Memorandum of Understanding for the Monitoring of NSW Police Force Critical Incidents which are also subject to Coronial Jurisdiction

between

Law Enforcement Conduct Commission

and

New South Wales State Coroner

In accordance with

Part 8 of the *Law Enforcement Conduct Commission Act 2016*

Version dated 1 April 2025

This Memorandum of Understanding ("the Memorandum") is made between the New South Wales State Coroner ("**the State Coroner**") and the Law Enforcement Conduct Commission ("**the LECC**").

Purpose

1. To set out the arrangements between the State Coroner and the LECC pursuant to s 115(3)(b) of the *Law Enforcement Conduct Commission Act 2016* ('the *LECC Act*') in investigations involving a coronial investigation scene under Chapter 5 of the *Coroners Act 2009*.

2. To outline the procedures to be followed by a Senior Coroner and the LECC when a critical incident is declared that is within the jurisdiction of the Senior Coroner and the LECC has decided to monitor the critical incident.

3. To facilitate cooperation between the LECC and Senior Coroners in undertaking their respective functions in respect of critical incident investigations under the *LECC Act*, and coronial investigations and inquests falling within s 23(1) of the *Coroners Act 2009*.

Background

4. The LECC has responsibilities under the *LECC Act* to detect, oversight, investigate and expose serious misconduct and serious maladministration within the NSWPF, and to monitor critical incident investigations conducted by the NSWPF.

5. To monitor a critical incident investigation[1], the LECC may exercise a number of powers under s 114 of the *LECC Act*. This includes a power to attend the place where a critical incident occurred and to observe police exercising any investigatory powers.

6. The Senior Coroner has jurisdiction to hold an inquest into the death of a person where it appears that the person has died as a result of a police operation or whilst in the custody, or escaping the custody, of a police officer, or while proceeding to an institution or place to be admitted as an inmate, while accompanied by a police officer. In such cases, the Senior Coroner also has the power to issue a coronial investigation scene order under s 40 of the *Coroners Act 2009*.

Coronial directions in NSWPF critical incident investigations

7. If a critical incident involves a coronial investigation scene order, the LECC recognises that it has an obligation to perform its monitoring function in accordance with any directions made by the Senior Coroner as provided for in section 115(3)(b) of the LECC Act.

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[1] As defined in ss 108, 110-111 of the *LECC Act*.

8. Where a direction is made in relation to a critical incident scene, the Senior Coroner agrees to provide the LECC with a copy of the written direction as soon as practicable.

9. If the LECC considers that a NSWPF critical incident investigation does not accord with a direction made under either s 51 of the *Coroners Act 2009*, or a direction made by a Coroner as referred to in s 115(3)(b) of the *LECC Act*, the LECC will raise the issue directly with the nominated NSWPF contact officer. If the issue is not able to be adequately resolved by the nominated contact officer, the LECC may provide written advice to the Senior Coroner and the NSWPF Region Commander responsible for the critical incident investigation.

Advice in NSWPF critical incident investigations

10. Where a coronial investigation scene also involves a critical incident scene, the Senior Coroner may note on the coronial investigation scene order that any person authorised under s 114(3) of the LECC Act may also be present at the scene.

11. The Senior Coroner may consult the LECC about the critical incident investigation monitoring arrangements if they have concerns about whether the critical incident is being investigated in a competent, thorough or objective manner. The LECC will attempt to ensure that the Senior Coroner's concerns are addressed while monitoring the NSWPF critical incident investigation.

12. If a Senior Coroner forms the view that the NSWPF have failed to declare a person's death a critical incident under s 110 of the *LECC Act*, the Senior Coroner will raise the matter with the Commissioner of Police, and then with the LECC if necessary.

13. Under s 116 of the LECC Act, the LECC may advise the Senior Coroner if it considers that the investigation was not conducted in accordance with the *LECC Act*. Such advice may also be given before the conclusion of the critical incident investigation.

Provision of information

14. The State Coroner recognises that the LECC will be assisted in monitoring a critical incident investigation through access to:
    i. A copy of coronial investigation scene orders.
    ii. Any submissions made to the Senior Coroner.
    iii. Issues and witness lists in inquest matters where the LECC has an oversight role.
    iv. The name and details of the counsel assisting the Senior Coroner in a particular matter.
    v. An unredacted copy of the Coronial findings.
    vi. Court proceedings via Audio-Visual-Link (AVL).
    vii. Protected material under non-disclosure or suppression orders.[2]

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[2] Protected material may be disclosed when the State Coroner has supported the LECC to be included in the list of parties/stakeholders who may be granted access for an individual matter. Where protected material is sought, the solicitor assisting will raise the issue of inclusion of the LECC on the list of persons able to access the material at the Coroner's recommendation.

15. The State Coroner agrees that those assisting the Senior Coroner will provide the LECC with the materials listed in 14(i)]and 14(iv). Those assisting will raise for instructions from the presiding Senior Coroner in a particular inquest access to the other matters outlined in 14. A copy of any coronial recommendations relating to a critical incident will be provided to the LECC by the Registrar of the Lidcombe Coroners Court. A copy of any responses received by the NSWPF will also be forwarded to the LECC by the Registrar so that the LECC can ensure that any recommendations are appropriately considered in the final NSWPF critical incident investigation report.

16. A copy of any coronial findings that involve a concern about NSWPF misconduct will also be provided to the LECC by the Registrar of the Lidcombe Coroners Court.

17. If the LECC has information that may assist the coronial investigation, LECC representatives may contact the solicitor assisting the Senior Coroner in relation to any concerns arising in a matter where LECC has oversight, that LECC considers the Senior Coroner should be aware of.

18. If the LECC decides to cease monitoring a coronial investigation, the LECC will advise the solicitor assisting the Senior Coroner.

Contact points

19. The parties agree that maintaining open lines of communication is essential to maintaining an effective relationship.

20. All requests for the LECC's assistance or information should be directed to the Team Leader, Critical Incident Investigation Monitoring at *cimonitoring@lecc.nsw.gov.au*.

21. Any issues identified by the State Coroner relating to relationship management or the operation of this agreement should be directed to the LECC's Director Oversight at *cimonitoring@lecc.nsw.gov.au*.

22. All requests for the Senior Coroner's assistance or information should be marked for the attention of the presiding Senior Coroner and directed to *lidcombe.coroners@justice.nsw.gov.au.*

23. Any issues identified by the LECC relating to relationship management or the operation of this agreement should be marked for the attention of the Executive Officer to the NSW State Coroner at *lidcombe.coroners@justice.nsw.gov.au.*

24. The LECC and the State Coroner agree that requests for information and assistance will be made in writing, or if made orally, should be confirmed in writing as soon as practicable. The requesting body will provide a receipt for such supplied material.

Approval

The Hon Peter Johnson SC

Chief Commissioner

Signed for and on behalf of the

Law Enforcement Conduct Commission:

Signed: .....

Date: 1 April 2025

Her Honour Magistrate Teresa O'Sullivan

State Coroner, New South Wales

Signed for and on behalf of the New South

Wales State Coroner:

Signed: .....

Date: 8 April 2025