

Inquest into the death of Jason Paul Protheroe

Mr Protheroe was shot and killed on 17 April 2012 when he produced a replica firearm and pointed it at a plain clothes constable. When the officer ran for cover, Mr Protheroe followed him and again pointed the replica gun at the officer in a manner which led the officer to reasonably believe his life was at risk and could only be preserved by firing at Mr Protheroe.

The then State Coroner, Michael Barnes, delivered his findings of inquest on 14 June 2013.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported. Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Recommendation 1 – Security of critical incident scenes

In order to avoid the uncontrolled and unintended release of information and the adverse impact that can have on the integrity of an investigation, I recommend the Queensland Police Service review its policies and procedures to ensure access is only granted to the outer cordon of critical incident scenes to those needed to investigate and/or respond to the incident. Union officials and employees should of course be given ready access to their members to support them but that should happen away from the incident scene whenever possible.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service.

An amendment for the *Operational procedures manual* section 1.16: 'Fatalities or serious injuries resulting from incidents involving members (police related incidents)' to address the access of union and/or legal representatives' movements within an incident scene was approved by Queensland Police Service senior executive. This amendment restricts access to the inner cordon to investigating officers. Legal and union representatives are to have access to their clients or union members in the outer cordon, away from the incident scene.

The amendments were published in the June 2014 issue of the *Operational procedures manual* and all members were informed via a statewide email.

Recommendation 2 – Initial family liaison

I am aware the Queensland Police Service has a family liaison policy that provides for the allocation of a specific family contact person in all cases of homicide. In deaths in custody, the investigators from the Ethical Standards Command discharge this role. That happened in this case.

However, as this case demonstrates, in some instances, family or 'secondary victims' will be at the scene at the time of the incident or very soon after. Queensland Police Service procedures which stipulate how the incident scene is to be managed should stipulate that those with a special interest in the incident, such as family members of the deceased, are to be treated appropriately and, as soon as possible, given as much information as can be released to them without compromising the investigation.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service.

An amendment to section 1.16: 'Fatalities or serious injuries resulting from incidents involving members (police related incidents)' of the *Operational procedures manual* was approved by the deputy commissioner.

The policy advises investigating police that until the arrival of the family liaison officer, identified family and next of kin at the incident scene are to be treated appropriately and provided with as much information as can be released without compromising the investigation.

The amendments to the *Operational procedures manual* were published in June 2014 and all members were informed via a statewide email.

Recommendation 3 – Union officials' competing responsibilities

The president of the Queensland Police Union of Employees has responsibilities to the union and its members but he or she remains a member of the Queensland Police Service and is subject to and must comply with its policies and procedures. There currently seems some uncertainty as to how these roles are to be accommodated if they conflict, for example, in relation to accessing and disseminating confidential information held by the Queensland Police Service. Accordingly, I recommend the Queensland Police Service in conjunction with the union review those aspects of the union's areas of activity that may cause this conflict to arise to ensure both parties have in place appropriate policies and protocols so they can be managed without compromising the functions of the Queensland Police Service, while allowing for the legitimate and necessary industrial activities of the union's officials.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service

As mentioned above, an amendment for the *Operational procedures manual* section 1.16: 'Fatalities or serious injuries resulting from incidents involving members (police related incidents)' to restrict access to the inner cordon to investigating officers was approved by Queensland Police Service senior executive.

Legal and union representatives are to have access to their clients or union members in the outer cordon, away from the incident scene. This amendment addresses concerns in relation to maintaining the integrity of the incident scene and preservation of any evidence.

The amendments to the *Operational procedures manual* were published in June 2014 and a statewide email was forwarded to all members advising them of the changes.

Recommendation 4– Responsible media comment

Public comment concerning a critical incident involving police officers can negatively impact on the integrity of the investigation of the incident, the reputation of the officers involved, the reputation of the Queensland Police Service and the public confidence in those investigations. It is therefore essential the comments be limited to the release of sufficient information to satisfy the public's right to know in very general terms what has occurred and to engender confidence the incident is under rigorous and impartial investigation, the results of which will be made public at the appropriate time. I recommend the Queensland Police Service review its policies in relation to such matters and have regard to the report of the office of police integrity's suggestions as to the

limit of matters that should be included in such public comments. The resulting policies should be binding on all police officers, including union officials.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service.

Following a review, it was ascertained that both section 1.9: 'Release of information' of the *Operational procedures manual* and the Queensland Police Service media guidelines contain sufficient direction about the unauthorised release of information by employees of the Queensland Police Service following a serious incident.

The issue was raised with the union president by the Queensland Police Service senior executive. Along with the amendment to *Operational Procedures Manual* section 1.16 and the current guidelines contained within the media guidelines, the Queensland Police Service believes there are sufficient guidelines available to all officers in dealing with the media at incidents, which are binding on all officers.

The *Operational procedures manual* stipulates that upon being notified of the incident, a regional duty officer or district duty officer is to travel to the scene and take command, pending the arrival of officers assigned to the investigation. Section 1.9.11 of the *Operational Procedures Manual* states that only the officer in charge of the investigation (or nominated officer) is responsible for the release of any information to the media, and further reinforces that members are not to make statements to the media assigning blame or fault to any person in respect of the incident.

The media guidelines reinforce the policies in the *Operational procedures manual* by stating only the officer in charge of the investigation is to release information to the media. It also details actions by members in relation to coronial cases, whereby the coroner must be consulted before any media releases are made.

The report to the office of police integrity was considered but the Queensland Police Service believes its current policies adequately address the issue of release of information by members. The Queensland Police Service senior executive endorsed the outcome of the review undertaken.

Comment, page 48

Section 48(3) of the Coroners Act provides that a coroner may give information about official misconduct or police misconduct to the Crime and Misconduct Commission [now the Crime and Corruption Commission].

I suspect the dissemination to the media of the 'mug shots' of Ms Sinn and Mr Protheroe and details of their criminal histories involved either official misconduct and/or police misconduct. Counsel for the Queensland Police Service told the inquest this matter is already the subject of an investigation, although I was also advised this investigation commenced only after concerns were raised during the inquest. I intend to provide this information to the Crime and Misconduct Commission to ensure the matter is vigorously pursued.

I consider I am also obliged to refer to the Crime and Misconduct Commission the failure of Inspector Reid to report this suspected misconduct, which must have been apparent to him by at least 29 May 2012.

Response and action: the recommendation is implemented.

Responsible agency: Crime and Misconduct Commission.

On 17 June 2013, the State Coroner wrote to the then Crime and Misconduct Commission advising that, in accordance with section 48(3) of the *Coroners Act 2003*, he was referring concerns to the Crime and Misconduct Commission of the unauthorised release of confidential information to the media by officers of the Queensland Police Service.

Specifically, the State Coroner was concerned that in the days after Mr Protheroe's death, copies of 'mug shots' and criminal histories of Mr Protheroe and Ms Krystal Sinn appeared in the media.

The State Coroner also referred concerns Inspector Reid of the Ethical Standards Command of the Queensland Police Service had failed to report Ms Sinn had repeatedly expressed concerns to him that her privacy had been breached by the release of this information.

The Crime and Misconduct Commission determined that the concerns were appropriate to be dealt with by the Queensland Police Service on the basis that the Crime and Misconduct Commission would review a final report before further action was taken.

In a letter dated 27 February 2014, the assistant commission of the Ethical Standards Command provided a copy of the investigation report for review.

The investigation into the concerns raised by the State Coroner was conducted by the Ethical Standards Command. None of the concerns referred by the State Coroner to the Crime and Misconduct Commission were capable of being substantiated. While acknowledging that the release of the information was unauthorised, the investigation was unable to identify the individuals(s) who were responsible for the release to the media.

Further, the investigation found Inspector Reid did report the misconduct alleged in the correct manner and therefore the criteria for exoneration was met.

In a letter dated 6 March 2014, the Crime and Misconduct Commission advised the Ethical Standards Command that it was satisfied that the matter could be finalised and the Crime and Misconduct Commission's monitoring had concluded. The Crime and Misconduct Commission requested that, in finalising the matter, the Ethical Standards Command was to advise the State Coroner of its findings.