NSW POLICE FORCE P190B

STATEMENT OF POLICE

In the matter of:	Special Commission of Inquiry into LGBTIQ Hate Crimes
Place:	Homicide Squad - State Crime Command
Date:	5 May 2023

Name:	Daniel DOHERTY	Tel. No:	[redacted]
Rank:	Detective Superintendent		
Station/Unit:	Commander, Homicide Squad		

STATES:

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give in court as a witness. The statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false, or do not believe to be true. In this statement, if there is any information I have obtained from a particular source, I set out the source of that information.

2. I am 61 years of age.

3. I make this statement in respect of the Request for Statement issued by the Special Commission of Inquiry into LGBTIQ Hate Crimes (**Inquiry**) on 13 April 2023, specifically requesting information concerning the recommendations of Deputy State Coroner Milledge in the context of the inquest into the deaths of Ross Warren, John Russell and Gilles Mattaini in 2003-2005 (**Taradale Inquest**) (**Request for Statement**). A copy of the Request for Statement is attached as '**Annexure 1**'.

4. In this statement, I specifically address the following three recommendations made in the Taradale Inquest:

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
5 May 2023

Signature: [redacted]

Daniel DOHERTY
Detective Superintendent
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a. Review procedures in relation to the recording of possible causes of death at early stages of any investigation in order to minimise erroneous or lazy conclusions based on incomplete information (**Recommendation 8**);

b. Reinforce the requirements of the Charter for Victims Rights where Victims of Crime are entitled to be given information concerning their investigations in a timely fashion, and that all Victims of Crime are to be dealt with compassionately (**Recommendation 9**); and

c. Audit outstanding homicides and suspected deaths to ensure investigations are active and ongoing. Where investigations have stalled these matters are to be referred to the State Coroner for his consideration (**Recommendation 10**).

5. This is the second statement I have made in the context of the Inquiry. My first statement was made on 18 April 2023 (**First Statement**).

6. At the time of signing this statement, I have been shown a zipfile of electronic documents marked with electronic document IDs in the format '**NPL.XXXX.XXXX.XXXX**'. Where I refer to a document in this statement, I refer to it by its document ID.

7. At the outset, I note the Request for Statement requests information covering an 18-year period between 2005 to the present day. I have only served as Commander of the Homicide Squad since 2019. I was not a member of the Homicide Squad in 2005 when the Taradale Inquest recommendations were made. Neither I, nor anyone else in the NSWPF is able to comprehensively address the relevant matters for the whole period from their own knowledge. I have nevertheless attempted to provide the information requested, by reference to documents held by the NSWPF.

8. In the context of responding to the Request for Statement, searches were conducted of records held within:

a. the NSWPF Intranet Site;

b. Homicide Squad digital drives;

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c. Records Management System;

d. Koda digital search;

e. Government Record Repository;

f. NSWPF Governance Command;

g. NSWPF Crime Prevention Command; and

h. NSWPF Professional Standards Command.

9. I respond to each of the Inquiry's questions in the Request for Statement in the following sections of my statement below:

   a. **Section A**: addresses Recommendation 8 and questions 1 – 5 in the Request for Statement concerning this recommendation;

   b. **Section B**: addresses Recommendation 9 and questions 1 – 5 in the Request for Statement concerning this recommendation;

   c. **Section C**: addresses Recommendation 10 and questions 1 – 5 in the Request for Statement concerning this recommendation.

10. At the outset, I note that there had been significant changes to the manner in which homicide investigations were conducted and to policing practices and systems more generally since the investigations which were the subject of the Taradale Inquest (which concerned deaths between 1985 and 1989) and when the recommendations were made in the Taradale Inquest in 2005. In my First Statement, I describe the nature of some of those changes.

11. Furthermore, there were significant structural changes occurring within the NSWPF in around 2002 to 2005 in response to recommendations and findings arising from other internal and external reviews, which I detail in my First Statement, including:

    a. the introduction of State Crime Command, and in turn the Homicide Squad, in 2002;

    b. the introduction of the Unsolved Homicide Team in 2004;

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c. accreditation of the Homicide Investigators Course in around 2005; and

d. changes to the manner in which missing persons investigations were conducted, including the role and function of the Missing Persons Unit (now the Missing Persons Registry).

12. While these structural changes were not directly in response to the Taradale Inquest recommendations, in my view the changes represented a positive development in the investigation of homicides in NSW and are relevant to the concerns expressed by Deputy State Coroner Milledge at the conclusion of the Taradale Inquest in her findings and recommendations. I understand that the Taradale Inquest heard evidence on various dates between about March and September 2003, received final submissions in December 2004, and produced findings in December 2005.

ROLE AND POLICING EXPERIENCE / QUALIFICATIONS & TRAINING

13. I am a Detective Superintendent, and Commander of the Homicide Squad of NSWPF. I have held this position since 2019.

14. An explanation of my current role, policing experience, qualifications and training is set out in paragraphs 8 – 12 of my First Statement.

A. RECOMMENDATION 8

15. In this section of my statement I address Recommendation 8 which recommended the Minister for Police and the Police Commissioner:

> *Review procedures in relation to the recording of possible causes of death at early stages of any investigation in order to minimise erroneous or lazy conclusions based on incomplete information*

(a) Whether and by what means the NSWPF accepted the recommendation

16. Based on the information available to me at the time of making this statement, detailed below, I understand the NSWPF accepted Recommendation 8 and reviewed the procedures in place in

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2005 relating to that recommendation. Advice was then provided by the NSWPF Professional Standards Command (**PSC**) (who I understand co-ordinated the response of various Commands within the NSWPF in relation to the Taradale Inquest recommendations) to the Ministry of Police (which I understand to be a reference to the Office of the Minister for Police as it then was) for the purpose of the Minister of Police preparing a response to the State Coroner.

17. In the context of preparing this statement I have been shown a copy of a document dated August 2005 being an issues paper circulated by the PSC requesting comment from the State Crime Command (**SCC**) in relation to a number of the Taradale Inquest recommendations (including Recommendation 8 and Recommendation 10) (**PSC Issues Paper**). I understand, from my review of that document, that the PSC Issues Paper was prepared with the advice and recommendations of then Detective Superintendent Paul Jones, the then Commander of the Homicide Squad. It was also reviewed and signed off by:

    a. (then) Detective Chief Superintendent Peter Dein, the then Manager of Operations of SCC; and

    b. (then) Superintendent Malcom Lanyon, the then Acting Commander of the SCC.

18. A copy of the PSC Issues Paper is at **NPL.0100.0009.0073**.

19. Based on my review of that document, then Detective Superintendent Jones (now retired) recommended that the advice be provided to the PSC. That recommendation was supported by then Detective Chief Superintendent Dein (who retired from the NSWPF in July 2014) and then Detective Superintendent Lanyon (now Deputy Commissioner Lanyon), who was acting Assistant Commissioner at the time. Then Detective Superintendent Lanyon also commented:

    'I support D/Supt Jones comments, though I would recommend the Service ensure its satisfaction with physical exhibit retention facilities & procedures are adequate across all Cmds [Commands]'

20. Relevant to Recommendation 8, Detective Superintendent Paul Jones has commented:

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'The NSW Police has a process which requires mandatory notification to the Homicide Squad, State Crime Command of all possibly suspicious deaths and instances of persons injured who may die. These notifications are reviewed by an experienced Detective Inspector who provides advice and in most cases arranges the attendance at the scene of the death by experienced homicide investigators who are available 24 hours a day, seven days a week'.

21. This description is consistent with my understanding of the processes in place in relation to the operation and responsibility of the Homicide Squad in the context of homicide investigations in around 2005, which I discuss at paragraphs 44 to 48 of my First Statement.

22. I understand that in 2002, when the SCC was established, the Homicide Squad and other major crime squads within the NSWPF introduced an on-call response team for the purpose of the mandatory notification of all major crimes (including homicides and suspicious deaths, in the case of the Homicide Squad). The on-call response team operates within the Homicide Squad to this day.

23. As detailed in my First Statement, there were a number of benefits which came from centralising the Homicide Squad within the SCC in 2002, namely:

    a. It established the primary responsibility for investigating suspicious deaths and missing persons cases to a central body;

    b. Communication issues which previously existed at the regional level were removed, and intelligence and information sharing was improved;

    c. It enabled an improved service and level of support to the field (Police Area Commands and police departments);

    d. Internal and external agencies were able to have one point of specialist contact at the Homicide Squad; and

    e. It enabled uniformity for training, development of skills and consistency for all advice and guidance provided.

Witness: [redacted]

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24. In terms of assessing whether a death was 'possibly suspicious' as at 2005, based on my experience working at numerous metropolitan Local Area Commands across Sydney for most of my service, including in 2005, whether a death was 'possibly suspicious' was, by that time, assessed and determined based on all the circumstances and information surrounding the death, including:

    a. the investigating officer's interpretation of the crime scene, which involves (among other things) that officer reviewing the scene and assessing the location of the deceased's body, the nature of any wounds sustained (if any), looking for the presence of weapons, reviewing the scene for any CCTV or other surveillance devices, looking for evidence of forced entry (if relevant) or robbery and speaking to potential witnesses;

    b. communication with the crime scene officer. The crime scene officer's primary role on an investigation is to identify and examine forensic evidence and provide evidence regarding their examinations in the context of any criminal prosecution or coronial inquiry. This includes attending and assessing the scene and recording, collecting and processing forensic evidence and exhibits from the scene to support NSWPF investigations; and

    c. the results of forensic inquiries and examinations, such as fingerprint and DNA analysis, as well as medical evidence obtained from pathologists and / or other medical practitioners in the context of post-mortem examinations or the provision of advice to police at a preliminary stage of the investigation as to possible causes of death.

25. It is my understanding from my personal experience that as at 2005, local officers and detectives responding to scenes involving deceased persons would have received training and developed experience in assessing and interpreting crime scenes, including via training provided in the context of the detectives training course (which was at that time – and continues to be – mandatory training required for all police officers to receive the designation

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of detective) and the Homicide Investigators Course (which was introduced in 1996, as discussed in paragraphs 124 to 131 of my First Statement).

26. As at 2005, my experience was that local officers and detectives communicated with their superior officers, who were experienced detectives, in relation to their assessment and interpretation of the scene and the circumstances surrounding the death, for the purpose of determining if there were suspicious circumstances. Local Area Commands would then make a mandatory notification to the Homicide Squad if there were incidents of homicides or suspicious deaths via the on-call call response team within the Homicide Squad.

27. The Homicide Squad would then provide specialist investigative services, via experienced homicide detectives, to the Local Area Command in which the incident occurred. The mandatory notification to and involvement of the Homicide Squad was to ensure that an experienced investigator was involved at the early stages of the investigation into a homicide or suspicious death, in particular to ensure that:

    a. all available evidence was being captured which may be relevant to the investigation and the determination of the possible cause of death at the early and most critical stages of the investigation;

    b. briefs of evidence were being properly prepared with assistance of and / or guidance from experienced homicide detectives; and

    c. the management and documenting of the crime scene and collation of relevant information was recorded in order to not only assist with the investigation by police, but to assist the pathologist responsible for examining the body and, ultimately, help the Coroner to determine and record the possible cause/s of death.

28. In terms of recording the possible cause/s of death, this was and remains a decision ultimately made by the pathologist responsible for examining the body and the Coroner (assisted by the information provided by police in connection with the investigation, including information obtained via the autopsy of the deceased).

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(b) Whether, by what means, and to what extent, the NSWPF has implemented the recommendation

29. As stated above, based on the information available to me at the time of making this statement, I understand the NSWPF accepted Recommendation 8 and implemented the recommendation by reviewing the procedures in place in 2005 relating to that recommendation. For the reasons I have outlined, the conclusion of that review was that the procedures in place in 2005 were appropriate in light of Recommendation 8. As I explain below, it is my understanding based on inquiries I have made when preparing this statement that although the relevant procedures have been changed and improved since 2005, no specific changes were made by the NSWPF directly in response to Recommendation 8.

30. In preparing this statement, I have been shown a document dated on or around 16 September 2005, which I understand to be a submission to the Ministry for Police (which, as above, I understand to be a reference to the Office of the Minster of Police as it then was), prepared by Caroline Braden, concerning the recommendations made in the Taradale Inquest (**Ministry Submission Paper**). Ms Braden was a Project Officer within the PSC who worked in the Policy and Projects, Corporate Advice Policy team. In 2005, her role as Project Officer was an administrative function, where she would collate information in response to correspondence and / or recommendations from the NSW Ombudsman, the Police Integrity Commission or the NSW State Coroner. A copy of the Ministry Submission Paper is at **NPL.0100.0009.0066**.

31. The Ministry Submission Paper notes that on 11 May 2005, the Ministry for Police advised the PSC, who I understand (from the PSC Issues Paper referred to in paragraph 18 above) was co-ordinating the response from various Commands within the NSWPF to the Taradale Inquest recommendations that:

> *'The Minister will respond on this occasion as there are considerable cost implications for the portfolio in [the] proposals'.*

32. The document notes that advice was obtained from the following Commands within the NSWPF, which advice was attached to the submission:

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a. Commander, Education Services;

b. Commander, Operational Information Agency;

c. Director, Forensic Services Group;

d. Commander, Crime Management Faculty; and

e. Commander, State Crime Command.

33. The Ministry Submission Paper was signed by Caroline Braden (as Project Officer). It was also reviewed and signed off by:

a. Director, Strategic Support Services, Christopher Leeds; and

b. Assistant Commissioner John Carroll of the PSC.

34. There are additional signatories noted at the end of the document, being the:

a. Deputy Commissioner, Specialist Operations;

b. Deputy Commissioner, Operations;

c. Commissioner of Police (who at that time was Commissioner Ken Moroney); and

d. Minister.

35. Relevant to Recommendation 8, the Ministry Submission Paper extracts the advice of then Detective Superintendent Jones contained in the PSC Issues Paper.

36. In the time available to prepare this statement, I have not been able to locate a version of this document signed by the relevant individuals who would have held the relevant rank or position in around September 2005 listed at paragraph 34 above within the NSWPF's holdings. I have also not been able to locate a copy of any document recording the 'response' of the Minister of Police to the State Coroner foreshadowed in the Ministry Submission Paper.

37. In the time available to prepare this statement, I have not been able to locate any documents which record any changes to police procedures made by the NSWPF directly as a result of the

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review conducted in response to Recommendation 8. That said, I am aware of changes and improvements to police procedures since 2005 in response to other internal or external reviews and recommendations, which are relevant to Recommendation 8, which I detail in paragraphs 38 to 49 below.

(c) Whether the NSWPF's current practices are consistent with the recommendation

38. Since 2005, and as detailed in paragraphs 49 to 62 of my First Statement, the role, responsibility, and authority of the Homicide Squad in the context of homicide and suspicious death investigations has expanded significantly.

39. [redacted]

40. In the context of preparing this statement, I have been shown a copy of a document dated 23 April 2010, being an internal memorandum issued by Detective A/Assistant Commissioner Beresford (then Commander of the SCC) to Assistant Commissioner Murdoch (then Commander of the South Region) concerning the 'Leadership of Homicide and suspicious death investigations'. A copy of that document is at **NPL.0100.0009.0040**.

41. Based on my review of that document, I understand that the changes in 2010 came about as a result of recommendations made by Deputy State Coroner Culver in around 2008 concerning a Coronial Inquest into the death of Rachelle Lee Childs.

42. In terms of the current processes and procedures in place concerning the early stages of an investigation into a homicide or suspicious death (which reflect the changes made in 2010), the Homicide Squad will receive a notification in relation to any deceased person identified in NSW

where the police are involved. Such notifications will be received by the Homicide Squad in the following circumstances:

a. [redacted]

b. Even in incidents where local detectives have not identified 'suspicious circumstances' in relation to a death, the Homicide Squad will receive an automatic notification of all situational reports (also known as a 'SITREP') concerning deaths in NSW on a daily basis, via the SITREP system. Those situational reports are detailed and will record the attending officer's observations regarding the scene, including:

    i. the nature and background of the incident;

    ii. [redacted]

    iii.

    iv.

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
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Signature: [redacted]

Daniel DOHERTY
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Homicide Squad
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43. Once the SITREP form is completed by the duty officer, it is forwarded to a supervisor and checked. Once checked, the NSWPF's SITREP system will automatically disseminate the SITREP notification to the required location, such as SCC and the respective squad (including the Homicide Squad in the case of incidents involving death). The SITREP form is to be completed by the duty officer as soon as is reasonably practicable immediately following the incident. A copy of a template SITREP form is at **NPL.0100.0009.0075**.

44. The on-call team within the Homicide Squad (comprised of experienced homicide detectives) are responsible for reviewing all SITREP forms received, as soon as they are received. The on-call team will assess if there are reasons which would justify the Homicide Squad becoming involved in an investigation (for example, because there is something in the SITREP which arouses suspicion, which has not been identified by the attending officer, or because, in the opinion of the on-call homicide detective reviewing the SITREP, there are essential details missing from the form which warrant clarification with the officer in charge of the investigation). In those circumstances, the Homicide Squad would contact the officer in charge of the investigation to discuss any concerns. A decision would then be made as to whether the Homicide Squad should become involved in the investigation moving forward (for example, by providing consultation services to the investigation team or taking over leadership of the investigation for a period of time). The Homicide Squad, in consultation with SCC, has the ultimate authority to make the final decision as to the level of involvement of the Homicide Squad on any investigation in these circumstances.

45. In the context of missing persons investigations, and as detailed in paragraph 109 of my First Statement, it is mandatory for there to be immediate notification to the on-call team within the Homicide Squad if suspicious circumstances exist.

46. In terms of ensuring attending local detectives are able to identify whether the circumstances surrounding a death or missing persons investigation are 'suspicious', all detectives receive training in assessing and interpreting crime scenes, including training provided in the context of the detectives training course (which, as noted, is mandatory training required for all police officers to receive the designation of detective). Furthermore, for the purpose of completing and submitting the SITREP in relation to a specific crime (or suspected crime), all officers and

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detectives are required to consult with the forensic crime scene officers (who receive their own specific training concerning the investigation and management of crime scenes) and the senior officers and detectives within their Command.

47. The above procedures serve to ensure that to the extent there is a homicide, suspicious death or suspicious missing persons investigation, there are experienced detectives involved in that investigation in the early stages and at the most critical point of that investigation, to ensure best practice is being following in relation to:

    a. capturing evidence (including exhibits, potential witness statements, canvassing the area and the collection of other material such as CCTV footage);

    b. appropriate management of the crime scene and exhibits;

    c. the management and co-ordination of searches;

    d. the management and co-ordination of other specialist resources and teams on the investigation; and

    e. information management on the investigation generally (including communications with witnesses, persons involved in the investigation and the public).

48. Having regard to the above processes and procedures which apply to homicide, suspicious death and suspicious missing persons investigations, I am of the view that the NSWPF's current practices are consistent with Recommendation 8.

49. During my time as Commander of the Homicide Squad, my experience is that officers are careful and diligent in identifying possible causes of death and take careful account of available information regarding possible causes of death. I have not witnessed any obvious 'erroneous or lazy conclusions based on incomplete information' being made by officers on any investigation. To my observation, there is a clear understanding among homicide and other detectives that a great deal of caution should be exercised in concluding that there are no suspicious circumstances surrounding a death. Each team is managed and oversighted by an experienced Detective Inspector who reviews and monitors investigations. This oversight

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ensures that safeguards are built into the procedures and practices in place. Those safeguards are designed to ensure that proper procedures and practices are followed and greatly reduce and mitigate the risk that an unduly hasty conclusion will be reached that death was an accident or suicide, when in fact it was a homicide. Even if that were to occur in the work of an individual officer, the current processes and procedures require consultation and collaboration amongst officers, and (as noted above) oversight by an experienced Detective Inspector, such that I expect that any deficiencies in the conclusions reached by an individual officer would be identified and addressed.

(d) Results of any reviews undertaken by the NSWPF as a result of the recommendation

50. In the time available to prepare this statement, I have not been able to locate any documents which record any reviews undertaken by the NSWPF beyond those referred to in paragraphs 16 – 20 and 30 above). However, and in addition to the matters I address in my First Statement, I have endeavoured to detail above the changes and improvements to police procedures since 2005 in response to other internal or external reviews and recommendations, which are relevant to Recommendation 8.

(e) Any other action undertaken by the NSWPF as a result of the recommendation

51. In the time available to prepare this statement, I have not been able to locate any documents which record any other action undertaken by the NSWPF directly in response to Recommendation 8 (outside the documents referred to in paragraphs 18 and 30 above). Again, I have addressed a number of changes and improvements to police procedures since 2005 in response to other internal or external reviews and recommendations, which are relevant to Recommendation 8 both above and in my First Statement.

B. RECOMMENDATION 9

52. In this section of my statement I address Recommendation 9 which recommended the Minister for Police and the Police Commissioner:

Witness: [redacted]

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Reinforce the requirements of the Charter for Victims Rights where Victims of Crime are entitled to be given information concerning their investigations in a timely fashion, and that all Victims of Crime are to be dealt with compassionately.

(a) Whether and by what means the NSWPF accepted the recommendation

53. Based on my review of the Ministry Submission Paper (referred to in paragraph 30 above) I understand the NSWPF accepted Recommendation 9 and reviewed the procedures in place in 2005 relating to that recommendation. Advice was then provided by the PSC to the Ministry of Police for the purpose of the Minister of Police preparing a response on all recommendations to the State Coroner.

54. I understand, both from my review of the Ministry Submission Paper and also from my experience as an officer of the NSWPF at that time, that in 2005 the importance of the Charter of Victims Rights (which I understand was at that time embodied section 6 of the now repealed *Victim Rights Act 1996* (NSW)) and its requirements were (and still are) communicated to all officers within the NSWPF from the time they joined the force. As I explain below, this occurs both in formal induction and other structured training and in the course of 'on the job' training by senior officers.

55. The requirements of the Charter of Victims Rights (now embodied in the sections 6 and 6A of *Victims Rights and Support Act 2013* (NSW)) are reinforced in multiple ways during an officer's time on the force. For example, the Charter of Victims Rights represents a core component of the NSWPF Code of Ethics. It is reinforced in multiple mandatory training courses and modules undertaken by all officers (which are detailed in the Ministry Submission Paper).

56. The requirements of the Charter of Victims Rights are also a key component of the detectives training course, the Homicide Investigators Course and the mandatory courses undertaken by all officers in relation to hate crimes (referred to in paragraphs 136 to 140 of my First Statement).

57. From the perspective of detectives serving in the Homicide Squad, the importance of the Charter is reinforced from day-one in the squad, through the training and induction packages

provided to new detectives (referred to in paragraph 134 of my First Statement) and the Homicide Squad Business Charter (referred to in paragraph 62 of my First Statement).

(b) Whether, by what means, and to what extent, the NSWPF has implemented the recommendation

58. As noted above, my experience is that the need for adherence to the Charter of Victims Rights was, and continues to be, reinforced to detectives and general duties police in a variety of ways.

59. In the time available I have not located any documents to indicate whether there were any changes to the way the Charter of Victims Rights was reinforced to officers as a direct result of Recommendation 9. In any event, I believe that the systems in place in 2005, which have changed and improved since 2005 in response to other internal or external reviews and recommendations, were consistent with Recommendation 9.

(c) Whether the NSWPF's current practices are consistent with the recommendation

60. As stated above, the importance of the Charter of Victims Rights and its requirements are communicated to all officers within the NSWPF from the time they join the force and are reinforced in multiple ways during an officer's time on the force.

61. By way of example only, and in addition to the matters I discuss above, at paragraph 62 of my First Statement I discuss the current 'Homicide Squad Business Charter' which details the services and products provided by the Homicide Squad.

62. The Homicide Squad Business Charter emphasises the importance of the Charter of Victims Rights and victim support, to address and meet the needs of victims of crime through awareness of a victim's family's needs and ensuring those needs are met by regular updates regarding investigations and informing them of significant developments and seeking feedback. Members of the Homicide Squad (including myself) are in contact with Victim Support Groups regularly to afford them the opportunity to interact with investigators and Command from the Homicide Squad.

Witness: [redacted]

Nigel WARREN
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63. As Commander of the Homicide Squad, I have observed a culture of strict compliance with the Charter of Victims' Rights by all detectives on the squad and all officers involved in homicide investigations. I have observed this on every homicide investigation in which the Homicide Squad has been involved since my time as Commander, and have seen this demonstrated by all officers from the time of initial contact with the family all the way through to criminal and coronial processes.

64. Further, a key component of the Homicide Squad's role in a homicide investigation is the introduction (and mandatory notification) by the Homicide Squad of any victim of homicide to the Homicide Victims Support Group (**HVSG**). As explained in my First Statement, the Homicide Victims Support Group is a State Government funded organisation that provides support to victims of homicide and which, following the mandatory notification by the Homicide Squad, initiates counselling and support for victims.

65. Having regard to the above processes and procedures which seek to reinforce the importance the Charter of Victims Rights, I am of the view that the NSWPF's current practices are consistent with Recommendation 9.

(d) Results of any reviews undertaken by the NSWPF as a result of the recommendation

66. The Homicide Squad regularly reviews its processes and systems to ensure it is following best practice in relation to the support provided to victim's families and advocacy groups. To the extent potential improvements are identified (either internally or as a result of external review), they are implemented.

67. Recommendation 9 does not appear to have required a formal review to be conducted. As noted above, I have not identified any review beyond that referred to at paragraphs 30 and 53 above.

68. As detailed above, the requirements of the Charter of Victims Rights are a key focus of the training and instruction provided to officers. This was demonstrated only recently in 2022 in response to a suggestion by the HVSG seeking support from the Homicide Squad for Victim's Advocate Cards for families impacted by homicides.

Witness: [redacted]

Nigel WARREN
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69. The Homicide Squad worked closely with the HVSG and implemented a pilot program for Victim's Advocate Cards, to assist the families and next of kin of victims of homicides in gaining greater empathy and understanding of their circumstances in dealing with their personal affairs and dealings with financial institutions, rental agencies, insurance companies and the like.

70. A Victim's Advocate Card, pamphlet and poster was designed by the NSWPF in conjunction with the HVSG. I understand from my discussions with members of the HVSG that this initiative has had a positive impact on the families and next of kin of victims of homicide.

71. In addition, following a recommendation arising from the Lindt Café siege, the NSWPF has introduced a Family Liaison officer program, whereby Family Liaison officer/s are appointed to homicide investigations. The Family Liaison officer is the contact point for the family and next of kin of any victims of homicide. Those officers work with the officer in charge of the homicide investigation (although would ordinarily be an officer independent of the investigation) and receive training for that role. This initiative and training is managed by the Counter Terrorism & Special Tactics Command. The implementation of the program is presently in its initial stages across the NSWPF.

(e) Any other action undertaken by the NSWPF as a result of the recommendations

72. In the time available to prepare this statement, I have not been able to locate any documents which record any other action undertaken by the NSWPF directly in response to Recommendation 9 (outside the Ministry Submission Paper referred to in paragraph 30 above). However, and in addition to the matters I address in my First Statement, I have endeavoured to detail above the changes and improvements to police procedures since 2005 in response to other internal or external reviews and recommendations, which are relevant to Recommendation 9.

C. RECOMMENDATION 10

73. In this section of my statement I address Recommendation 10 which recommended the Minister for Police and the Police Commissioner:

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
5 May 2023

Signature: [redacted]

Daniel DOHERTY
Detective Superintendent
Homicide Squad
5 May 2023

> *Audit outstanding homicides and suspected deaths to ensure investigations are active and ongoing. Where investigations have stalled these matters are to be referred to the State Coroner for his consideration*

(a) Whether and by what means the NSWPF accepted the recommendation

74. Based on the information available to me at the time of making this statement, namely the PSC Issues Paper (referred to in paragraph 18 above) and the Ministry Submission Paper (referred to in paragraph 30 above), I understand the NSWPF accepted Recommendation 10 and reviewed the procedures in place in 2005 relating to that recommendation. Advice was then provided by the PSC to the Ministry of Police for the purpose of the Minister of Police preparing a response on all recommendations to the State Coroner.

75. The PSC Issues paper also addresses Recommendation 10 of the Taradale Inquest. Relevant to Recommendation 10, then Detective Superintendent Jones has commented:

> *'The Unsolved Homicide Team within the Homicide Squad are currently reviewing unsolved homicides that occurred between approximately 1970 – 2000. A number of these investigations have been confirmed as ongoing. The Homicide Squad has also commenced a process of identifying all homicide investigations that are unsolved from the year 2000 to current. Subject to their status a formal review of that investigation will be offered to the Local Area Command who has responsibility for that investigation. This review process is regularly applied to other current homicide investigations so that the expertise held within the Homicide Squad can be applied to an ongoing investigation'.*

76. This section of the PSC Issues Paper is extracted in the Ministry Submission Paper referred at paragraph 30 above.

77. The observations of Detective Superintendent Jones extracted above are consistent with my understanding of the role and function of the Unsolved Solved Homicide Team (**UHT**) within the Homicide Squad in around 2005, which I discuss at paragraphs 72 to 79 of my First Statement.

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
5 May 2023

Signature: [redacted]

Daniel DOHERTY
Detective Superintendent
Homicide Squad
5 May 2023

78. As stated in my First Statement, the UHT was first established in 2004, after the conclusion of evidence in the Taradale Inquest but prior to the making of final submissions and, in turn, findings and recommendations. It was not established in response to those recommendations, but rather in response to recommendations made in the context of earlier Coronial Inquests.

79. In this regard, I understand the Taradale Inquest proceeded on various dates from March 2003 to September 2003. I understand that submissions in the Taradale Inquest were received in around December 2004 (at around the time the UHT was established). Deputy State Coroner Milledge then delivered her findings and recommendations in May 2005. While I do not know precisely what evidence was before her Honour in the context of the Taradale Inquest, based on my understanding of this timeline, it is likely there was no evidence before her Honour concerning the UHT at the time the findings and recommendations were made (as the UHT did not exist at the time evidence was heard).

80. That said, I believe the establishment of the UHT as part of the Homicide Squad addressed the concerns raised by Coroner Milledge in the Taradale Inquest, particularly the concerns that led her Honour to make Recommendation 10. I say that because one of the key roles and functions of the UHT (which was its sole function at its inception) is to actively review and monitor all unsolved homicide cases and to ensure those cases are being monitored and reviewed, and re-investigated if the UHT identifies deficiencies in the original investigation or if and when new information or evidence is identified.

(b) Whether, by what means, and to what extent, the NSWPF has implemented the recommendation

81. As detailed in paragraphs 72 to 79 of my First Statement and above, the UHT was first established in 2004. Its initial remit was to review unsolved homicides and suspicious deaths which were identified following an audit by the UHT of available records in relation to unsolved homicide offences.

82. By 2008, over 400 unsolved homicide offences had been reviewed, with 201 cases identified as warranting re-investigation. It was at that time that four investigative teams were established within the UHT which expanded the remit of the UHT to not only review unsolved

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
5 May 2023

Signature: [redacted]

Daniel DOHERTY
Detective Superintendent
Homicide Squad
5 May 2023

homicides or suspicious deaths, but to also conduct re-investigations into cases which were assessed as warranting a further investigation. The investigative capacity and number of units assigned to the UHT significantly increased at this time to the number of officers and units it has today.

83. In around 2012, the UHT broadened its parameters to include pre-1970 and post-2001 homicide cases, including suspicious missing persons cases.

84. As detailed in my First Statement, in particular paragraph 85, the UHT continues to have a Review and Coronial Support Unit. That team is responsible for reviewing and triaging unsolved homicides or suspicious deaths throughout metropolitan and all regional areas in NSW, including examining and assessing the daily intelligence reports received by the NSWPF to assess whether there is any fresh evidence of relevance to an unsolved investigation.

85. Further, and as detailed in paragraphs 109 – 112 of my First Statement, in the context of long-term missing persons cases, current operating procedures (which have been in force since at least 2019) require that all long-term missing persons' matters are to be reported to the Coroner within 12 months of the initial report being made by the relevant unit in charge of the investigation.

86. At any subsequent coronial inquest, a Coroner may recommend a long-term missing persons case be referred to the UHT. If such a recommendation is made, responsibility for long term management of the investigation will transfer to the Homicide Squad.

87 [redacted]

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
5 May 2023

Signature: [redacted]

Daniel DOHERTY
Detective Superintendent
Homicide Squad
5 May 2023

[redacted]

(c) Whether the NSWPF's current practices are consistent with the recommendation

88. Based on the procedures outlined above and in my First Statement, I consider the NSWPF's current practices (as documented in the current standard operating procedures of the UHT referred to at paragraph 87 of my First Statement) are broadly consistent with Recommendation 10, subject to the observations I make below regarding the referral of 'stalled' investigations to the State Coroner.

89. Unlike the situation which existed prior to the introduction of the UHT (being the situation which I understand informed Deputy State Coroner Milledge's recommendations in the Taradale Inquest), there is a now a centralised and dedicated team of experienced detectives within the Homicide Squad responsible for reviewing, monitoring and re-investigating unsolved homicides, suspicious deaths and suspicious missing persons investigations.

90. I note that Recommendation 10 suggests that '[w]here investigations have stalled these matters are to be referred to the State Coroner for his consideration'. As a matter of practically, it is not the case that all 'stalled' investigations are referred to the State Coroner. Rather, all unsolved homicide, suspicious death and suspicious missing persons investigations are reviewed and actively monitored by the UHT.

91. The UHT review team monitors daily intelligence reports for information or leads which may give rise to new evidence in an investigation. Depending on the meaning given to the word "stalled" there are likely to be at least several hundred "stalled" investigations (categorised as 'undetected' investigations by the UHT) at any given time. The referral of all of those matters for detailed consideration by the State Coroner would be a very significant imposition on the extremely limited resources of the Coroners Court.

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
5 May 2023

Signature: [redacted]

Daniel DOHERTY
Detective Superintendent
Homicide Squad
5 May 2023

92. Consistent with section 83 of the *Coroners Act 2009* (NSW), an inquest will be re-opened (referred to as a 'fresh inquest') where new evidence and facts come to light which make it necessary or desirable in the interests of justice to hold a fresh inquest.

93. However, if there is no new evidence or facts in an investigation, it will remain with the UHT to monitor the case in the hope that the passage of time will allow for new opportunities to progress the investigation. Should new investigative opportunities emerge (for example, as a result of new evidence via witnesses or advances in forensics or technology) cases are reinvestigated.

94. Where new evidence or facts come to light, depending on the nature of the evidence and its probative value, such new evidence may lead to a person being indicted (in which case the matter would not be referred back to State Coroner). Alternatively, and if there is no prospect of obtaining an indictment (for example, because a suspect has died) the matter would be referred back to the State Coroner for a fresh inquest under section 83 of the *Coroners Act 2009* (NSW).

(d) Results of any reviews undertaken by the NSWPF as a result of the recommendation

95. In the time available to prepare this statement, I have not been able to locate any documents which record any reviews undertaken by the NSWPF directly in response to Recommendation 10 (outside the documents referred to in paragraphs 18 and 30 above). However, and in addition to the matters I address in my First Statement, I have endeavoured to detail above the changes and improvements to police procedures in response to other internal or external reviews and recommendations, which are relevant to Recommendation 10.

(e) Any other action undertaken by the NSWPF as a result of the recommendation

96. In the time available to prepare this statement, I have not been able to locate any documents which record any other action undertaken by the NSWPF directly in response to Recommendation 10 (outside the documents referred to in paragraphs 18 and 30 above). However, and in addition to the matters I address in my First Statement, I have endeavoured to

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
5 May 2023

Signature: [redacted]

Daniel DOHERTY
Detective Superintendent
Homicide Squad
5 May 2023

detail above the changes and improvements to police procedures in response to other internal or external reviews and recommendations, which are relevant to Recommendation 10.

Witness: [redacted]

Nigel WARREN
Detective Inspector
Homicide Squad
5 May 2023

Signature: [redacted]

Daniel DOHERTY
Detective Superintendent
Homicide Squad
5 May 2023

ANNEXURE 1

This and the following 1 page is Annexure 1 to the statement of Detective Superintendent Daniel DOHERTY dated 5 May 2023.

New South Wales

Special Commission of Inquiry into LGBTIQ hate crimes

13 April 2023

Ms Katherine Garaty
Director – Crime Disruption and Special Inquiry Law
Office of the General Counsel, NSW Police Force
Locked Bag 5102
PARRAMATTA NSW 2124

By email: [redacted]

Dear Ms Garaty,

Special Commission of Inquiry into LGBTIQ hate crimes: Recommendations of Taradale Inquest

I refer to the above Inquiry and to the inquest into the deaths of Ross Warren, John Russell and Gilles Mattaini, which was held before Deputy State Coroner Milledge in 2003-2005 ("the Taradale Inquest"). As you are aware, Deputy State Coroner Milledge made some twelve recommendations at the conclusion of the Taradale Inquest on 9 March 2005. I **enclose** a copy of the Coroner's "Findings and Recommendations" made that day for reference.

The Inquiry requests the provision of a statement by an appropriate officer of the NSW Police Force ("NSWPF") addressing the following topics in connection with the recommendations of the Taradale Inquest:

1. Whether and by what means (annexing any relevant document) the NSWPF accepted each of the recommendations, including in particular the following recommendation:

   Audit outstanding homicides and suspected deaths to ensure investigations are active and ongoing. Where investigations have stalled these matters are to be referred to the State Coroner for his consideration

2. Whether, by what means, and to what extent, the NSWPF has implemented each of the recommendations (annexing any relevant document);
3. Whether the NSWPF's current practices are consistent with the recommendations;
4. The results of any reviews undertaken by the NSWPF as a result of the recommendations (annexing documents as appropriate); and
5. Any other action undertaken by the NSWPF as a result of the recommendations.

Where the officer refers to a NSWPF policy, guideline or chapter of the NSWPF Handbook, a copy of the relevant document (historical and current) should be annexed to the statement.

Non-publication orders

I anticipate that the Inquiry will tender the statement/s in evidence and that they will be uploaded to the Inquiry's website. In the event that the Commissioner of the NSWPF seeks any non-publication orders in relation to the statement and/or any annexures, a schedule of the proposed orders sought should be provided to the Inquiry at the same time as the signed statement/s, for consideration by Senior Counsel Assisting.

Timeframe for provision of statement

Please provide the Inquiry with the requested statement and any schedule of non-publication orders sought by no later than **5pm on 5 May 2023**.

In the event that you anticipate any difficulty with the above timeframe for the provision of the statement, please forward a request for an extension of time in writing as soon as possible. To assist in considering the application for an extension, please provide a brief outline of the reasons an extension is sought and the date by which you anticipate being in a position to produce the material sought.

Please do not hesitate to contact me on 0498 484 133 if you have any queries in relation to this matter.

Yours faithfully,

E. Camporeale

Enzo Camporeale
Director, Legal
Solicitor Assisting the Inquiry

Encl (1)