seconding sworn police to be part of the CCC led DIC and DIPO investigative teams is beyond the scope of our review. It is, however, central to the Commission of Inquiry announced on 31st January 2022.

The need for multi-disciplinary teams with a diverse range of skills investigating DIC and DIPO was one of the universal themes across all of our stakeholder interviews. The DIC/DIPO teams were imagined as having a blend of sworn police and non-sworn investigators, lawyers, analysts, people with culturally and linguistically diverse (CALD) skills, counsellors and specialist communications personnel with highly developed family liaison skills, especially with First Nations communities. If the CCC led DIC and DIPO investigations, respondents were clear that the teams needed to include experienced, sworn police. A decision as to whether or not these experienced and sworn police officers are retained by the ESC and partake in the investigations led by the CCC or they are seconded to the CCC is beyond the scope of our review. We note that it is a matter central to the Fitzgerald and Wilson Commission of Inquiry announced on 31st January 2022.

Many of the respondents commented on DIC and DIPO investigations making use of police from other jurisdictions. The rationale was that they were not part of the local police culture and that they would arguably bring a broader lens to the investigation. Respondent 7, for example, noted that team members could be recruited from the United Kingdom, other states or territories in Australia and that analysts could come from both the army and defence. Respondent 12 suggested that more use could be made of Australian Federal Police officers: 'they have significant resources, they're not necessarily tied to the state police and some of those you know relationships that either inhibit or advance aren't there. But there's also a deal of respect I think between the two organisations.' Respondent 6 commented on the New Scotland Yard model where they send people out to do large-scale incidents in other countries.

Respondents were also quick to point out that the role of family liaison, CALD expert and specialist communications expert would not be police officers allocated to those roles. These civilian team members were imagined as additionally recruited personnel to bring a more diverse perspective to the DIC or DIPO investigation. Our respondents were equally making the point that sworn police were critical to the success of a DIC or DIPO investigation and that the depth of investigative skills was highly valued in the DIC and DIPO investigative process. Respondent 8 stated that 'I think a multi-disciplinary team would be the way to go with lawyers and police and First Nations people, ideally.' Respondent 6 highlighted the need for '…communication skills to talk to Indigenous people and build up that relationship and understanding.' Similarly, Respondent 3 said 'we could get people who are trained as counsellors to deal with the next of kin.' The need for flexibility in appointing a DIC or DIPO team is critical to its success. One respondent (4) stated: 'I think formal [liaison] role is incredibly important but the capacity to be agile and flexible and put more to it or take away

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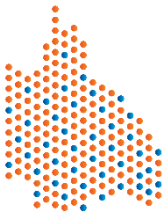
This inquiry is reviewing the CCC's structure in regard to its investigatory and charging functions, and the role of seconded police officers at the CCC. It is chaired by Tony Fitzgerald and retired Supreme Court Judge The Honourable Alan Wilson QC.

from it, or have a community hall as opposed to just a meeting on a side, that is incredibly important.'



Recommendation 3: Provide sufficient resources to the Crime and Corruption Commission to establish and lead multi-disciplinary, multi-skilled teams to investigate deaths in custody and deaths in the course of police operations with specific resources to recruit a First Nations/cultural expert, a cultural safety and trauma-informed communication specialist and non-sworn investigators.

One consistent theme emerging from the interviews was the need for DIC and DIPO investigations to be broad in scope taking account of the social and organisational context of the DIC or DIPO. This would mean that the investigations need to go beyond whether policies and procedures were followed so that they examine what more could have been done socially and organisationally to prevent the incident. One respondent (8) commented that '…the investigators are police officers from the Ethical Standards Command, so that's the lens that they approach the [investigative] task from. They don't tend to rewind and look at…what other factors were at play or what else police might have done in terms of, preventative actions…It [the investigation] tends to be fairly focussed on that final frame.' Establishing multi-skilled, multi-disciplinary investigative teams is one way to broaden the scope of investigations to consider the social and organisational context of a DIC or DIPO incident.

One of the questions we posed to respondents was the resources that were needed to adequately investigate DIPOs and DIC across Queensland. Respondents identified a range of limitations in the current system, including workload and resourcing pressures on the ESC, the Coroner's Office and the CCC with long delays in the process (also see time lapse calculations in Coroner Report Analysis) and limits to how recommendations are fed back to improve processes. Respondent 2 noted that 'some of the delay is definitely caused by that ESC investigation phase, because the coroner relies on the report that the ESC prepare, I guess to inform them about whether further evidence needs to be obtained or what the issues are for the inquest, those things. They do take some time; a year doesn't seem uncommon. And I don't know if that's to do with the resourcing of the unit or what; probably a bit of that. But yeah, there is delays at each stage, I guess. And also, then delays with the coroner's court as well.' Respondent 13 had a similar viewpoint stating: 'I also think the issue about delay is really significant, like that it takes so long for the coroner to look at a particular case.' The workload and stress issues for the ESC investigators is significant. Respondent 11 stated that 'investigators in Ethical Standards Command are going to death after death after death after death.' Another respondent stated:

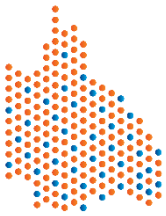
> …a couple of weeks ago we had three critical incidents in 24 hours. A team of five every time - that's 15 staff out, gone. And if they are carrying several of these quite critical, you know they're reporting to the Coroner or a couple of different Coroners on the jobs, you're managing … and this is not unlike any police job, police carry multitude of different files with different complainants, and different family members, and different offenders, and things like that. Every single one of these jobs is high profile, high risk, involves significant media, a thirst for information that must be managed…the family want answers, and there is a high paced tempo that is engaged in the first instance, which is absolutely necessary to gather evidence quickly, to kind of get some situational awareness about what's going on. That is extremely stressful. (Respondent 14)

Servicing the entirety of Queensland with DIC and DIPO investigations is incredibly challenging. The State of Queensland covers 1.85 million square kilometres with many remote regions that take days of travel to reach. Respondent 11 commented that '…the other problem we have here is tyranny of distance in terms of time to get to things. Most of the other jurisdictions aren't a big state like ours with lots of satellite towns and remote locations. Sometimes the length of time to get to some of these places and commence the investigation is delayed, and that's problematic but I don't know how you'd get around because you don't know where an event's going to occur…if I have to get to Thursday Island it's two planes and a boat. A whole day to get there.' Respondent 9 also noted that '…the tyranny of distance plays a big part in what could be done in an urban environment and what can be done in a, if I describe it as an isolated environment.' Another respondent (14) stated that 'we have to organise our air wing flights, or our commercial flights, and get on the ground. But all of that is lost time in terms of your first response, gathering evidence, getting there and doing the investigation.' The challenges of such a large and diverse state is also an issue for thinking about the composition of multi-skilled, multi-disciplinary teams. Respondent 6 commented that 'some of the capability in remote areas is not as good because they're all based out of Brisbane, so if something happens in a region, they've got to get on a plane and get there, so in the first instance they're using officers on the ground to secure evidence, to pull in witnesses, and do that initial getting and preserving the evidence.'

In our review, we considered the option of decentralising the multi-skilled, multi-disciplinary DIC and DIPO investigative teams. We posed this as a potential model to our respondents. For a range of reasons (relatively small numbers of cases per year, unpredictability of the incidents, the need to travel regardless of where a second non-Brisbane based team was located) we have opted to not recommend a decentralisation of the DIC and DIPO investigative function. Rather, it is our view that the composition of the investigative teams should be flexibly staffed, depending on the race, culture, gender and circumstances of the person who has died in a DIC or DIPO situation. The unpredictability of the DIC and DIPO incidents (with the potential for clusters of incidents to occur in close time proximity) will also pose a range of resourcing challenges for rapid deployment of multi-skilled, multi-disciplinary teams.

Overall, if the recommendation is adopted to vest in the CCC the coordination function of DIC and DIPO investigations, then the MOU that underpins the current arrangements will need to be replaced with a new MOU that simultaneously strives to resolve the range of problems

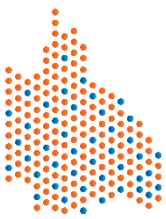
identified in our review, particularly the matter pertaining to staffing the multi-skilled, multi-disciplinary teams and resolving the delays in finalising matters.



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

a) principles for cooperation between the parties with the Crime and Corruption Commission taking over from Ethical Standards Command the responsibility to lead and coordinate investigations into police-related deaths.
b) that the Crime and Corruption Commission is to be notified of any police-related death as soon as Ethical Standards Command becomes aware of it, and that the Crime and Corruption Commission then assumes responsibility to coordinate attendance at the scene in consultation with the Coroner and Ethical Standards Command.
c) that Crime and Corruption Commission investigative reports are to be submitted to the Coroner within 6 months, and coronial inquiries (if held) are to be completed within a further 6 months, except in exceptional circumstances.

The respondents also identified some low hanging fruit that could help ease coronial workloads, delays in finalising matters and the tyranny of distance issue. One option is to allow all of the coroners across the State to deal with DIC and DIPOs. Currently, it is only the State Coroner or the Deputy State Coroner who is authorised to undertake the DIC and DIPO matters.



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

Transparent and streamlined processes and coordination

We asked respondents to describe their perception of the various roles of ESC, the CCC and the Coroner, and how investigations into DIC and DIPOs occur in practice. Respondents demonstrated a good understanding of the roles of ESC and Coroner, but much less clarity about how the CCC performs its oversight role. In relation to ESC and the Coroner, one QPS respondent described the process as a 'well-oiled machine' (Respondent 11) in that everyone knew what they were doing, and in general, as already noted, most respondents were satisfied with the standard of ESC investigations.

Respondents generally characterised the CCC role as 'oversight' but had varying degrees of insight into how this role was performed. One respondent commented about incident site investigations where 'the CCC… attend and overview. Their role is pretty unclear' (Respondent 8). Another respondent said that despite involvement in several DIC or DIPO involving potential serious police misconduct 'I saw no evidence of any CCC involvement whatsoever' (Respondent 3). Another respondent, involved in many DIC and DIPO, said 'they say the CCC oversees these investigations. I've never seen any evidence of that occurring. I hope it's happening behind the scenes… from the family's perspective, it would be better if they were more openly involved' (Respondent 2).

Respondents from both QPS and CCC described how ESC notifies any potential DIC or DIPO to the CCC assessments area. This leads to a conversation between a senior CCC officer and the ESC that leads to a decision as to whether or not to send CCC investigators to the site. That decision might be influenced by factors including the recency of police contact for DIPO. A CCC team would always attend a DIC but more judgement might be exercised for DIPO, with decisions often 'erring on the side of caution' and sending a team (Respondent 7). To our respondents' knowledge there are no formal CCC criteria guiding decisions on this, with judgements instead made based on experience and any advice from the Coroner (Respondent 7). Contact between CCC teams and coroners was characterised as occasional rather than systematised (Respondent 8). CCC investigative teams comprise a mix of seconded QPS investigators (typically on a 3 to 5 year secondment), and non-sworn investigators mostly comprising former police from Queensland and other national and international jurisdictions, with some members with legal, intelligence, or other investigations backgrounds (Respondents 1, 7).

CCC respondents said that from their perspective, their role was clear and was to 'ensure that ESC attends an incident and reports to the CCC … our role is to send out, depending on the type of incident, investigators or staff to make sure that the investigation is firstly appropriate, … and that ESC are managing the crime scene appropriately, dealing with witnesses appropriately' (Respondent 7). The CCC presence at the scene would involve 'trying to stay out of the way, but also being present to watch some of the interviews, being able to view the body worn footage, look at in-car footage, neighbour's footage' (Respondent 7). After that initial response, if the CCC team see no evidence of misconduct or corrupt

conduct ‘the matter is put on bring up and we’ll monitor the progress of that investigation which is usually asking for an update from ESC’ (Respondent 7).

From the perspective of other participants, this process was described as ‘hands off’ with the CCC ‘really just observers… I don’t know how often they even review the reports that the ESC prepares for the coroner’ (Respondent 8). Another commented on this point ‘the CCC will push it back [to ESC] (Respondent 12) with another agreeing ‘it often goes back to ESC’ (Respondent 5).

However, one respondent described a process of systemic monitoring by the CCC as occurring, including the undertaking of public interest reviews, merit and compliance reviews, and audits aimed at strengthening internal processes (Respondent 1). The same respondent pointed to the principle of devolution enshrined in the *Crime and Corruption Act*, which requires that where an agency has capability and capacity to conduct its own investigations, the CCC should refer matters back to the agency. They noted ‘QPS has a well-established and increasingly professional ethical standards command that are experienced in investigating these sorts of matters’ (Respondent 1). However, this monitoring is not made public, and it is not clear how extensive it is in relation to DIC and DIPOs as opposed to misconduct and corruption investigations more generally.

The lack of clarity around the role of the CCC, coupled with the paucity of publicly available information around the DIC and DIPO investigation processes generally, led many respondents to call for greater transparency and role clarity. This was seen as bringing benefits especially for families and communities affected by DIC and DIPOs.

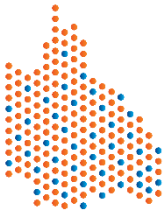
On role clarity, one respondent said ‘ESC investigators are performing two functions. They’re investigating for the Commissioner of Police in terms of the disciplinary process, and they’re also investigating for the State Coroner’ (Respondent 2). But the respondent commented in relation to families ‘no one really explains… the process or the interaction between ESC and the Coroner… or what the ESC are tasked to do…. If there was more transparent communication from the outset, that might assist in building trust’ (Respondent 2). Another respondent said this ‘has to be done impartially by a body that is seen to be independent and it should be the CCC’ (Respondent 15).

Several respondents also referred to the HRA and its possible implications for responses to DICs and DIPOs. Any move to strengthen independence of the investigative function will assist in protecting the rights to due process and fairness. Similarly, cultural rights will be addressed by ensuring information and support is made available in culturally appropriate ways especially to First Nations peoples.

Most respondents who were not from either the QPS or CCC generally considered that, for reasons of transparency and public confidence, the primary investigation of DIC and DIPO should move from ESC to the CCC. In addition, there was a call for more publicly available information about the process for families, and more regular communication through to the

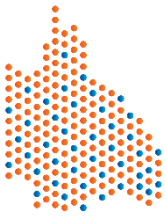
point of inquest. By contrast, QPS and CCC respondents conceded that there was a perception that the process involved the police investigating police, but thought that ESC had the skills, experience and resources to undertake this task. Thus, any shift in the responsibility for investigations needs to also consider shifting resources and expanding them to include improved public information and family liaison capabilities.

Several respondents noted that currently there is a lack of systemic overview of DIC and DIPO to identify causal factors, possible preventive actions and overall trends (Respondents 2, 8, 15). While inquests can perform this function to some extent in relation to factors relevant to the particular death, no mechanism exists for ongoing follow up on what action has been taken to implement that reform. For other types of death, this system review function is performed by specialist boards, including the Domestic and Family Violence Review and Advisory Board, and the Child Death Review Board. These boards are limited to systemic issues rather than individual investigations, and report annually on trends in deaths, government actions and responses, and the status of coronial and prior board recommendations. Boards can therefore provide a degree of insight and transparency, while not interfering with specialised investigative functions. By including expert and community representation, including from First Nations and other marginalised peoples, Boards can also provide a conduit for information and improved understanding and help build public confidence. They require only modest resourcing to support a small secretariat and to appropriately remunerate members.



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

a) have purposes including: to build public trust and confidence in the independence and transparency of investigations of police-related deaths; identify systemic conditions and issues leading to police-related deaths and preventive measures that could reduce the occurrence of such deaths; monitor and review the investigation and coronial processes relating to such deaths including their timeliness and appropriateness; review the extent of implementation of coronial recommendations relating to such deaths particularly those related to the functions of the Crime and Corruption Commission, Queensland Police Service and Coroner's office; and make recommendations to the relevant Minister/s for implementation to prevent and reduce the likelihood of police-related deaths.
b) prepare an annual report which is made public and which reviews system issues including trends in police-related deaths, recommendations made and whether they have been implemented, and other relevant matters, but the Board should not have any function to investigate individual deaths.
c) be co-chaired by the Coroner and a prominent First Nations person and also include community expert representation.



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

Another relevant theme that emerged through the interviews relates to the better use of technology in DIC and DIPO investigations. Several respondents commented on the role already played by BWCs. This has primarily arisen in providing clear evidence for investigators on the events immediately preceding the death, with several respondents noting that making this footage available to families and their advisors at an early stage can help in clarifying what happened (Respondents 4, 7, 9, 12). However, video technology could also conceivably be used in other ways, including monitoring remote crime scenes prior to an investigations team arriving, which can involve significant delays. Live streaming of incident

sites could be used to aid immediate decision-making about the nature of the incident and what level of response is required, as noted by one QPS respondent (Respondent 9). Others noted that while all general duties QPS officers are now equipped with BWCs, investigators generally don't have them at least partly because they are not issued with standard equipment vests (Respondent 7). The QPS could investigate whether in these cases QLites, mobile phones or other devices could be used as a substitute to record the immediate investigative response. This would aid decision-making but in appropriate cases could again be used to reassure those affected by deaths about the processes of investigation being undertaken.

Analysis of Past Inquiries and Reports Relevant to DIC and DIPO

Reports analysed and method of analysis

Our review examined a number of prior and related reports that were used to explore ways to strengthen DIC and DIPO investigations in Queensland. Searches were conducted using Google and Google Scholar of Australian inquiries into the investigation of deaths in police custody. The references in the relevant reports identified in our search were scanned to identify other relevant inquiry reports that should be included in the analysis.

Knowing that the United Kingdom had recently completed an inquiry into the Independent Police Complaints Commission's processes and procedures, relevant reports regarding that inquiry were included in the analysis. The search uncovered a further international report prepared by the International Committee of the Red Cross, which was considered relevant to the current review. Research on other overseas models used for the investigation of deaths in police custody that were mentioned in the reports, was also conducted. A full list of the reports included in the analysis appears in Table 3.

The reports were analysed using a thematic content analysis, extracting information about the matters that are of most concern regarding an investigation, concerns of the deceased's family, the most important requirements for an investigation to be considered adequate, and different investigative models and agencies.

Table 3: Reports and inquiries related to DIC and DIPO in analysis

Name of Report and (Abbreviated Name)	Author	Year	Jurisdiction
Australian Deaths in Custody Inquiries and Reports			
Royal Commission into Aboriginal Deaths in Custody: National Report (RCIADIC report)	Australian Government, Royal Commission into Aboriginal Deaths in Custody (RCIADIC)	1991	Australia
Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples: Final Report (Pathways to Justice report)	Australian Law Reform Commission	2017	Australian
Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody (Select Committee report)	New South Wales Parliament, Legislative Council	2021	New South Wales
Crime and Misconduct Commission Review of the Queensland Police Service's Palm Island Review (CMC Review of QPS's Palm Island Review report)	Crime and Corruption Commission	2010a	Queensland
Part 2: The Palm Island Death in Custody – Crime and Misconduct Commission Review of the Queensland Police Service's Palm Island Review (CMC Part 2 report)	Crime and Corruption Commission	2010b	Queensland
United Kingdom and Swiss Deaths in Custody Inquiries and Reports			
The Independent Police Complaints Commission Investigations into Cases Involving a Death – Independent Research Report (IPCC report)	NatCen Social Research	2014	United Kingdom
Independent Review of Deaths and Serious Incidents in Police Custody (IRDSIPC report)	Rt Hon Dame Elish Angiolini DBE QC	2017	United Kingdom
Guidelines for Investigating Deaths in Custody (Red Cross report)	International Committee of the Red Cross	2013	Switzerland

Independence and transparency of investigations

Overwhelmingly, consistent with our Stakeholder Interviews, the reports highlighted the need for independence when conducting investigations of DIC or DIPO to minimise or erase any risk of a conflict of interest arising. This was of particular concern, when investigating First Nations deaths in custody. According to the *Select Committee* report several submissions raised this as a concern. For example, the Deadly Connections Community and Justice Services submission noted:

> The lack of independent investigations into deaths in custody undermines outcomes and accountability and confidence in the process. It weakens the independence of coronial and criminal investigations. … In NSW, the prosecution work hand in hand with the police in preparing potential criminal cases. This creates distinct problems when police … are suspects in deaths in custody matters. Aboriginal families and organisations have claimed that the current process amounts to a conflict of interest because it involves 'police investigating police'. It lends itself to processes and outcomes that are biased against First Nations victims. (New South Wales Parliament, Legislative Council, 2021, p. 154)

Adjunct Professor Hugh Dillon's submission claimed that the issue of independence and transparency is the most 'difficult problem to solve' and that the 'current system is not trusted by Indigenous people' (New South Wales Parliament, Legislative Council, 2021, p. 155).

The *Pathways to Justice* report contained similar observations, also noting 'ongoing concerns about police investigating police following a death in custody' (Australian Law Reform Commission, 2017, p. 466). The Human Rights Law Centre submitted that '[r]elations between Aboriginal and Torres Strait Islander people and police could be improved if allegations of police misconduct and deaths in custody were independently investigated' (Australian Law Reform Commission, 2017, p. 465). Even Coronial processes may be considered tainted because police are tasked with the responsibility of preparing the brief of evidence for the Coroner.

All of the inquiries referred back to the *RCIADIC* report which emphasised the need for impartiality when conducting investigations of deaths in custody. Even back then, it was recognised that police officers should not investigate themselves or the actions of other police officers they are close to, otherwise the 'credibility and quality' of such an investigation would be jeopardised (*RCIADIC*, 1991, vol 1, p. 120). The report went on to note that '[i]t is not only a question of justice, but of justice being seen to be done' (*RCIADIC*, 1991, vol 1, p. 120). It was put to the *RCIADIC* that police should not be involved at all in investigating police deaths, but at the time, the *RCIADIC* thought that that would probably be impractical.

There was some indication in the *IPCC* report that several stakeholders did not perceive the United Kingdom Independent Police Complaints Commission (IPCC) as independent because of the following reasons: (1) The IPCC employed former police officers and staff; (2) The IPCC has a similar mindset and culture to the police service; and (3) The IPCC relies on police forces at vital points in its investigations. On the other hand, other stakeholders

thought that the IPCC had not treated police officers fairly and had already determined blamed prior to gathering all the facts. Some of the submissions thought that the IPCC needed to use its powers of arresting officers and to interview officers under caution more assertively. One suggestion was to turn IPCC into a process that was more akin to a judicial inquiry. External stakeholders were concerned about the lack of adequate mechanisms to hold the IPCC to account. Some suggested the development of statutory guidance regarding IPCC's conduct. As in Australia, historically there has been a lack of successful prosecutions in the United Kingdom of police involved in a custodial death, with the *IRDSIPC* report highlighting the need for more coordination and sharing of information between agencies.

The *Red Cross* report notes that at the conclusion of an investigation, the investigation and its findings should be made public for the purposes of transparency and accountability.

Perceived bias on the part of the police

The *Select Committee* report noted that using the term 'treating the death as not suspicious' in media announcements is inappropriate. Using this language encourages a perception that police have already determined the outcome.

Suggestions of racial bias and discrimination were common in the Australian reports focusing on Aboriginal and Torres Strait Islander deaths in custody, but they were also mentioned in the *IRDSIPC* report, which recommended that the IPCC in the United Kingdom should ensure 'that race and discrimination issues are considered as an integral part of its work' and that the IPCC needed to address issues of discrimination 'robustly' (Angiolini, 2017, p. 93). Recommendations also focused on mandatory training for police on the nature of discrimination and race issues. Since the NatCen Social Research review the IPCC has prepared an information pack for families that sets out the investigation and coronial process, it has increased its diversity in the workplace and is recruiting from non-police backgrounds for senior management positions. It has also developed a conflict of interest policy covering issues such as having personal relations with those under investigation or having previously been employed by the police force being investigated. The IRDSIPC further recommended that an expert Deaths and Serious Injuries Unit be developed within the IPCC for the investigation of all deaths in police custody in England and Wales. It noted that the unit should be staffed by senior and expert officers from a non-police background and that '[e]x-police officers should be phased out as lead investigators in the IPCC' (Angiolini, 2017, p. 137). Instead of leading investigations, the report recommended that ex-police officers should only act as consultants and that the IPCC should look beyond England and Wales for expert consultants.

Police notification of the death to families

A recurrent concern – and raised also in our Stakeholder Interviews – was the way families were notified of a death and kept abreast of an investigation of a DIC or DIPO. In New South

Wales there were reports of police being callous, lacking in cultural sensitivity and not providing adequate information to families regarding a DIC/DIPO. In its submission to the New South Wales Select Committee, the Jumbanna Institute recommended that the role of informing the families be given to an Aboriginal Liaison Officer working independently of police and corrective services. These concerns led to the Select Committee making recommendation 23 that there be a review of internal processes regarding the way families are notified of the death with a view to:

- ensuring appropriate notification of death processes are in place
- establishing a single point of contact for families
- establishing clear communication protocols with families, including the provision of counselling and support services up to and including the coronial hearing
- ensuring all staff within facilities receive training in culturally sensitive and trauma informed care, with training prioritised for staff in roles specific to the investigation or oversight of deaths in custody (New South Wales Parliament, Legislative Council, 2021, p. xiii).

The inadequacy of support and notifications of families of deceased is not new, particularly when it concerns Aboriginal and Torres Strait Islander families of a deceased, having been a substantial focus of the RCIADIC inquiry. The *RCIADIC* report noted that '[t]he historical background of Aboriginal police relations has resulted in custodial deaths being regarded with a high degree of suspicion by Aboriginal people, even in cases which are ultimately found to be straightforward deaths by natural causes' (*RCIADIC*, 1991, vol 1, p. 157). The inquiry concluded that this demonstrated a need for openness and frankness when dealing with the family of the deceased. Authorities have tended to be defensive and secretive about a death in custody and family members have been treated as 'trouble-makers' (*RCIADIC*, 1991, vol 1, p. 158). Police hide behind the Coronial investigation in not allowing family members to view the body, the site of the death or access any information. Similar to the New South Wales Select Committee, the *RCIADIC* supported the need for an Aboriginal or Torres Strait Islander person accompanying the police officer (suggesting it could be an Aboriginal Legal Services field officer) when notifying the family of the death. Cultural differences need to be respected when notifying the family and an awareness of differences who is considered next of kin. Access to the body should be provided to the family as soon as possible. Some restrictions may need to be placed on seeing the body so that there is no interference with the investigation into the death, but there should be no blanket refusals to see the body. Relatives should be given access to the site where the death occurred if requested, even if it requires some restrictions as to what can be done when there.

The *RCIADIC* report noted that legal representation for the families at the Coronial Inquest should be provided and covered by Legal Aid. Aboriginal Legal Services might also be an option but at times, the Aboriginal Legal Service may have conflicts of interests. Which legal service is most appropriate, should be decided by each community. Counselling support by

Aboriginal Health Services or another appropriate body should also be made available to the families. Two relevant recommendations made by the *RCIADIC* in relation to this issue are:

> Recommendation 19 - That immediate notification of death of an Aboriginal person be given to the family of the deceased and, if others were nominated by the deceased as persons to be contacted in the event of emergency, to such persons so nominated. Notification should be the responsibility of the custodial institution in which the death occurred; notification, wherever possible, should be made in person, preferably by an Aboriginal person known to those being so notified. At all times notification should be given in a sensitive manner respecting the culture and interests of the persons being notified and the entitlement of such persons to full and frank reporting of such circumstances of the death as are known. (*RCIADIC*, 1991, vol 1, p. 174)
>
> Recommendation 20 - That the appropriate Aboriginal Legal Service be notified immediately of any Aboriginal death in custody. (*RCIADIC*, 1991, vol 1, p. 174)

The *IPCC* report prepared by the NatCen Social Research found that external engagement and communication was lacking, with both family members and police pointing to the need for timely, useful and regular communication. Family members of the deceased who were interviewed for the research did not feel supported or kept informed in a timely manner. They thought that the family liaison unit was not as well-resourced as the rest of IPCC. It was acknowledged that legal restrictions could place limitations on the IPCC's ability to communicate to the public.

The 2017 *IRDSIPC* report also considered the issue of support for families of the deceased and acknowledged that police needed to be careful about what they say to the media, that there was a need for communication training and that families should be involved in that training, and that financial support should be provided to families so that they could attend inquests and access appropriate bereavement services. The IRDSIPC report recommended that families should be referred to an independent legal specialist immediately being told about the death of a loved one.

Similar recommendations, reflecting the information presented above, appear in the guidelines prepared by the International Committee of the Red Cross. The guidelines require next of kin being notified immediately of the death once the body has been identified, the authority conducting the investigation regularly reporting to the next of kin, counselling services and legal representation being provided to families of the deceased, and involvement of the families in the investigation process.

Ensuring the investigation is adequate

The New South Wales *Select Committee* report noted that the location of the death needs to be treated as a crime scene to improve confidence in the investigation. This was, indeed, a crucial recommendation of the *RCIADIC*:

> Recommendation 35 - That police standing orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be

determined, it is the view of the Commission that such directions should require, inter alia, that:

a. Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed;

b. All investigations should extend beyond an inquiry into whether death occurred as a result of criminal behaviour and should include inquiry into the lawfulness of the custody and the general care, treatment and supervision of the deceased prior to death;

c. The investigations into deaths in police watch-houses should include full inquiry into the circumstances leading to incarceration, including the circumstances of arrest or apprehension and the deceased's activities beforehand;

d. In the course of inquiry into the general care, treatment or supervision of the deceased prior to death particular attention should be given to whether custodial officers observed all relevant policies and instructions relating to the care, treatment and supervision of the deceased; and

e. The scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography. (*RCIADIC*, 1991, vol 1, p. 178)

The *RCIADIC* made it clear that

> [i]nvestigations should extend beyond consideration of whether death occurred as a result of criminal behaviour. The general care, treatment and supervision of the deceased prior to death should be inquired into with particular attention to whether custodial officers observed all relevant departmental policies and instructions relating to the duty of care owed to the deceased while in custody. Any comprehensive investigation of the events leading to death should also consider the circumstances under which the deceased was taken into custody and the legality of his/her detention. (*RCIADIC*, 1991, vol 1, p. 116)

Changes to the police OPM occurred because of the *RCIADIC* recommendations and subsequent to the review of the Palm Island death in custody. Notably the OPM was amended to include a provision stating that 'investigating officers should treat a death in custody as a homicide until otherwise determined' (Crime and Misconduct Commission, 2010a, p. 176). The CMC, at the time, emphasised the need for accountability and transparency in investigations and the importance of following OPM processes and procedures particularly in relation to perceived or actual conflicts of interest.

The CMC Review of the Queensland Police Service's (QPS's) *Palm Island Review* report found that troubling activities in the investigation of the Palm Island death in custody in 2004 included: the appointment of investigators who were friends with the officer in charge of the watch-house at the time, Senior Sargent Hurley (Hurley); that Hurley picked up investigators from the airport and drove them to the scene of the arrest and other locations (but did not do the same with the police liaison officer); that the investigators had dinner at Hurley's place; discussions took place between officers prior to the investigating team arriving on Palm Island; the fact that there were many 'off the record' discussions; the police liaison officer's evidence was insufficiently probed and not added to Form 1; there was a lack of support for First Nations witnesses which affected communication during questioning; the deceased's

family was not immediately notified of the death and were sent away from the police station by Hurley; and there were questions regarding the forensic and investigating processes. After conducting its review, the CMC concluded that the Investigation Review Team's investigation process was 'seriously flawed' and that their integrity was ‘gravely compromised’ (Crime and Misconduct Commission, 2010a, p. 164). As a result of the *Palm Island Review*, the CMC recommended disciplinary proceedings for misconduct against four of the investigating officers and against members of the Investigation Review Team, and that the QPS initiate management action in relation to their performance.

In relation to who should be selected to conduct investigations, the *RCIADIC* made the following recommendations:

> Recommendation 32 - That the selection of the officer in charge of the police investigation into a death in custody be made by an officer of Chief Commissioner, Deputy Commissioner or Assistant Commissioner rank. (*RCIADIC*, 1991, vol 1, p. 177)
>
> Recommendation 33 - That all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and in every respect should be as independent as possible from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death. (*RCIADIC*, 1991, vol 1, p. 177)
>
> Recommendation 34 - That police investigations be conducted by officers who are highly qualified as investigators, for instance, by experience in the Criminal Investigation Branch. Such officers should be responsible to one, identified, senior officer. (*RCIADIC*, 1991, vol 1, p. 178)

The *IPCC* report recommended that policies are needed regarding timeframes for attending incident sites and for conducting investigations. Police forces need to protect the scene of a death and be held accountable (as a form of misconduct) if they don't. There was a perception that some staff lacked the necessary investigative skills (such as interviewing skills, forensic investigation skills, search procedure and arrest knowledge). More training and support were needed generally by staff and there was also a lack of clear structure, procedures and guidelines within the organisation.

Reflecting many of the points made above, the Red Cross report lists the following two factors as important aspects of an investigation: 1. Clarification of the circumstances of the death (was it natural, accidental, suicide or homicide; and 2. Ensure that there is a thorough, prompt and impartial investigation. A preliminary investigation should take place immediately by the head of the custodial facility and then a brief handed over to an authorised officer. The guidelines recommend that if the death was due to homicide or negligence a judicial investigation is required, but if the death is due to natural or accidental causes then a non-judicial investigation may be sufficient. Like other reports, the guidelines also emphasise the need for the site of the death to be treated as a crime site regardless of the manner and cause of death until the investigation of the scene is complete. A medical officer should be involved at the start to confirm the death and check for evidence of violence.

Alternative models

RCIADIC Report

The *RCIADIC* report proposed the following investigative models:

1. Maintaining the authority of police to do the investigation provided the investigator is independent and comes from a different area.
2. Using civilian investigators (however, there was no mention of what expertise would be required).
3. Using police officers seconded to the coroner's office. The police officers would be under the direct supervision and instruction of the coroner.
4. Combining the expertise of the coroner's office and police (either civilian investigators or seconded police officers) so that police do the initial investigation with the coroner looking at the wider issues.

The preference was for options 1 and 3 (see *RCIADIC*, 1991, vol 1, p. 121). A coroner should be appointed straight away who takes on full responsibility for the investigation, including the power to direct police investigations and to define the scope of the investigation. A solicitor or barrister should also be appointed as soon as possible to assist the coroner. The report noted:

> While police investigators may not immediately welcome such supervision, … in time, its advantages will be appreciated. The removal of ultimate responsibility for the adequacy of investigations will also remove the prospect of allegations of bias. The broader scope of investigations designed to examine the duty of care owed by custodial authorities and to identify systemic failures are matters in which the advice of a legal practitioner will assist police and enhance the quality of their inquiries. (*RCIADIC*, 1991, vol 1, p. 121)

New South Wales Select Committee Report

Currently in New South Wales there is a Critical incidents Unit within police that conducts the investigation. The Senior Coroner and the Law Enforcement and Conduct Commission (LECC) can monitor the conduct of the Critical Incident Unit investigation. The LECC will only get involved if there is suspected misconduct, but in doing so, they cannot control, supervise, direct or interfere with an investigation. The police also act on behalf of the Coroner, who gives them directions regarding what investigations need to be conducted for the Coronial Inquest, and they inform the family of the deceased and Aboriginal Legal Services of the death.

Some of the submissions referred to in the report suggested that the Independent Commission Against Corruption (ICAC) be given an oversight function, particularly in relation to evaluating and addressing systemic racism within the police force. It was suggested that ICAC should consider police deaths in custody of First Nations people using a ‘holistic

systems' approach (New South Wales Parliament, Legislative Council, 2021, p. 158). An observation was made that there is a lack of First Nations staff involved in oversight processes, including in the Coroner's Office.

The New South Wales *Select Committee* report listed five proposals for moving forward:

1. Expanding the role of the New South Wales Ombudsman (p. 162 of the report).
2. Enhancing the role of the Coroner's Court (p. 165 of the report).
3. Expanding the role of the LECC – but issues of independence and power over agencies were raised.
4. Appointing a First Nations Commission to monitor and protect rights of First Nations people and to oversee police complaints and deaths in custody of First Nations people (p. 172 of the report).
5. Establish a new independent oversight body that is First Nations led and that has appropriate powers to investigate First Nations deaths in custody. This body needs to be completely separate to New South Wales Police (p. 174).

Ultimately, the preference was to rely on existing resources and bodies rather than adopting something like option 5. The report recommended (recommendation 35) that the LECC be expanded to undertake full investigations with appropriate resourcing and support. In the end, this was not supported by the New South Wales government because it considered inconsistent with the LECC's current role. Recommendation 36 highlighted the need for a senior statutory First Nations position to be created to undertake engagement across the LECC and review policies and case work to make sure that they were culturally safe. Again, this was not supported by the New South Wales government. Recommendation 37 called for the implementation of a program to actively employ a greater number of First Nations staff across all areas of the criminal justice system. The NSW government supported this recommendation and Recommendation 38 (in principle) which called for the appointment of significantly more suitably experienced and qualified First Nations people to the judiciary.

Pathways to Justice Report

The *Pathways to Justice* report pointed to several international models:

1. Independent Police Conduct Authority (New Zealand) – This body has statutory independence from police, is led by a District Court judge and has a team of independent investigators. This body investigates deaths caused by a police officer if it is in the public interest. For further information see https://www.ipca.govt.nz/Site/about-us/What-we-do.aspx
2. IPCC (England and Wales) – The IPCC (now called the Independent Office for Police Conduct (IOPC)) is an independent body that deals with appeals regarding complaints against police, and also decides how all deaths and serious injuries,

whether someone has made a complaint or not, should be investigated. IPCC commissioners (now the Director General of the IOPC) are precluded from having worked for the police. There are four modes of investigating cases involving a death in custody in England and Wales: independent, managed, supervised and local. Independent investigations (involving the most serious cases) are carried out by IPCC investigators and an IPCC Commissioner oversees the investigation. Managed and supervised cases are carried out by the police with the IPCC giving some direction and oversight. Local investigations are carried out by the police with no IPCC oversight. The focus of the *IPCC* report was primarily on independent investigations and an independent research body (NatCen Social Research) was engaged to conduct research into the views and experiences of bereaved families, IPCC staff and Commissioners, police officers and other external stakeholders. At the time of the *IPCC* report, the IPCC had five offices covering England and Wales which left gaps in geographical coverage. For further information regarding the new body, IOPC, see https://policeconduct.gov.uk/

3. Police Ombudsman (Northern Ireland) – This body investigates complaints against police and is financially and institutionally independent of police. It can recommend prosecutions to the Director of Public Prosecutions. It claims it is the 'first fully funded and completely independent police complaints organisation in the world' (https://www.policeombudsman.org/About-Us/History-of-the-Office). Investigators include people from Customs and Excise, Department of Health and Social Security, lawyers and former police.
4. Garda Siochána Ombudsman Commission (GSOC) (Republic of Ireland) – This body investigates deaths where the conduct of police may have caused the death or serious harm. For further information see https://www.gardaombudsman.ie/
5. Special Investigations Unit (Ontario, Canada) – Former police officers are employed in this unit but they cannot investigate former police forces with which they were previously involved. They are an independent civilian agency that can investigate and charge police with a criminal offence. It was established in 1990 due to a crisis in public confidence 'in a system in which the police policed themselves'. The unit 'remains today at the forefront of civilian oversight of the police in Canada and around the world amid an international movement toward greater civilian accountability of police' (https://www.siu.on.ca/en/index.php).

Recommendations Related to Investigative Mechanisms for Deaths in Custody and in the Course of Police Operations

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

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

3. Provide sufficient resources to the Crime and Corruption Commission to establish and lead multi-disciplinary, multi-skilled teams to investigate deaths in custody and deaths in the course of police operations with specific resources to recruit a First Nations/cultural expert, a cultural safety and trauma-informed communication specialist and non-sworn investigators.

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

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

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

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

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

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

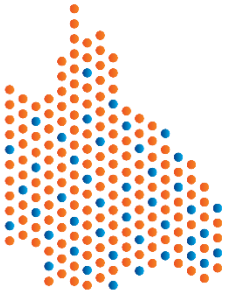
    a) have purposes including: to build public trust and confidence in the independence and transparency of investigations of police-related deaths; identify systemic conditions and issues leading to police-related deaths and preventive measures that could reduce the occurrence of such deaths; monitor and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

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

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

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

PART B: DOMESTIC AND FAMILY VIOLENCE (DFV) DEATHS WITH PRIOR POLICE CONTACT



Legislative and Policy Framework for Investigating DFV Deaths

Domestic and family violence is defined in section 6 of the *Domestic and Family Violence Protection Act 2012* (Qld) to include behaviour by one person towards another that is physically, sexually, emotionally, psychologically or economically abusive, threatening, controlling or in other ways causes that person to fear for their safety, wellbeing or that of someone else.

Domestic and family violence deaths are defined in section 91B of the *Coroners Act* as including homicides and suicides of people who have been in a relevant relationship that involved domestic and family violence. A relevant relationship is defined in the *Domestic and Family Violence Protection Act* as an intimate personal, family or informal care relationship. DDFV deaths can be of victims or perpetrators of DFV, bystanders (such as people who attempt to intervene in incidents, or new partners), or children in relationships affected by DFV.

Primary responsibility for investigating DFV deaths rests with police. The initial response at the site of the death is likely to involve first response units comprising general duties officers responding to a call for service. Investigators will be called in to collect evidence relating to the death, and generally they will be district homicide investigators working within the Criminal Investigation Branch. Depending on the history of prior police involvement there may also be participation by a Vulnerable Persons Unit which has a specific brief to respond to DFV matters. First responders and VPU members are usually local district resources across the State. Very recently the QPS has established a new DFV command, a description of which is given in the section Notification and Investigative Processes for Investigating DFV Homicides.

The *Coroners Act* requires the coroner to investigate all reportable deaths, including those that are violent or unnatural, which includes domestic and family violence deaths. For DFV deaths the coroner may determine to hold an inquest or may be directed to do so by the Attorney General or courts. In any event, the coronial investigation is assisted by QPS in conducting the investigation and preparing a report, with that role likely performed by homicide investigators. The process is also coordinated via the Coronial Support Unit within the coroner's office and led and staffed by a QPS Detective Inspector.

The *Domestic and Family Violence Death Review Unit* was created in 2011 and established within the Coroner's Office. It exists as an administrative unit with a role to assist coroners by providing information about the broader context in which DFV deaths occurred, and to assist in identifying systemic issues and shortcomings. The unit can review both open and closed cases, and it maintains a database of all DFV deaths in Queensland since 2006, to help in monitoring patterns or trends.

Following on from the 2013 Child Protection Commission of Inquiry and the 2015 Special Taskforce on Domestic and Family Violence Final Report, the unit received extra resources to support coronial investigations into child deaths where there has been prior child protection system contact, and to support the *Domestic and Family Violence Death Review and Advisory Board* established in 2016. This Board is established under Part 4A of the *Coroners Act*. It is responsible for the systemic review of DFV deaths including analysis of data to identify patterns, trends and risk factors; compile systemic reports including identifying key learnings and elements of good practice in prevention; and make recommendations for improvements to legislation, policies, practices, and services, among others. The Board also monitors the implementation of its recommendations. The Board is limited to reviewing systemic issues, rather than investigating individual deaths, and in doing this relies on coronial investigations. Board processes run independently of coronial inquiries.

At the current time, both the ESC and CCC have only limited roles in relation to the investigation of DFV deaths. This relates to their function to investigate potential police corruption or misconduct.

In summary, police are responsible for investigating crimes leading to DFV deaths. The Coroner, assisted by QPS investigators and the QPS Coronial Support Unit, is responsible for establishing the circumstances and causes of DFV deaths. The DFV review unit and board take a system approach to identifying patterns, trends and potential improvements. Both ESC and CCC become involved only when there is potential police misconduct (e.g., non-compliance with operational procedures) or corruption (dishonesty or discrimination).

Notification and Investigative Processes for Investigating DFV Homicides

Our review team sought to build a comprehensive understanding of the processes of notification and investigation of DFV homicides both with and without prior police involvement. During April 2022 a series of consultations occurred to map the current notification and investigative processes for deaths related to DFV. Figure 4 provides a graphic representation of these processes.

As Figure 4 shows, upon notification and confirmation of a domestic-violence death, the district's Criminal Investigation Branch (CIB) commences an investigation into the homicide in line with normal homicide investigations unrelated to DFV. The lead coordinating

investigator works closely with a team comprised of officers who form interview teams and a member is assigned as the Family Liaison Officer. The Family Liaison Officer will not be directly involved in the investigation with their role to demystify the investigative process and provide a link to the Coronial Support Unit should support or other agency services be needed by the family. This liaison is viewed as a critical role for supporting the family during this process.

The lead investigator oversees the investigation and team and is responsible for coordinating communications with key stakeholders throughout the investigation including:

- Briefing up the chain of command.
- Notifying the State Coroner of a DFV related death.
- Advising the Domestic, Family Violence & Vulnerable Persons Unit (DFV&VPU) by phone or email.
- Advising the Police Union by phone who provide support and advice to the police officers involved.

For both DFV deaths with and without prior police contact, the CIB investigates deaths on behalf of the Coroner[10] and they communicate directly with the Coroner's office through the Liaison Inspector who sits within the Coronial Support Unit. The State Coroner's direction formalises the investigation parameters (targeted or full investigation) and specifies if the DFV death should be investigated as death fitting with ESC should it involve the death occurring during the course of a police operation (DIPO) or in custody (DIC) or whether it should remain as a homicide investigation. The formal mechanisms for notifying and updating the State Coroner on the initial death and subsequent investigation is:

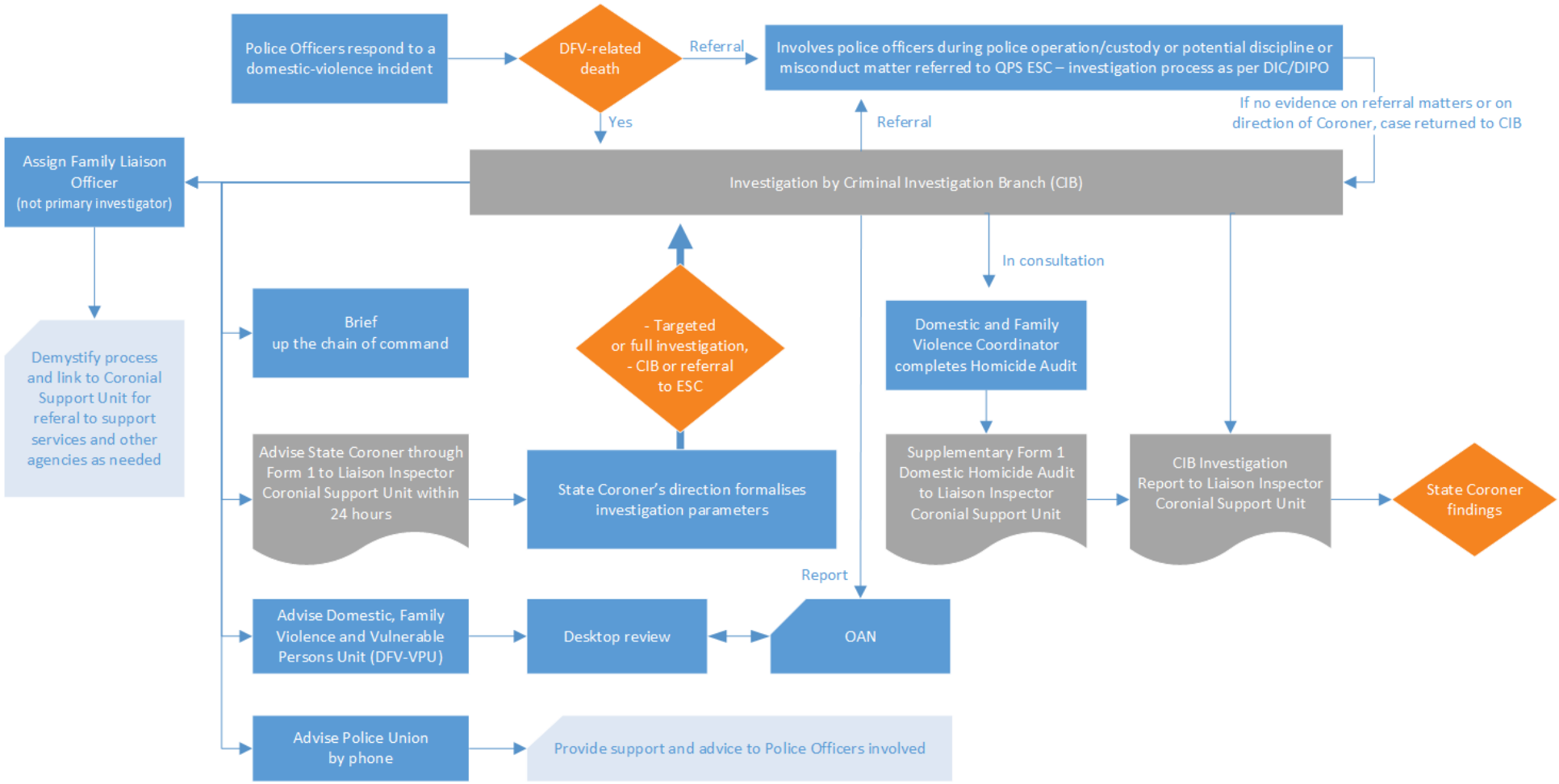
- Form 1 Police Report of Death to A Coroner (Queensland Coroners Act 2003, Section 7(3)) – within 24 hours of a DFV-related death incident
- Supplementary Form 1 Police Report of a Death to a Coroner (Queensland Coroners Act 2003, Section 7(3))
- Supplementary Form 1 Domestic Homicide Audit
- QPS Investigation Report – upon completion of the CIB homicide investigation.

The lead investigator ensures the relevant District Domestic and Family Violence Coordinator (DFVC) is notified. The DFVC will undertake the Homicide Audit in consultation with the lead investigator, who submits a Supplementary Form 1 to the Coronial Support Unit. The audit involves gathering background on the perpetrator including examining touchpoints related to DFV police-related incidents in the past, associated children and family, outcomes of breaches, actions police took throughout the history.

[10] DFV deaths can also be overseen by the Deputy State Coroner (*Coroners Act 2003* (Qld) (S11(7)).

While the model described in Figure 4 captures the investigative process it cannot however emphasise the iterative communication processes that occur throughout DFV homicide investigations. The investigation is completed on behalf on the Coroner by CIB, with communication and sharing of information guided by the Memorandum of Understanding (QPS, State Coroner and CCC).

Figure 4: DFV investigative process



DFV Homicide Cases Within Scope

In order to understand the scale of DFV homicide investigations with prior police contact we gathered all QPS recorded DFV homicides that occurred between January 2015 to April 2022. The data provided by the QPS included N = 154 unique domestic and family violence (DFV) related homicides including 137 homicides and 17 murder/suicides involving a total of 173 individual offenders. This translates into an average of 22 DFV homicide incidents per year in the seven-year period analysed for this review. The vast majority of incidents (92.2%) involved one victim and 91.6% involved one offender. Over half of the homicides were committed by an intimate partner (51.3%) and 46.1% were committed by a family member. An additional three cases involved both an intimate partner and family member and one case was deemed an 'informal' relationship.

Table 4 below provides a frequency distribution of the police region of the DFV homicide. As Table 4 shows, the regions where the incidents occurred are spread out across the state, with nearly a quarter of the incidents occurring in the Brisbane region and many occurring in regional and remote locations.

Table 4: Region of DFV homicide incident

Region	No. of offences	Percent
North Coast	1	0.6
Brisbane	38	24.7
Central	16	10.4
Far North	19	12.3
North Coast	23	14.9
Northern	11	7.1
South Eastern	34	22.1
Southern	12	7.8

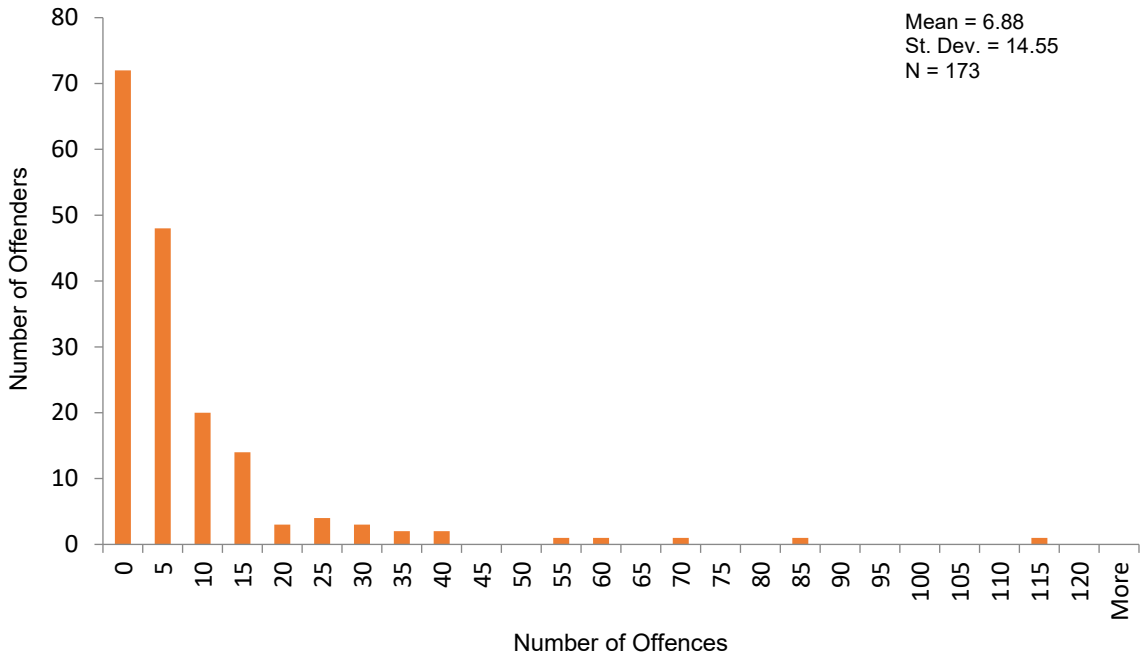
To better understand the offending histories of DFV homicide perpetrators, the QPS provided the review team with all criminal and traffic violation histories for the five years previous to the incident date for all of the N = 173 offenders in our in-scope sample of incidents[11]. Table 5 presents a frequency count of the number of prior police contacts the offenders in our sample had with police before the DFV homicide. These data are also depicted as a bar chart in Figure 5 below.

[11] At the time we made the request for data from the QPS, we did not request street check data for this analysis. Our stakeholder interviews, however, suggest that future definitions of "police contact" should include street checks, along with traffic violations and criminal incidents.

Table 5: Frequency count of the number of prior police contacts the offenders had with police before the DFV homicide

No. of Offences	No. of Offenders	Percent
0	72	41.6
1	19	11
2	4	2.3
3	11	6.4
4	9	5.2
5	5	2.9
6	10	5.8
7	5	2.9
8	1	0.6
9	3	1.7
10	1	0.6
11	5	2.9
12	1	0.6
13	1	0.6
14	2	1.2
16	2	1.2
19	1	0.6
22	1	0.6
23	3	1.7
28	1	0.6
29	1	0.6
30	1	0.6
35	2	1.2
36	1	0.6
38	1	0.6
54	1	0.6
57	1	0.6
70	1	0.6
82	1	0.6
111	1	0.6
Total	**173**	**100**

Figure 5: Number of offences by offenders



As Table 5 and Figure 5 show, the QPS data reveal that 101 (58.4%) of the DFV homicide offenders had some type of prior police contact (not including street checks) in the five years before the homicide. This translates into an average of 14.4 DFV homicide offenders each

year that have had prior police contact in the five years before the murder. Five of the offenders had more than 50 offences with police in the previous five years with one offender having 111 offences in 78 unique occurrences in the five years before the murder (an average of nearly 2 offences per month in each of the 60 months before the murder occurred). Nineteen (11%) had just one prior police contact. In total, 72 of the 173 DFV offenders (41.6%) had no prior police contact in the five years preceding the DFV homicide. We note that the Domestic and Family Violence Death Review and Advisory Board 2020-21 Annual Report reported that between 1st July 2006 and 30th June 2021 there were 375 DVF homicides in Queensland and that a history of DFV was established in 58% (206 of 353) DFV homicides. The report also stated that "in cases where there was a recorded service contact, most primary IPV victims had prior contact with police (84.6%) and the prior contact with police and Magistrates courts for primary perpetrators was 88.5% during that same period (p. 70).

We examined the extent of offending and the types of offences[12] committed by the 101 DFV offenders WITH police contact in the five years before the incident. We find that there was an average of 6.9 offences per offender in the five years before the DFV homicide (see Table 6).

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[12] Breakdown of offence types:

1. Domestic violence: Domestic Violence (Contravene DFVPA), Strangulation in a Domestic Setting.
2. Driving offences: Dangerous operation of a vehicle, Drink driving - 0.05 and under 0.08, Drink driving - 0.05 and under 0.10, Drink driving - 0.08 and under 0.15, Drink driving - 0.10 and under 0.15, Drink driving - 0.15 and over (includes under the influence of drugs), Drink driving - below 0.05, Driving whilst disqualified or restricted, Drug Driving - Saliva test, Type 1a(i) Dangerous operation of a vehicle, Type 1b Evade Police, Type 2b Driving whilst disqualified or restricted, Type 2c Drink Drive 0.15% and over (CERTIFICATE).
3. Drug offences: Drug - Permit premises to be used, Drug - Possess and/or use dangerous drugs, Drug - Possess things for use, or used in the administration, consumption, smoking of a dangerous drug, Drug - Produce dangerous drugs, Drug - Receive/possess property obtained from trafficking or supplying dangerous drugs, Drug - Supply dangerous drugs, Drug - Trafficking in dangerous drugs, Drugs offences (other).
4. Other violent offences (excluding domestic violence): Armed so as to cause fear or alarm, Assault occasioning bodily harm, Assault with intent to commit rape, Assault, Common, Assault, police (PPRA), Assault, serious (other), Demand property with menaces with intent to steal, Deprivation of liberty, Grievous Bodily Harm, Homicide - Attempted murder, Homicide – Murder, Incest, Indecent treatment of children, Offences against Children - Ill treatment of children, Offences against liberty (other), Offences against the person/life endangering acts (other), Rape, Robbery, armed, Robbery, unarmed, in company, Wounding.
5. Property offences: Bicycle - steal, unlawfully use, Burglary, Burglary, with breaking, Burglary, with violence or threats,, Burglary, with violence or threats, with breaking, Counterfeit currency offences, Enter with intent, other premises, Enter with intent, other premises, with breaking, Enter with intent, shop, with breaking, Forge, utter (other), Fraud - Possess Personal Financial Information without reasonable excuse, Fraud involving bank cards, credit cards, etc. (excluding ATM transactions), Fraud, Imposition (Other), Frauds on insurance companies, Fraudulent disposition of encumbered goods, Fraudulent falsification of records, Graffiti, Identity Fraud - Use of another identity, Motor vehicle - attempted steal/unlawfully use, Motor vehicle - steal, unlawfully use, possess, Possess, receive, dispose of tainted property (including money laundering), Possession of property suspected stolen, Receiving stolen property, Shop stealing, unlawfully take away goods, Steal as a clerk or servant, Steal from the person, Stealing (other), Stealing by conversion or by a trick, Stealing from dwelling houses, Stealing from other specified buildings (including ATM transactions), Stealing things sent by post, Vehicles - other, steal, unlawfully use, Vehicles - Stealing from/enter with intent, Wilful damage (not elsewhere classified), Wilfully kill, maim, wound animals (excluding stock with intent to steal).
6. Public nuisance offences: Child Protection - Fail to comply with reporting obligations, Consume Liquor in a public place, Disobey Move on Direction, Evade Police - Pursuit Policy, Fare evasion, refuse to pay, Liquor Act offences/other liquor offences, Pervert the course of justice (other), Public Nuisance – Disorderly, Public Nuisance – Offensive, Public Nuisance - Summary Offences Act, Public Nuisance - Threatening (includes threatening behaviour toward Police), Public Nuisance – Violent, Public Nuisance Offences Under The Vagrants, Gaming & Other Offences, Public Urination, Resist arrest, incite, hinder, obstruct police, Restricted area - attempt to take liquor in, Unlawfully on premises/trespassing, Wilful Exposure - Summary Offences Act
7. Excluded offences: Possession of things for unlawful entry, Possession/use of dangerous article (other weapon), Unlawful Possession of concealable firearm, Unlawful Possession of firearm (other), Weapons Act 1990.

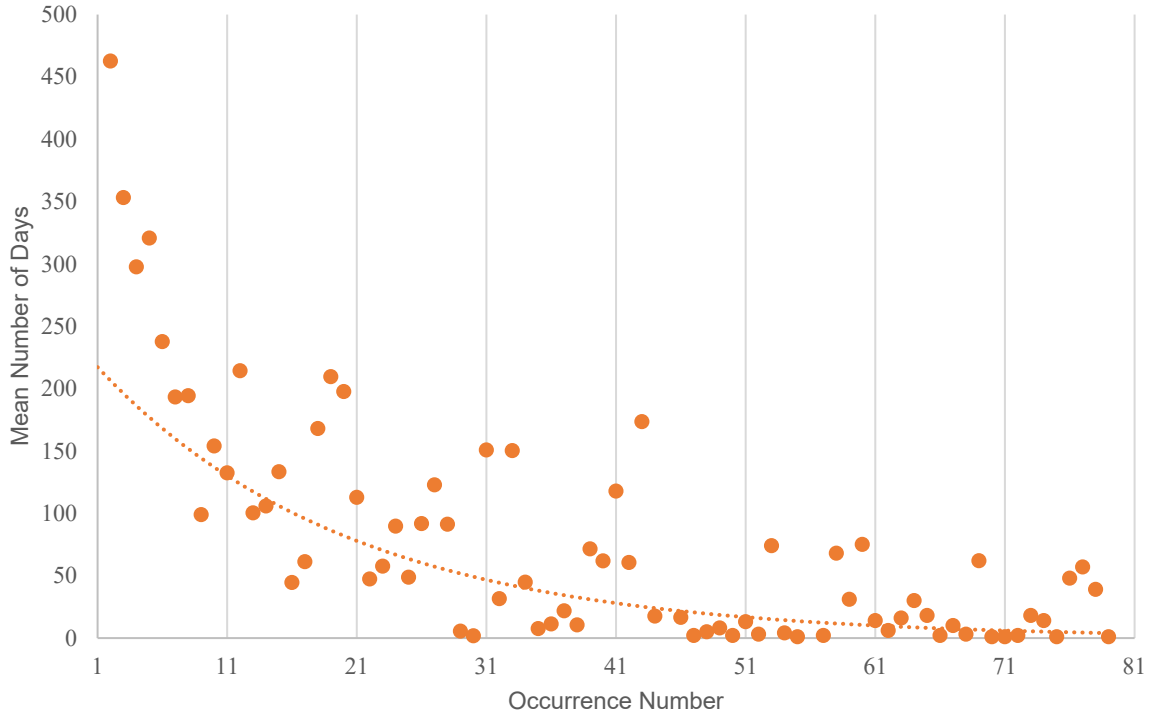
Table 6 also shows that there was an average of .5 DFV offences, 2.3 property offences, 1.2 drug offenses, .8 violence offences, 1.7 public nuisance offences and .5 driving offences.

Table 6: Mean number of offences per offender in the five years prior to DFV homicide

	All Offences	DV Offences	Property Offences	Drug Offences	Other Violence	Public Nuisance	Driving Offences
Mean	6.9	.5	2.3	1.2	.8	1.7	.5
Std. Deviation	14.6	1.4	7.2	3.0	1.7	4.1	1.4
Minimum	.00	.00	.00	.00	.00	.00	.00
Maximum	**111.00**	**11.00**	**55.00**	**20.00**	**12.00**	**31.00**	**11.00**

In order to evaluate the relationship between time and offence occurrences, the number of days between occurrences was calculated for each offender with prior police contact before the DFV homicide. This was done sequentially, i.e., the time between an offenders' first occurrence of offence(s) and the second occurrence of offence(s) was calculated, then second to third, third to fourth, etc. We calculated this time lag between police contacts for all offence types (as shown in Figure 6) including driving offences, domestic violence offences, public nuisance offences, drug offences, property offences, and other violence offences (not including domestic violence). As can be seen in Figure 6, the mean number of days between occurrences of all offences shows a pattern of decreasing days between offences as the numerical occurrence increases. This suggests that there is some level of increasing frequency of police contact leading up to a DFV homicide for those with prior police contact. This relationship was consistent across all offence types, with the important exception of domestic violence, where neither a decreasing nor increasing relationship between the time lapse in occurrence of repeat offences was found. Consistent with the criminological literature (see Bland, 2014; Thornton, 2011), our analysis confirms that prior DFV contact with police is not an especially good predictor of future DFV homicide.

Figure 6: Number of days between contacts with police (all offences)



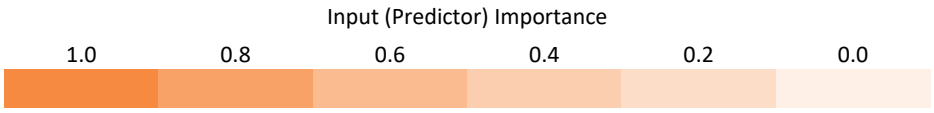
We used the offence categories described above in order to discriminate between different offender profiles in the population of DFV offenders with past police contact. A cluster analysis was performed on all offenders who had one or more offences in the five years before the DFV homicide across the following offence categories: driving offences, domestic violence offences, public nuisance offences, drug offences, property offences, and other violent offences (not including domestic violence). A cluster analysis assumes that a sample is not homogenous and establishes a number of subgroups of individuals within a sample.

Our cluster analysis reveals that there are two distinct profiles in the DFV offenders with prior police contact: high versus low intensity offenders (see Figure 7). As is consistent with what we know from the well-established criminological literature (see Farrington, 2006), 81.2 percent of the group of DFV offenders with prior police contact fall into the low intensity group, with 18.8 percent (N = 19 offenders) in the high intensity group. This group of 19 high intensity DFV homicide offenders generated 61 percent of all prior police contact in the sample. In the five-year period prior to the DFV homicide, they committed 14.5 property offences, 9.4 public nuisance offences, 6.7 drug offences, 3.2 other violence offences, 3 driving offences and 1.9 DV offences. Based on our Stakeholder Interviews with police, we understand that this group of high intensity DFV offenders were highly likely to have been on the radar and monitored closely by police in the High-Risk Offender Teams. High-intensity offenders showed higher frequencies of offending across all types of offences (*m* = 38.26 total offences, *range* = 9-111 offences), but particularly in the categories of public nuisance offences, driving offences, and drug offences. Of critical importance to this review is the fact

that high-intensity offenders showed a disproportionate amount of one or more DFV offences (63.2%) when compared to low-intensity offenders (36.8%).

Figure 7: Cluster analysis of DFV homicide offenders

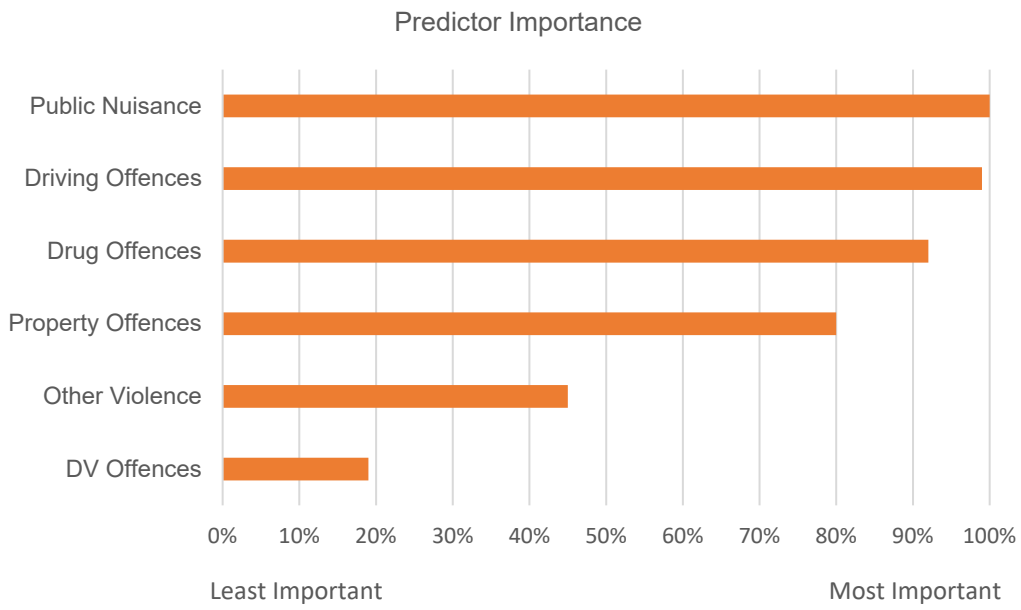
Cluster	1	2
Label	Low-intensity Offenders	High-intensity Offenders
Description	Offenders with low intensity and low frequency of offences	Offenders with high intensity and high frequency of offences
Size	81.2% (82)	18.8% (19)
Inputs	Public nuisance 1.4	Public nuisance 9.4
	Driving offences 0.3	Driving offences 3.0
	Drug offences 1.0	Drug offences 6.7
	Property offences 1.4	Property offences 14.5
	Other violence 0.9	Other violence 3.2
	DV offences 0.7	DV offences 1.9



Our review is limited in scope to focus on the most appropriate mechanism to ensure that prior police contact in DFV deaths is subject to independent, timely and transparent investigation. But the term 'prior police contact' means different things to different people. We recommend that 'prior police contact' be more clearly defined such that future DFV homicide reviews take a broad and consistent perspective in defining 'prior contacts with police,' going beyond contacts for DFV and focusing on a wide range of police contacts, including traffic violations, street checks (that we did not include in our analysis) as well as contacts with other agencies. The importance of casting a wide net is supported by the data depicted in Figure 8 below. This figure examines the predictive importance of different categories of offending. As the figure shows, public nuisance, driving offences and drug offences have the greatest predictive power for DFV homicides. There are two reasons why these data should be combined with QPS street check data as well as contacts with other government and service provider agencies to inform future investigations into DFV homicides: first, it would likely reveal that more DFV homicides involve prior police contact than is generally reported and second, the incorporation of a broader data net should feed into the reforms currently being implemented by the DFV Command of the QPS, especially the initiative around using

artificial intelligence (AI) technologies to better inform police operations (see Stakeholder Interview Analyses Pertaining to DFV Death Investigations).

Figure 8: Predictive importance of prior police contact by offence category



Recommendation 8: Ensure that the Queensland Police Service re-define 'prior police contact' in domestic and family violence deaths to include all prior contact with police (including traffic incidents and street checks) in the five years prior to the death.

Stakeholder Interview Analyses Pertaining to DFV Death Investigations

The review team undertook a total of 18 in-depth interviews with19 participants representing a range of stakeholder groups to explore perceptions and attitudes towards police investigations of DFV with prior police contact. The interviews took place either face-to-face or online via Microsoft Teams. All interviews were recorded and transcribed. The review team members asked respondents to answer questions about their perceptions about the current investigative arrangements pertaining to DFV deaths with prior police contact, including their

views on the strengths and weaknesses. We also asked about the stakeholders about their views around police investigating police actions as well as the current oversight and monitoring of investigative arrangements. We asked the stakeholders to express their perceptions about community, First Nations community and victim family views about the current investigative arrangements into DFV homicides with prior police contact. We explored the public trust issue around police investigations into DFV homicides that had prior police contact and explored ideas for how the processes and structural arrangements around the investigations could be improved, with attention to best practices in other jurisdictions.

Our analysis of the depth interviews leads us to identify three key themes: improving investigations into DFV homicide cases, DFV police capabilities and matters pertaining to the Domestic and Family Violence Death Review and Advisory Board. We provide an analysis around each of these themes below.

Improving investigations into DFV homicide cases

How police deal with reports of DFV was a key issue related to the investigative arrangements pertaining to DFV deaths with prior police contact. It was also a central matter evident in our analysis of prior inquiries on the topic of DFV (see Analysis of Inquiries and Reports Relevant to Police Investigations of DFV). According to the stakeholders we interviewed, the way DFV incidents are categorised and investigated and how certain officers respond to earlier complaints of DFV, heavily influences the nature of the QPS homicide detective investigation and, if involved, the way ESC might investigate a DFV homicide with prior police contact. This topic has already been covered in previous inquiries and will now become a focal point for a recent Commission of Inquiry that was established in May 2022 to examine QPS responses to domestic and family violence, headed by her Honour Judge Deborah Richards. In this section we supplement the existing evidence and knowledge on this topic to lend further support for the need for change in the way DFV complaints are treated by police.

The stakeholders we interviewed for this review compared the investigations of two recent DFV homicides – that of Doreen Langham and Hannah Clarke – and how police had responded to previous reports of DFV in both cases. The Coronial Inquests of both deaths, which were only a couple of weeks apart in time, uncovered the flaws and strengths of the police investigations into both deaths. Doreen Langham's experience of police responses to the violence that she had been experiencing 'was probably a red flag internally to police that something's been missed', which according to this respondent explained why the ESC was involved immediately in the investigation of her death (Respondent 10). Doreen Langham's experiences of DFV were often minimised by police or disregarded in favour of her perpetrator's accounts of what had occurred. On the other hand, Hannah Clark had a mix of both positive and negative experiences when she sought the support of police. These experiences affected who took charge of the investigations into their deaths, with respondents concluding that the lack of any ESC involvement in the investigation of Hannah

Clarke's death made a difference to the quality of the brief of evidence provided to the coroner:

> The brief of evidence – and they had the same counsel assisting – for Doreen Langham's matter was much, much better because there had been an ESC investigation. All of the appropriate documents and stuff had been obtained by ESC and they seemed to be used to compiling that information for the coroner in terms of their reports, whereas Hannah Clarke's one, we had to request a whole bunch of further information because it had been investigated by a separate unit within the police, not by ESC. (Respondent 2)

This respondent claimed that 'it would be better if ESC conducted the investigation and got the specialist advice or input they needed, which has been in other matters rather than shift the investigation away from ESC' for DFV related matters (Respondent 2). The general sentiment from our respondents is that investigations of DFV homicides need to take a historical and wholistic approach to identify patterns of abuse, which can only happen if prior DFV incidents are properly categorised and recorded. We look at this issue in more detail, in the DFV Policing Capabilities section, which appears below.

Our respondents identified several weaknesses that prevail in the capacity of police to prevent, respond and investigate DFV deaths. Several respondents noted a pattern of some police mis-categorising DFV incidents. One respondent stated that 'where it should have been like a DV Other, they were putting it down as a street check … which made it hard for us to assess what was something that was domestic and family violence about it' (Respondent 4). Another respondent said when you review QPRIME records there are a whole lot of incidents that were probably DV sometimes even based on what officers put as notes into the system and still mark it off as a non-DV incident, but because it only crops up in the system as a past attendance but non-DV, if the next officer goes in and actually has the time to pull the information to look at whether there's a history of DV, is not coming up (Respondent 16).

Workloads and police culture influenced whether or not an incident would be categorised as a DFV related matter. There is a disincentive for officers to 'respond appropriately to DV because the administrative workload is so high', something which, according to one of the respondents, has been raised as a concern for over 10 years (Respondent 16). Police have been known to put in overtime to do a 'decent job of completing the entries into the system for a DV matter as opposed to a noise disturbance or some other occurrence' (Respondent 16). More support was needed for police officers to properly dealt with DFV matters, including how they are recorded in QPS databases.

This practice of recording DFV incidents as street checks (a practice that has recently been corrected, according to Respondent 4) was identified by several respondents, with a few attributing it to pressure from more senior officers:

> The officer in charge was directing that a front-line officer to stop working on that case because he had six other tasks on his task list from comms that day and he needed to get back out on the road and this was only a DV matter, so, quickly, mark it down as a street

> check, not as a DV callout. You've just been asked to go and check a disturbance in the street and stuff it, you don't need to, that's not a DV matter. (Respondent 13)

The enormous number of DFV callouts per annum that police are required to respond to can also result in 'some members of the QPS … developing a desensitisation to DFV', which impacts on how police respond and ultimately categorise a call-out (Respondent 17). It was also noted that promotion within the QPS depends on 'doing things that are valued in the organisation, which might not be spending a whole lot of time doing DV matters', further encouraging a culture within the QPS that did not prioritise complaints of DFV incidents (Respondent 13). On the other hand, one respondent claimed that

> you'll get some police officers that is just CYA. As soon as there's the slightest hint of DV, slap an order out no matter what, and then that becomes frustrating, having to push against that. But then the officers, they're like, well, we want to protect ourselves from being pulled in and being told we're not doing a good job if there's such a hint of DV, we're just going to get involved and put an order on to protect them from any blowback from it too. So, you've got sort of two extremes within QPS. (Respondent 6)

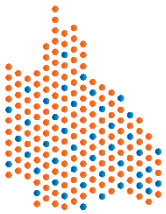
The consensus was that DFV matters are often not properly prioritised or understood, leading to outcomes that incorrectly identified who the primary perpetrator might be. As was noted in the DIC and DIPO part of this report (see Coroner Report Analysis), BWC footage has assisted in appropriately identifying perpetrators and whether a matter is DFV, as was the case in the Coronial Inquest of Doreen Langham's death. Systemic issues of negative police culture are not, according to one respondent, investigated by the ESC or CCC.

When it comes to more marginalised groups, particularly First Nations complainants, the police response and recording of the incident raised a number of concerns from our interviewees. As one of the stakeholders pointed out, 'the responses tend to be poorer from a policing perspective when it's an Indigenous household or Indigenous parties involved, and/or when it's marginalised, you know, whether we talk about poverty, mental health, unemployment, criminal histories' (Respondent 16). Respondents pointed to a lack of culturally sensitive approaches, and to the need for a 'co-responder model' where the QPS partners with First Nations communities and other service providers. This is reflected in our Recommendations.

Co-responder models are already in place in some urban districts, but these models likely need expanding to more remote and regional areas (a matter that is out-of-scope for our review). Police were seen by our stakeholders to not have the skills to address intergenerational traumas and cultural complexities, whether it be at the time of a complaint or when investigating a DFV related death with prior police contact. Without such skills, it is even more likely for officers to misidentify the primary perpetrator and to 'write it off' as a non-DFV incident, so that when the next officer responds to a call out, they will be just as 'DV uninformed as the previous ones, because they've got very little to go with if the history they look up is in the end a misleading one or not giving the right picture of what's happening in that household' (Respondent 16). In a similar vein, (Respondent 11) noted that there are a lot of DFV deaths in First Nations communities and that they are 'really complex issues',

because it can sometimes be difficult to determine if the female who kills her partner was 'protecting herself from a long history of domestic violence'. This, of course, will impact on the nature of the investigation of that DFV homicide.

Police investigators already undergo significant training to develop a range of investigative skills of which developing good communication techniques is already a component of detective training programs (Stevenson, 2020). We suggest, however, that embedding cultural safety and trauma-informed communication with families into all levels of investigative training for all investigators is likely to engender more family confidence in the investigative process.



Recommendation 9: Provide sufficient training resources to the Queensland Police Service to embed cultural safety and trauma-informed communication with families into all levels of investigative training for all investigators across the state (including regular refresher training).

DFV policing capabilities

Over the last 18 months, the QPS has instigated several reforms to better position the police service to respond to and investigate DFV. Perhaps the most central reform is standing up a new Domestic Family Violence and Vulnerable Persons Command. The new command is focused exclusively on DFV whereas previously such matters were treated more as local concerns and left to the regional and district management. We understand from our interviews that the new command currently only comprises the State Domestic Family Violence and Vulnerable Persons Unit whose objectives are to '…develop, enhance and support the QPS capability to prevent, disrupt, investigate and respond to domestic family violence and harm to vulnerable persons' (Respondent 17). The command is ultimately being positioned to 'inform, guide and support district led frontline operationalisation of DFV vulnerable person prevention, disruption, investigation and response activities' (Respondent 17).

The reforms associated with standing-up the new DFV Command offer a range of opportunities for the QPS to better prevent, respond to and investigate DFV. For example, one respondent noted that 'automatically now, that command goes into the entire history [of victims and perpetrators]…to look at what actions or interactions we've actually had with them and what learnings there are… there's a critical assessment immediately of our past interactions' (Respondent 4). This respondent went on to note that there are 'now really

robust systems in place that when we have either a death or something serious, that we automatically have a review and then we rectify through either discipline, training, or the Education Training System' (Respondent 4). Additionally, the QPS has 'attached…domestic violence people to Comms centres [and] at the operational level in some of our regions' (Respondents 4, 17).

Other very recent reforms include:

- Appointing six sergeants who are domestic and family violence specialists that sit within the Police Communications Centre (PCC) giving almost 24-hour seven day a week capability from the moment the QPS receives a call for service (Respondent 17).
- Undertaking a rapid (24-hour turn-around) desk top review for every domestic and family violence death to reveal in chronological order all prior police contact with the victim and/or perpetrator (Respondent 11).
- Trialling some artificial intelligence to better predict future harm (Respondent 11) drawing on QPS, Queensland Health and NGO data (Respondent 17).
- Implementing a high-risk high-harm dashboard based on the Cambridge Crime Harm Index whereby perpetrators are rank ordered based on a series of indices at all levels of the organisation (state level, regional level, district level, patrol group level and divisional level) (Respondent 17).

We asked the respondents about the past and current DFV investigative processes and what they identified as the strengths and weaknesses. We first examine the perceived strengths and then discuss the perceived weaknesses in the DFV investigative processes.

The recent reforms have created a rapid intelligence gathering process for police responding to calls for service about suspected DFV-related homicide. One of our interview respondents described the process as follows:

> domestic and family violence coordinators sit within the Police Communications Centre and their role is to monitor domestic and family violence calls for service. If they receive a call for service for a suspected DFV-related homicide, they immediately alert the command leadership and provide a briefing about the known circumstances. This briefing then triggers the production of a rapid desktop review of all available intelligence about the victim and perpetrator. (Respondent 17)

One respondent (17) stated that '…the review includes past QPRIME entries for domestic and family violence, mental health related reports as well as information from non-government organisations like DV Connect and the Brisbane Domestic Violence Service.' The importance of data gathered beyond police is widely known to be best practice in preventing, responding to and investigating DFV. Many of our respondents made statements about the police taking an interagency perspective and bringing together data from diverse sources including: known history of DFV which is reported to police; referrals to other agencies; presentations to public health facilities; past history of mental health issues;

suicidal ideation or intent; prior offending behaviour (including assault history, drug use, adverse firearms history) as well as past contact with the Child Safety Services.

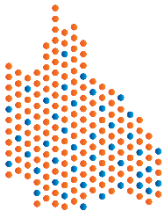
Another strength of the DFV investigative process is that the quality of reports from ESC on DFV deaths has improved in recent years. One respondent (18) stated that 'there's been some really great ethical standards reports that have been done with respect to some of [the] more recent homicides. We haven't seen them previously, but we've seen a couple come through that have been really good in terms of looking at that history of police contact.' Indeed, our respondents have generally spoken highly of the quality of ESC investigation with several respondents suggesting a strengthening of the resources to ESC such that ESC take over the homicide investigations of DFV deaths if there have been police officers engaged with the family prior to the death. The suggestion from respondents 18 (as well as from respondents 2 and 8) was to automatically transfer the investigation to ESC if there had been any police contact with the family within a specified time frame prior to the death. One non-police respondent stated that 'ESC [investigators] are probably in a better position to look at the actions of the officers [than the local CIB], otherwise the focus would just be on, more focused on the perpetrators' (Respondent 8). Respondent 2 similarly commented that 'ESC [investigators] are much better at compiling investigations and collecting investigation documents.'

Our review finds that DFV homicide investigations are currently dispersed across the QPS primarily because investigations are undertaken by the local CIB, unless evidence of police misconduct sees the ESC stepping in. Identifying system-wide issues with DFV deaths with prior police contact would be assisted if that investigative function was centralised. One of our recommendations, therefore, is to automatically transfer DFV homicide investigations to ESC where there has been prior police contact (in the five years prior) to death. We have suggested a five-year timeframe to define prior police contact based on our analysis in the section DFV Homicide Cases within Scope. Based on these data, we estimate there being about 14.4 DFV homicide offenders per year that have had prior police contact. Coincidentally, this is about the same number of DIPO/DIC incidents per year (14.8 DIPO/DIC investigations per year; see Investigative Capability for DIC and DIPO). As such, we propose that there should be no reduction in the level of investigator strength as is currently reflected in the number of investigating officers in the ESC as these investigators will need to be retained within the ESC if our recommendations are accepted to shift DIC and DIPO investigations to be led by the CCC (Recommendation 1) and, at the same time, shift DFV homicides with prior police contact to the ESC (Recommendation 10).

Yet, in undertaking these investigations, many of our respondents have consistently made the point that the investigation breadth would benefit from some of the approaches taken in child deaths. For example, Respondent 13 stated:

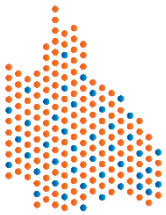
> they're getting quite skilled within Child Safety now, that team that do those internal investigations, so they come in straight, soon after, they've got a limited timeframe, so 6 months to do the internal review, which is the first stage of the tier one process. And they

> are quite good at getting in and doing, I mean it's very social workery, so it's got to be translated into a QPS kind of frame, but that reflective practice work that they do, of investigating what happened and who did what when, that is of real value, because they interview everyone that's been involved in the case, they get all the records, so they can actually challenge people, like it's not just 'Tell me what you think.' So it is a proper investigative process.



Recommendation 10: Require the Queensland Police Service to assign all domestic and family violence homicide investigations with prior police contact (excluding those that occur in the course of a police operation which should be referred to the Crime and Corruption Commission) to the Ethical Standards Command ensuring that the investigative team draws together a multi-skilled, multi-disciplinary team that includes a specialist First Nations/cultural expert and a family liaison person skilled in cultural safety and trauma-informed communication.

Our interview team asked all of our respondents to comment on what they perceived to be industry best practice in DFV investigations with prior police contact. Several respondents commented that the Victoria Police model and resourcing was the best in the country. One respondent stated: 'Victoria police were the first in the country to establish a family violence command…[and] they've got over 500 specialist domestic and family violence officers, they're got a 10-million-dollar centre for excellence for training frontline police, they have about 20 senior sergeants' (Respondent 17). This respondent went on to say that 'if you want be…best practice you want gold, gold standard you need to resource it, you know, absolutely we can't provide a specialist response to 120,000 plus domestic and family violence incidents' (Respondent 17).



Recommendation 11: Provide sufficient resources to the Queensland Police Service Ethical Services Command to recruit First Nations/cultural experts and cultural safety and trauma-informed communication specialists to partake in multi-skilled, multi-disciplinary teams to investigate Domestic and Family Violence Deaths with prior police contact.

Finally, our respondents identified several legislative and bureaucratic issues that compromises the capacity of police to better prevent, respond to and investigate DFV

deaths. These include reducing the time it takes to do DFV reports; police being able to do video trials; changing the cumbersome approaches to serving and witnessing documentation (e.g., the need to have officer signatures witnessed by a Justice of the Peace rather than a senior officer); allowing police electronic signatures on orders; and digital service of documents. Given that the Terms of Reference for this review is focused on police investigations into DFV deaths with prior police contact, it is out-of-scope for our review to make specific recommendations in this review about the range of reforms required to streamline police responses to DFV. Yet we note that these legislative and bureaucratic barriers to reporting and responding to DFV incidents were a focus for many of our respondents. We refer these streamlining reporting and response matters to the Commission of Inquiry into Police Responses to Domestic and Family Violence announced by the Palaszczuk Government on 10th May 2022 and led by her Honour Judge Deborah Richards.

DFV Death Review and Advisory Board

We explored with respondents the role and function of the Domestic and Family Violence Death Review and Advisory Board. There was general agreement that the Board played an incredibly valuable role in providing system-wide analysis of trends in DFV (Respondents 3, 8, 16). Respondents noted that while Coronial Inquiries are limited to the circumstances of particular deaths, this type of advisory board can take a broader view, looking at social and cultural contexts in which DFV deaths take place. One respondent described the role of the Board as 'predominantly around improving service responses across some of the key service areas …improving responses to priority populations such as culturally and linguistically diverse victims, First Nations victims, LGTBIQ populations' (Respondent 16). The respondent added that the role was not to contribute to specific investigations but to rely on existing records and reports and 'take that system-wide view'.

Another respondent added that there is value in the Board's role because it is not about attributing blame to an individual in a way that might occur in police and coronial investigations, but about 'being focused on developing learnings and trends and issues within organisations, particularly organisations that are high-risk, so that they can learn from their mistakes' (Respondent 13). This respondent expanded 'it's dangerous to be making recommendations about the improvement of a system without actually taking a systems perspective on what you're doing and looking at it holistically' (Respondent 13).

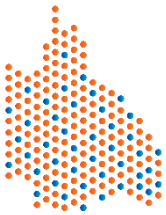
While most respondents recognised the value in this systems-wide role, some potential limitations were noted. These included resourcing limits (Respondent 18), but also a lack of capacity on the Board's part to follow through on the extent of implementation of recommendations made in past reports (Respondent 8). One respondent noted that while the Board plays an important role, their insights often 'don't filter down to that operational level… there's an annual report at the end of the year looking at deaths from two to three years down the track. They're looking at deaths that occurred years ago while the system, the DV

system as a whole has changed significantly… It needs to be contemporaneous' (Respondent 17).

It was also noted that while the Board can make recommendations, there is a need for a more formal feedback mechanism to ensure those recommendations are received and acted on by agencies. One respondent noted that while Coroners can make a disciplinary referral during an inquest, there is no mechanism by which the Board can refer matters for attention to say the Commissioner of Police (Respondent 8). These recommendations may relate to cultural or training issues rather than individual discipline, but nevertheless some form of formal response should be required.

One mechanism to achieve a better feedback loop between reviews and agencies is to require agencies that are subject to a formal recommendation in a Board report to provide a formal response to that recommendation, including whether and how the agency intends to adopt it. This response could be required to be furnished to the Board within a reasonable period, say three months of the release of the report, and then be published alongside the Board's report on its website.

The DFV review unit within the Coroner's office was also mentioned by respondents who described the role it performed in supporting investigations into individual DFV deaths through the collation and provision of prior service contact analyses (Respondents 16, 18). The unit also supports the Board and acts as its secretariat. It relies heavily on the support provided by a seconded QPS Senior Sergeant, who acts as liaison to facilitate access to police records and other resources. The importance of the role to both the unit and the Board was noted by one respondent, who commented that the role had been left vacant by QPS, or inadequately filled, for extended periods (Respondent 18). Clearly having consistent and able QPS staffing in this role is critical to the performance of the DFV review function.



Recommendation 12: Amend the *Coroners Act 2003* (Qld) so that the relevant Minister is required to provide a formal response to any recommendations for government action contained in reports from both the Domestic and Family Violence Death Review and Advisory Board and the Police-Related Deaths Advisory Board. Ministerial responses should be made public alongside the report on the relevant Board's website.

Analysis of Inquiries and Reports Relevant to Police Investigations of DFV

DFV reports analysed and method of analysis

To augment our Stakeholder Interviews and data analysis of DFV homicides with prior police contact in Queensland, we conducted searches using Google and Google Scholar to identify Australian inquiries into the investigation of deaths related to DFV. Coronial inquest reports were excluded since they are being analysed separately. Relevant reports were scanned to identify other relevant inquiry reports that should be included in the analysis.

The reports shown in Table 7 were analysed using a thematic content analysis, extracting information about the matters that are of most concern regarding a DFV investigation, concerns of the deceased's family, the most important requirements for an investigation to be considered adequate, and different investigative models and agencies.

Table 7: Reports and inquiries related to domestic and family violence included in analysis

Name of Report (abbreviated)	Author	Year	Jurisdiction
Hear Her Voice – Report One (Hear Her Voice report)	Women's Safety and Justice Taskforce	2021	Queensland
Not Now Not Ever: Putting an End to Domestic and Family Violence in Queensland (Not Now Not Ever report)	Special Taskforce on Domestic and Family Violence in Queensland	2015	Queensland
Domestic and Family Violence Death Review and Advisory Board 2020-21 Annual Report (DFV Death Review and Advisory Board 2020-21 report)	DFV Death Review and Advisory Board	2021	Queensland
Royal Commission into Family Violence Report (Victorian Royal Commission into Family Violence report)	Victorian Government, Royal Commission into Family Violence	2016	Victoria

Police culture

A recurrent theme in all four DFV related reports was the negative and prejudicial attitudes of police regarding DFV related incidents. The *Hear Her Voice* report highlighted the widespread cultural issues within the QPS that lead to a lack of adequate and appropriate responses to reports and investigations of DFV. The report noted that police culture 'refers to the mix of informal prejudices, values, attitudes, and working practices' which are 'commonly found among the lower and middle ranks of the police that influence the exercise of discretion' (Women's Safety and Justice Taskforce, 2021, vol 3, p. 553). Indicators of the existence of cultural issues included reports of sexist behaviour by police towards victims, treating online DFV training as unimportant by lying about the completion of such training,

and the existence of some police officers who are themselves perpetrators of DFV. Flaws relating to the recruitment and promotion of police officer which contributed to the existence of a toxic and discriminatory organisational culture were also identified in the *Hear Her Voice* report.

DFV training becomes voluntary, rather than remaining mandatory, after an officer has been with the QPS for 12 months, which doesn't assist with changing police attitudes regarding domestic and family violence. The *Hear Her Voice* report noted that changing police culture is not easy, despite the availability of training and changes to operational procedures and processes:

> Despite the best efforts of the senior leadership team and the commitment of officers specially trained in domestic and family violence, cultural problems within the QPS persist and appear to be widespread. These cultural issues undermine the successful implementation of the promising operational initiatives developed to improve responses. … These widespread cultural issues are apt to undermine community confidence in the QPS and ultimately in the administration of justice in this state. (Women's Safety and Justice Taskforce, 2021, vol 2, p. 383)

Concerns about negative and prejudicial police culture was also highlighted by the *Not Now Not Ever* report resulting in the following recommendations:

> Recommendation 137 – The Taskforce recommends that the Queensland Police Service appoints the Deputy Commissioner (Regional Operations) to champion best practice domestic and family violence prevention and first responder practice in the Queensland Police Service. The Deputy Commissioner would be responsible, among other things, for increasing officers' awareness and understanding of domestic and family violence and its impact on involved parties, police and the community, with a view to creating positive cultural change within the Queensland Police Service.' (Special Taskforce on Domestic and Family Violence in Queensland, 2015, p. 328)
>
> Recommendation 138 – The Taskforce recommends that the Queensland Police Service facilitates an external independent audit and review of training packages currently available to officers, with a view to assessing the appropriateness and frequency of compulsory professional development opportunities relevant to domestic and family violence. Components for enhancement of officers' conceptual understanding of dynamics of domestic and family violence, communication skills, as well as cultural awareness and sensitives should be assessed. (Special Taskforce on Domestic and Family Violence in Queensland, 2015, p. 329)

Despite acknowledging the need for training and the development of accredited and effective training courses by the QPS since the *Not Now Not Ever* report, the Women's Safety and Justice Taskforce thought it unlikely that the QPS would be 'able to simply train its way out of these widespread cultural problems' (2021, vol 2, p. 384). Cultural changes were instead needed and the Taskforce, by majority, recommended that an independent commission of inquiry be established to examine widespread cultural issues with the QPS pertaining to the police response and investigations of DFV.

Police response to reports of DFV

Cultural issues surrounding the treatment of reports of DFV, resulted in highly inadequate and inappropriate QPS responses. The *Hear Her Voice* report documented numerous accounts of police not satisfactorily responding to and investigating reports of DFV, including victims being told that any application for a protection order would unlikely succeed because it would be one person's word against another despite the complainant having visible physical injuries; police failing to bring criminal charges; victims being blamed for the abuse; and victims being turned away at police stations due to the prioritisation of other work. Similar examples were documented in the *Not Now Not Ever* and the *Victorian Royal Commission into Family Violence* reports. The failure of police to respond appropriately deterred women from making future reports, particularly women who were of Aboriginal or Torres Strait Islander descent, women from culturally and linguistically diverse backgrounds and women with disabilities. Women living in rural and remote areas often faced even greater obstacles in seeking help from the police.

Both the *Hear Her Voice* and the *DFV Death Review and Advisory Board 2020-21* reports made note of the inaccurate recording of domestic and family violence in police data systems. Contact with police may at times be recorded as a 'street check', 'welfare check', 'child harm report' or 'community assist' instead of a domestic and family violence incident (DFV Death Review and Advisory Board, 2021, p. 68); see also our Stakeholder Interviews. Related to this the Victorian Royal Commission into FV report noted gaps in data collection in various information systems, including the National Coronial Information System.

Complaints against police and investigations of police conduct

The *Hear Her Voice* report identified that concerns were raised with the Women's Safety and Justice Taskforce during their consultations and in submissions, regarding the devolution of responsibility for managing complaints against police to the ESC rather than remaining a responsibility of the CCC. Most complaints are therefore, dealt with internally via the internal police disciplinary process. The CCC in its consultation with the Women's Safety and Justice Taskforce 'expressed a high level of confidence in the QPS Ethical Standards Command' when the Commission oversees the process, but this was not always noted as the experience of complainants who made submissions to the Taskforce inquiry (2021, p. 190). Of particular concern to the Taskforce, was the way complaints against police who were perpetrators were treated, with one submission suggesting the existence of a 'boys club' which controlled all aspects of domestic and family violence related complaints (Women's Safety and Justice Taskforce, 2021, vol 2, p. 192).

The Women's Safety and Justice Taskforce recognised the difficulty of changing certain aspects of organisational culture, making recommendation 31 for the Queensland Government to 'develop and implement a transformational plan to address widespread

culture, values, and beliefs within the Queensland Police Service to enable the QPS to achieve better outcomes for victims of domestic and family violence … and better hold perpetrators to account' (Women's Safety and Justice Taskforce, 2021, vol 3, p. 554). The *Hear Her Voice* report listed the strategies needed for a transformational plan, including revising recruitment and promotion practices with a focus on diversity, establishing a 'safe, transparent, open and accountable complaints process for victims that is accessible and confidential', and 'an independent process to investigate police involvement in domestic and family violence deaths' based on this review (Women's Safety and Justice Taskforce, 2021, vol 3, p. 556). Establishing dedicated specialist DFV units in each police district that were properly resourced and reviewing/updating all relevant operational policies and procedures were also mentioned as part of the transformational plan.

Recommendation 36 in the *Hear Her Voice* report particularly focused on an accessible complaints process:

> The Queensland Police Service, in consultation with domestic and family violence and First Nations stakeholders and people with lived experience of domestic and family violence, develop and implement a victim-focused and trauma-informed complaints process that allows victims to make a complaint safely and confidentially against sworn or non-sworn QPS staff.
>
> The complaints process will include independent, confidential, transparent, and accountable mechanisms for complaints about police responses to domestic and family violence to be received and investigated, including complaints about police responses in relation to perpetrators who are sworn and non-sworn QPS staff.
>
> The process should include informing complainants about the outcome of their complaints.
>
> The QPS should provide information in its annual report about the complaints it has received and the responses made, including those related to domestic and family violence allegations against QPS staff (Women's Safety and Justice Taskforce, 2021, vol 3, p. 579)

Recommendations Related to Investigative Mechanisms for Domestic and Family Violence Deaths with Prior Police Contact

8. Ensure that the Queensland Police Service re-define 'prior police contact' in domestic and family violence deaths to include all prior contact with police (including traffic incidents and street checks) in the five years prior to the death.

9. Provide sufficient training resources to the Queensland Police Service to embed cultural safety and trauma-informed communication with families into all levels of investigative training for all investigators across the state (including regular refresher training).

10. Require the Queensland Police Service to assign all domestic and family violence homicide investigations with prior police contact (excluding those that occur in the course of a police operation which should be referred to the Crime and Corruption Commission) to the Ethical Standards Command ensuring that the investigative team draws together a multi-skilled, multi-disciplinary team that includes a specialist First Nations/cultural expert and a family liaison person skilled in cultural safety and trauma-informed communication.

11. Provide sufficient resources to the Queensland Police Service Ethical Services Command to recruit First Nations/cultural experts and cultural safety and trauma-informed communication specialists to partake in multi-skilled, multi-disciplinary teams to investigate Domestic and Family Violence Deaths with prior police contact.

12. Amend the *Coroners Act 2003* (Qld) so that the relevant Minister is required to provide a formal response to any recommendations for government action contained in reports from both the Domestic and Family Violence Death Review and Advisory Board and the Police-Related Deaths Advisory Board. Ministerial responses should be made public alongside the report on the relevant Board's website.

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