OPERATION ALMAS

SUBMISSIONS OF COUNSEL ASSISTING

29 December 2025

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A. OVERVIEW AND SCOPE

1. From 3 December 2025 to 8 December 2025, Commissioner Johnson held public examinations in relation to Operation Almas, an investigation conducted pursuant to Part 6 of the *Law Enforcement Conduct Commission Act 2016 (**LECC Act**)*.

2. The scope and purpose of the public examinations was as follows:

    1. *First*, to investigate the circumstances surrounding the NSW Police Force response to the 000-call made at 7.03pm on 3 January 2023 reporting that a woman was being bashed behind the Salvation Army building in Ballina including:

        a. the radio broadcast and dispatch of police in relation to the '000' call received;

        b. the response (including timing) of NSW Police Force Officers to the radio broadcast;

        c. the actions of NSW Police Force Officers on attending the location of the alleged assault; and

        d. the decision by NSW Police Force Officers not to declare a critical incident in relation to the death of Lindy Lucinda, and any review of that decision;

2. *Second*, to consider whether any conduct is (or could be) police misconduct, administrative officer misconduct, serious misconduct or agency maladministration and relatedly to consider whether any systemic issues arise that could be areas for agency improvement.

3. These submissions address the issues outlined above, given the evidence (oral and documentary) received during the public examinations.

B. CIRCUMSTANCES RELATING TO POLICE RESPONSE TO '000' CALL AT 7.03 PM ON 3 JANUARY 2023

1(a): Radio broadcast and dispatch of police in relation to '000' call

Nature of dispatch and dispatch assist roles

4. On 3 January 2023, Mr A and Ms B were both working at the Newcastle Communications Centre as Senior Communications Officers (**SCOs**). This essentially involves being a radio operator in either a dispatch or dispatch assist role.[1]

5. The role of the dispatcher includes effective coordination of incidents and ensuring a timely police response; reviewing the current list of jobs on a regular basis (that is, "housekeeping"), ensuring that acknowledged incidents do not sit in the list for an extended time without action, maintaining a situational awareness of incidents, and monitoring the location and welfare of Police units.[2] The dispatcher is the "driver" in charge of what happens on the channel.[3]

6. The role of the dispatch assist is essentially to assist the dispatcher: it includes taking '000' calls; putting checks on jobs; reading through jobs if the dispatcher is busy, calling other emergency services and contacting informants as required.[4] A dispatch assist can be asked to do things by the dispatcher, send a 'service request' through the CAD system, or otherwise just be proactive based on "listening and … channel awareness".[5] The dispatch assist can make broadcasts.[6] The dispatch assist may or may not sit next to the dispatcher, because if working as a "shared offsider" they could be located elsewhere. A "shared offsider" means working as dispatch assist for two dispatchers on two separate channels (although it is only possible to listen to one channel at a time).[7]

7. The roles of dispatcher and dispatch assist are rotated during the course of any shift for fatigue reasons.[8] There is also a shift supervisor for each shift at the Newcastle ROG, which involves overseeing the whole radio room (as well as being the rescue coordinator, if required).[9]

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[1] T25.18-40 (Ms A), 3 December 2025 (**Day 1**).
[2] T26.29-27.5 (Ms A), Day 1; Exhibit 2C (Radio Operation Group SOPS); see also T77.28-78.19 (Mr B), Day 1.
[3] T33.12-13 (Ms A), Day 1.
[4] T30.18-28 (Ms A), Day 1.
[5] T30.33-36 (Ms A), Day 1.
[6] T33.28-30 (Ms A), Day 1.
[7] T31.14-33 (Ms A), Day 1.
[8] T25.42-47 (Ms A), Day 1.
[9] T34.37-47 (Ms A), Day 1.

8. The normal set-up is to have a dispatcher and dispatch assist; however, as Mr B explained, due to a lack of staff, "it does happen where you don't work you can work on your own, just due to staffing levels. It's not the ideal situation but that has happened and continues to happen now."[10]

9. The set-up of the dispatcher is that the CAD system is spread across three main screens: a screen with a map on the right hand side; the main (or centre) screen which displays the "job list" broken up into different sections for jobs that are "unviewed", "viewed", broadcast/ acknowledged etc and smaller panels containing information;[11] and then the left hand screen with the job list (or "working screen")[12] where specific CAD jobs can be opened in 'extended view'.[13] When first sent through to dispatch via CAD, a job will appear on the job list screen with bar numbers on it; it is opened by being clicked on. Priority 2 jobs appear in 'red'.[14]

10. The period from 7:00pm onwards is typically busy because most operational police work 12-hour shifts, and change-over for both operational police and ROG staff is at 6:00 or 7:00pm, at which time any jobs not completed during the day shift are also handed over.[15]

Senior Communications Officers at Newcastle Radio Operations Group (ROG) – Ms A and Mr B

11. Ms A provided a 's 54 response',[16] and also gave evidence at the public examinations.[17] She has been a SCO since 2008; and has worked at the Newcastle ROG since 2004.[18] Ms A was operating in the dispatch assist role as a shared offsider from 7 to 7.30pm on 3 January 2023.[19]

12. Mr B also provided a 's 54 response'[20] and gave evidence.[21] Mr B had been a communications officer for 34 years; he has been a SCO since 2001.[22] Mr B has worked at the Newcastle Radio Operations Centre since 1996.[23] Mr B was the dispatcher for the relevant period from 7:00 to 8:00pm on 3 January 2023.

Applicable ROG Standard Operating Procedures

13. The NSW Police Force ROG has particular dispatch standard operating procedures (SOPS) which set out the requirements for the timing of initial broadcasts and re-broadcasts of information. The ROG SOPS in force at the time were dated June 2022 (Version 64).[24]

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[10] T79.2-20 (Mr B), Day 1.
[11] T82.42-45 (MR B), Day 1.
[12] T82.38-39 (Mr B), Day 1.
[13] T27.31-28.20 (Ms A), Day 1.
[14] T28.22-35 (Ms A), Day 1.
[15] T85.29-30 (Mr B), Day 1 (who stated that "it's just generally a busy time for jobs happening").
[16] Exhibit 1C.
[17] On 3 December 2025, Day 1.
[18] T23.16-30 (Ms A), Day 1.
[19] T33.37-41 (Ms A), Day 1.
[20] Exhibit 5C.
[21] On 3 December 2025, Day 1.
[22] T75.3-14 (Mr B), Day 1.
[23] T75.23 (Mr B), Day 1.
[24] See Exhibit 2C.

14. The initial call concerning the assault at the Salvation Army was classified by the telephonist as a Priority 2 job; this classification was accepted by Mr B (who had the authority to upgrade or downgrade the job).[25] The only higher priority are Priority 1 (or Signal 1) jobs, which are "very rare".[26]

15. In terms of 'Incident Priority', a Priority 2 job requires an "IMMEDIATE RESPONSE", with the 'NSWPF Police CAD Incident Priority' policy stating (emphasis added):

> Responding immediately, unless responding to a Priority 1. Incidents where there is a serious threat to life or property occurring now, requiring an immediate Police response, i.e. armed robbery, violent domestics, serious assaults, person trapped in motor vehicle etc, or urgent action is required to apprehend offenders.
>
> Note: These incidents should be preceded with a "2 tone alert" by the dispatcher.[27]

16. As noted above, the 'priority' of a CAD incident is initially entered by the telephonist receiving the '000' call; however, it can be changed by the dispatchers at police radio.[28] Telephonists also assign "Incident Types" to identify each individual incident; this can also be changed by dispatchers. The incident type is important, as it can impact upon the police response.[29]

17. In this case, the matter was classified as a 'Concern for Welfare' incident, defined as: "Where Police or a member of the public have concerns for the welfare of a person or animal".[30] Another more specific incident type, namely 'Assault', defined as "Actual or threat of force of any kind, without consent, against another person", was not used.[31]

18. Once a Priority 2 CAD incident is received, for the initial (or first) broadcast, the ROG SOPS require that "all reasonable efforts and attempts will be made" to broadcast the incident within 90 seconds.[32]

19. As to subsequent broadcasts, the ROG SOPS require that for a Priority 2 Incident, "all reasonable effort and attempts must be made to re-broadcast" Priority 2 incidents "Every 60 seconds."[33]

20. Additionally, if there is no acknowledgment of a Priority 2 incident within 5 minutes from the initial broadcast, the dispatcher is to ensure that the duty officer or supervisor is contacted and a direction sought. If that does not occur, the incident is to be brought to the attention of the ROG Shift Coordinator.[34]

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[25] T36.5-19 (Ms A), Day 1.
[26] T29.21-31 (Ms A); T86.11 (Mr B) Day 1.
[27] Exhibit 16C (NSWPF Police CAD Incident Priority).
[28] Exhibit 2C, p [8647030].
[29] Ibid, p [8647085].
[30] Ibid, p [8647087].
[31] Ibid, p [8647086].
[32] Ibid, p [8647039].
[33] Ibid, p [8647040].
[34] Ibid, p [8647041].

21. Importantly, Ms A made the following caveat in evidence as to the ROG SOPS:

> … I just think the standard operating procedures, in their wording, is very specific and doesn't give the opportunity for movement. And I know they need to be black and white, but until you sit on a channel, on a whatever night it is, and have multiple priority 2 jobs coming in plus all your logistical jobs, those SOPs are not human it's not humanly possible to adhere to them 100 per cent.[35]

Summary of dispatch timing

22. The timing for the various broadcasts is set out in Annexure A (at [1] to [13]). In short form, at 7:03pm after the telephonist received the call from the anonymous informant (to the effect that "there's a man bashing the hell out of his woman at the back of the Salvation Army in Ballina"), the following occurred:

a. At 7:03pm, the message was entered into CAD as:

> BEHIND THE SALVATION ARMY BLD, 73 TAMAR ST, MOON ST, BALLINA,BALLINA (LGA), 2478
>
> M STATED A FM BEING BASHED BEHIND SALVATION ARMY BLDG[36]

(the **Salvation Army Incident**).

b. At 7:03:28, the incident was sent from the CAD system to the mobile data terminals (MDTs) in the field (as indicated by the CAD Incident Log which states: USER (SYS): "Incident Broadcast: Automatic ALL RESOURCES broadcast for 756667-03012023";[37]

c. At 7:05:03 pm, Ms A, who was then operating as a shared dispatch assist for Channel P and O, first opened the job (although did not necessarily read it at this time);[38]

d. At 7:10:03 pm, Mr B made the initial broadcast of the incident over the police radio: see Annexure A at [5]; he would have opened it prior to this, but could not recall when;[39]

e. At 7:24:25 pm, Mr B broadcast the incident a second time: see Annexure A at [7];

f. At 7:34:49 pm, Mr B broadcast the incident a third and final time;

g. At 7:46:57 pm, the incident was acknowledged by BLN 14, who had just attended a motor vehicle incident on the Pacific Highway: see Annexure A at [9] This acknowledgment was some 43 minutes after the incident was first sent to dispatch via CAD.

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[35] T43.38-47 (Ms A), Day 1.
[36] Exhibit 3C: CAD Incident Log for 756667.
[37] Ibid; T94.25 (Mr B), Day 1.
[38] T50.4-11 (Ms A), Day 1.
[39] T93.13-23 (Mr A), Day 1.

23. An anomaly in the police radio broadcast recording for the relevant period was that the third and final broadcast at 7:34pm was not captured. A suggestion was advanced (by an officer within NSWPF) to the effect that this may have been the result of a particular error by the dispatcher (Mr B) in effect unintentionally selecting a "tile" that may have caused a brief loss of transmission, such that the broadcast would not have been heard by cars in the Ballina area. This contention was rejected (in emphatic terms) by both Mr B and also Ms A.[40]

Submissions

Ms A and Mr B

24. Both Ms A and Mr B were impressive and candid witnesses, whose evidence would be accepted without reservation. Experienced SCOs, both gave evidence in an open, responsive and reflective manner. Both impressed as highly knowledgeable and professional communications officers. Each was obviously impacted by the adverse outcome in this case and were thoughtful in contributing their views about non-compliance with the applicable ROG SOPS, and related systemic issues.

25. Certainly, no individual criticism is warranted in relation to Ms A or Mr B; nor is there any indication of any need for further training, given their skill and expertise in undertaking their respective roles. Both communications officers were evidently doing their best during the busy evening shift on 3 January 2023.

26. As to the anomaly at [23], the evidence of Ms A and Mr B would be accepted, given how ready they were to make concessions. It is open to be satisfied that the transmission reached the Ballina crews - in particular, BLN14 and WB29 - then on scene at the motor vehicle accident in Newrybar.

27. Against that backdrop, the matters set out below should be viewed through a systemic prism, with a view to informing recommendations for agency improvement: see further, Part C at [302] to [326], and Recommendation 1.

Non-compliance with ROG SOPS

28. The evidence disclosed a number of instances of non-compliance with the ROG SOPS, being as follows:

    a. *First,* the incident was most appropriately categorised as an 'assault', rather than a concern for welfare (given use of the word "bash"); it is best practice to ensure that an incident is categorised as accurately as possible;[41] Ms A frankly stated that classifying the incident as a 'concern for welfare' had the potential to downgrade the seriousness of the incident "to a certain extent", given her experience of how police in the field may respond.[42] Mr B explained that he would not generally change an incident type unless

[40] See Exhibits 37C; 38C and 39C.
[41] T36.33-37.13 (Ms A), Day 1.
[42] T37.8 (Ms A), Day 1.

it was specifically wrong; however, he agreed that best practice required an allocation that most accurately reflected the incident.[43] Mr B agreed that an assault was the more appropriate incident type in the circumstances.[44] Mr B noted that this would not otherwise have changed any other aspect of the response,[45] but readily accepted that it was possible police in the field may have taken greater note of an assault, rather than a concern for welfare incident.[46] As it happens, it seems the officers understood the matter to be an assault in any event: see [88], [115];

b. *Second,* the initial broadcast did not occur within 90 seconds of receipt of the CAD.[47] Ms A stated that the initial broadcast within this timeframe occurred "most of the time" for incidents.[48]

c. *Third,* there was no 're-broadcast' every 60 seconds thereafter, as was required:[49] it was first re-broadcast at 7:24pm was 14 minutes after the initial broadcast at 7:10. Mr B agreed this was a significant delay;[50] he thought delay was because he was busy with other tasks, recording information from police and acting on it.[51] The final broadcast was at 7:34pm. Ms A thought the delay could only be put down to the workload on the channel as a whole, and also the underlying impression of knowing there were no other crews.[52] She explained that the re-broadcast requirement was "not always" met;[53] it was probably met 70 or 80 per cent of the time, dependent on the channel and how busy it was.[54] However, none of the general duties police were aware of the re-broadcast requirement every minute, and nor was this their experience of police radio: see for example, Officer C at [89], who did not think he had heard a Priority 2 job being called every 60 seconds for a prolonged period; Supt. Tanner (at [143]); and A/AC Chapman at [225];

d. *Fourth*, there was no escalation to the supervisor in the field within five minutes (in this instance, BLN 14).[55] Ms A explained that the process should have worked along the following lines:

> Ballina 14, there's an outstanding concern for welfare. It's come through as a priority 2." And name the location. "Do you have a direction?" …

[43] T86.47-87.5 (Mr B), Day 1.
[44] T87.17 (Mr B), Day 1.
[45] T87.20-32 (Mr B), Day 1.
[46] T87.20-40 (Mr B), Day 1.
[47] T40.29; T64.30 (Ms A); T100.23 (Mr B) Day 1;
[48] T40.37-38 (Ms A), Day 1.
[49] T64.28-30 (Ms A); T100.28-29 (Mr B) Day 1.
[50] T94.43 (Mr B), Day 1. However, as the transcript reveals there was a confusing domestic violence incident (Priority 2) at Murwillumbah with conflicting information that consumed air time from around 7:10 to 7:20pm: see T94.47-95.28 (Mr B), Day 1.
[51] T96.35-36 (Mr B), Day 1.
[52] T59.4-7; T61.8-13 (Ms A), Day 1.
[53] T41.45 (Ms A), Day 1.
[54] T42.3-9 (Ms A), Day 1.
[55] T64.35 (Ms A); T100.33 (Mr B) Day 1.

> Yeah, "Do you have a car crew?" "Do you want it downgraded?" Yes. So - and then generally speaking, they'll just say, "We're aware of it", or "Give it to another car crew", or something, yeah …[56]

Ms A agreed that according to the ROG SOPS, there should have been an escalation by around 7:15pm.[57] If unable to speak with the mobile supervisor, the internal supervisor should be contacted.[58]

29. Of note, Ms A also stated that the fact of only receiving one call for a particular job can impact prioritisation "quite considerably", as normally multiple calls are received (depending on location, time of day and number of people around). Ms A agreed, however, that it was dangerous to assume there will be multiple calls for a Priority 2 incident: ultimately, there may only be one call (as in this case).[59]

30. Ms A explained that it could not be assumed on the information available, that the incident was a domestic assault.[60] Although the Telstra '000' operator told the telephonist that the informant had said someone was "beating the hell of <u>his</u> woman", those precise words were not repeated in the telephonist's direct discussion with the informant, who told him: "there's a woman getting bashed behind the Salvation Army in Ballina": see Annexure A at [2]. There was no basis to assume the matter was a domestic incident in the circumstances.

31. Otherwise, the reasons for the non-compliance appear to relate to the following matters:

    a. *First*, for the period 7:00 to 8:00pm, Channel Papa – which covers the Richmond and Tweed-Byron Polices Districts[61] – was staffed by Mr B, as dispatcher, and Ms A as shared offsider for both Channels Papa and Oscar.[62] The relevant period (from 7:00pm to 8:00pm was unquestionably busy; this is confirmed by a number of on-air remarks,[63] and was consistent with the evidence of both Ms A (who estimated it to be a '7 out 10' on a scale of business, with 10 being the most busy[64]). Of note, "talk time" on air is not a reliable indicator of how busy the dispatcher and dispatch assist are: during periods of silence, other work (for example, computer checks, putting checks on jobs etc) is being done.[65]

    b. *Second,* Ms A, operating as dispatch assist, appears to have opened the CAD job at 7:05:03, and accidentally clicked the job on the left hand screen section; she explained:

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[56] T41.26-35 (Ms A), Day 1.
[57] T60.46 (Ms A), Day 1.
[58] TT42.18-22 (Ms A), Day 1.
[59] T38.24-39.3 (Ms A), Day 1.
[60] T39.24-40.16 (Ms A), Day 1.
[61] T91.29-30 (Mr B), Day 1.
[62] T46.35-43 (Ms A), Day 1. Ms A could not recall how busy Channel Oscar was during this period.
[63] As canvassed with Ms A at T 57.6-21 (Day 1) – for example, comments from the dispatch such as: "Ballina 14 stand by unless it's urgent"?; "I'm not sure who's available to pick up this job but"?; "There's something in the air tonight, Ballina, there's a job at X". See also Mr B's evidence at T40-98.3 (Day 1).
[64] T56.34-42 (Ms A), Day 1.
[65] T69.27-40 (Ms A), Day 1.

> There's a little box down the bottom that gives us prompts and it can be for updates, it can be for information from other external agencies. That list can be exorbitant. I can accidentally click on a job, by clicking on that, expecting to be looking at an update of a job. So I'd suggest that that's possibly what happened, but I don't know.[66]

The effect of this is that the job would drop off the "little red bar" on the top of the dispatcher's main screen and thus disappear.[67] The only safeguard is that the job would sit in the list of jobs, but would no longer be an "unviewed job", instead dropping into the broadcast list (acknowledged) list.[68]

Ms A said this had happened before, and actually occurs "all the time"; it had been raised as a problem, but it was a "CAD thing" as CAD was no longer being upgraded to her knowledge.[69] Ms A also noted that any redundancy in the CAD system depended on how lengthy the broadcast list was: only a certain number of jobs could be viewed without scrolling; this meant that Priority 2 jobs could "sit down the bottom" and out of view.[70] For his part, Mr B explained that once Ms A had viewed the job, " … it's gone from there and to the top of the screen, and although it's still in my view, I have not obviously seen it, as I've been doing other things. It was quite busy, from what I heard on the recording;" it may have been broadcast earlier had Ms A not viewed it.[71] In effect then, Mr B stated that the job "was removed from where I would normally see that job on initial broadcast, so that I didn't broadcast it straightaway because it wasn't exactly where I would get a priority 2."[72] This apparently common scenario raises clear concerns about the functionality of the CAD system (as to which, see Recommendation 1).

c. *Third,* the Priority 2 incident was not escalated to the mobile supervisor (BLN 14), nor the ROG shift supervisor.[73] As a systemic issue, Ms A identified the lack of staff in the field, as indicated by BLN 14 having to attend jobs in person, rather than supervising and prioritising as was his role. [74] Mr B reflected that in hindsight, he should have raised it with BLN 14 when he attended the crash (which he had assumed was more pressing for him to attend); Mr B agreed it was not safe to make such assumptions.[75] Mr B also candidly accepted that it was not a safe basis to prioritise jobs based on the number of calls made.[76]

d. *Fourth*, as a final matter, Ms A raised the workload of staff at the Newcastle Radio Operations Centre: she described it as "exorbitant" and said that the workload continued to increase.[77]

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[66] T14-47 (Ms A), Day 1.
[67] T51-14 (Ms A), Day 1.
[68] T51.18-40 (Ms A) Day 1.
[69] T52.4-19 (Ms A), Day 1.
[70] T53.22-47 (Ms A), Day 1.
[71] T94.9-17 (Mr B), Day 1.
[72] T100.42-45 (Mr B), Day 1.
[73] T35.16-18 (Ms A), Day 1.
[74] T64.46-65.6 (Ms A), Day 1.
[75] T99.3-11; T105.26-106.7 (Mr B), Day 1.
[76] T100.1-13 (Mr B), Day 1.
[77] T65.9-15 (Ms A), Day 1.

e. *Finally*, Mr B stated his view that the current CAD system is not fit for purpose.[78]

32. Ms A's evidence was also that notwithstanding the significant delay by dispatch (as outlined above), the matter was not raised with her following Ms Lucena's death.[79] Mr B was also first approached by officers from the Commission in relation to the incident;[80] he could not recall any supervisor from the Newcastle ROC raising the matter with him.[81]

33. The foregoing evidence informs proposed Recommendation 1: see Part C at [322].

1(b) and (c): Response (including timing) of NSW Police Force Officers to the radio broadcast and the actions on attending the location of the alleged assault

34. It is convenient to set out the evidence relevant to Issues 1(b) and (c) together.

Resourcing in the Ballina sector

35. The events occurred in the Richmond Police District, which covers some 10,870 square kilometres. It is comprised of 13 policing sectors and provides a police response for 15 townships. The three main 24-hour police stations are Lismore, Ballina and Casino.

36. The rostering for the night shift on Tuesday, 3 January 2023, was relevantly as follows:

a. In the *Ballina sector* – there were four police in totally, namely a supervisor (as Officer C, in BLN 14), a station officer, and one car crew (AO18, comprised of a Senior Constable and Probationary Constable);

b. In the *Lismore sector* – there was a supervisor, a custody officer, a station Officer and two car crews (Lismore 15 and 16), some seven staff in total;

c. In the *Casino sector* – there was a supervisor (a Senior Constable), a station officer and one car crew; and

d. In the *Lower Rivers sector* (Coraki and Woodburn), two officers – one in WB29 (Officer D) and another in CKI22, were rostered on from 11am to 9pm.

37. There was also a Duty Officer, a Chief Inspector (Officer E), rostered from 2pm to midnight.

38. Shift change-over from day to night shift occurs at around 6pm.

[78] T101.26-102-27 (Mr B), Day 1.
[79] T63.46-64.13 (Ms A), Day 1.
[80] T90.10-28 (Mr B), Day 1.
[81] T103.4 (Mr B), Day 1.

Summary of response by police (general duties)

39. In summary, the evidence indicates the following:

a. At 6:38pm, a concern for welfare incident for a female about to self-harm was broadcast on police radio; AO18, WB29 and BLN14 each responded (as it was necessary to first try and locate the female);

b. By 7:01pm, radio had broadcast a job involving a motor vehicle accident (Priority 3) on the Pacific Highway; the details from the CAD job were as follows:

> PACIFIC HWY, BROKEN HEAD RD, NEWRYBAR, BALLINA (LGA), 2479, BLN 1 VEH HAS HIT A TREE IN THE SERVICE LN NR AA *[LANE NEAR ABOVE ADDRESS]* – NPT *[NIL PERSON TRAPPED]* – NPI *[NO PATIEN INJURED]* - 1 VRT *[ONE VEHICLE REQUIRES TOWING]* - NO FLUIDS - NK IP *[NOT KNOWN INTOXICATED PERSON]* - VEH DESC MAZDA 3 WHFTE – NFI;[82]

c. At 7:04pm, BLN14 (Officer C) acknowledged the motor vehicle accident job, stating: "Yeah, copy that, radio. I'll head up and have a quick look at that however I don't have an alcometer…". WB29 responded shortly after stating that he would also proceed to the accident ("I can help out 14 with an alco").[83]

d. At 7:10pm, the initial broadcast was made for the incident concerning a female being bashed behind the Salvation Army building: Annexure A at [5];

e. At 7:21pm, BLN14 (Officer C) arrived on scene at the motor vehicle incident at Newrybar, and broadcast the following:

> Yeah radio, I found that accident, he's on the Pacific motorway northbound lanes, right at Bangalow Road, I mean Broken Head Road overpass …
>
> It's a 110 zone and they're not, literally coming around a blind corner, so I need the truck up here probably to park back and slow the vehicles down if they can. Yeah, actual lanes, number one lane is partially obstructed.[84]

Radio then confirmed that WB29 should proceed red (urgent duties) to the scene; this was broadcast over the radio, with WB29 confirming.[85]

f. At 7.24pm, there was the second radio broadcast for the Salvation Army Incident: see Annexure A, at [7].

g. At 7:25pm, WB29 was on scene at the accident.[86]

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[82] Exhibit 4C.
[83] Exhibit 41C * (Transcript), p [8630743].
[84] Ibid, p [8630748]
[85] Ibid.
[86] Exhibit 4C, p [8630713].

h. At 7:33pm, BLN14 broadcast "… no one's injured. It's definitely a P5 or minor collision'; he also noted: "we're just going to assist with traffic".[87]

i. At 7.34pm, there was the third (and final) broadcast for the Salvation Army Incident.

j. By 7:46pm, BLN14 called in to radio that he and WB29 were back on from the motor vehicle accident; he asked about the outstanding Priority 2 job, and the dispatcher (Mr B), directed him to the Salvation Army Incident: see Annexure A at [9];

k. By 7:55pm, BLN14 and WB29 were on scene: BLN14 contacted police radio seeking clarification of the location and the initial call: see Annexure A at [10];

l. At 7:56pm, BLN14 responded to a query from the Duty Officer (Richmond 10, Officer E) confirming that he did not need a hand at that time, stating: "BLN14: Yeah Ballina 14, I don't think so, we've only got that one outstanding job at the moment now, the one at Wollongbar … and that's through a third party, so that can wait for a while."[88]

m. At 7:58, BLN14 broadcast: "Back on the air from Holden Lane, nothing sighted. There is numerous residents here. I'm sure we would have got more calls if there was something going on in the street there." WB29 confirmed he was also back on: see Annexure A, at [12].[89]

n. At around 12:40am on 4 January 2023, Mr Huber attended Ballina Police Station to report that he thought his partner (Ms Lucena) was dead.[90] Officer C (amongst other police) attended the scene where Mr Huber then directed him down the side of the Salvation Army premises, where the body of Ms Lucena was found.[91]

Civilians encountering Mr Huber on the evening of 3 January 2023

40. Statements were taken from various witnesses in connection with Strike Force Blaikie, the investigation into the homicide of Ms Lucena.

41. On 5 January 2023, Ms Hudson-Moon provided police with a statement to the effect that at 7.20pm, she was walking along Tamar St, Ballina in a Westerly direction, and approached the Salvation Army building. She then heard a distressed male and was able to peer through slats in the gate where she saw a female lying down on some bedding. She assumed the female was asleep; around this time, she also saw a male get up and start walking around (namely, Mr Huber).[92]

42. In a statement dated 4 January 2023, Mr Peter Leadbetter stated that at around 9.30pm on 3 January 2023, he had driven into the rear car park of the Salvation Army and parked his

[87] Exhibit 41C*, p [8629628].
[88] Ibid, [8629635].
[89] Ibid.
[90] Exhibit 22C at p [8641401]; Exhibit 14C, at [12], p [8634136].
[91] Ibid, Exhibit 14C at [19] to [20], pp [8634137] to [8634138].
[92] Exhibit 23C.

vehicle. He recalled a woman (who he knew as Tim) yelling out to a man he knew as 'Rob"; both were known to Mr Leadbeatter from earlier interactions that day at the Salvation Army. Mr Leadbeatter said he could see the man, Rob, standing down the side of the building; Rob then started yelling and swearing; fearing for his own safety, Mr Leadbetter decided to leave.[93]

Evidence of Officer D (WB29)

Background

43. Officer D, a Senior Constable, provided a police statement dated 6 December 2023;[94] he was also called to give evidence on 3 December 2025.

44. Officer D attested from the academy in May 1997. From November 2019 to August 2023, Officer D worked in general duties at Woodburn within the Richmond Police District.[95]

Attendance at motor vehicle accident on Pacific Highway

45. Officer D was working as an alpha (solo) unit for that shift from 11:00am to 9:00pm. His vehicle had an MDT, but it was temperamental, and he could not recall if it was working.[96] Priority 2 jobs are displayed on the MDT screen in red.[97]

46. In relation to attending the motor vehicle accident, Officer D proceeded to the scene as he had the alcometer, so that "we could breath test the driver".[98] Given the information available, Officer D did not consider breath testing the driver an "urgent matter", but it required a prompt response, given the risk of intoxicated drivers.[99] However, the alcometer was not the only reason for attending: given the Pacific Highway (a priority road, in policing terms) and the risk after a collision (noting also the failing light), Officer D stated that it was normal for a second car to attend to provide protection from the traffic "because they just don't slow down".[100] He later referred to the risk of BLN14 being hit by passing traffic.[101]

47. Officer D could not recall where he was when the Pacific Highway job came in.[102] He presumed he was travelling Code Blue;[103] he recalled the point when Officer C made a broadcast about needing assistance, and then proceeding Code Red. [104]

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[93] Exhibit 24C (Statement of Peter Leadbeatter dated 4 January 2023).
[94] Exhibit 6C.
[95] T109.29-32 (Officer D), Day 1.
[96] T110.39-111.25 (Officer D), Day 1. Officer D later explained it got to the stage where some days he would not "even bother logging on", and would instead use radio as the form of communication: T177.11-16 (Officer D), Day 2.
[97] T111.25 (Officer D), Day 1.
[98] T114.44-115.1 (Officer D), Day 1.
[99] T115.12-15 (Officer D), Day 1.
[100] T118.46-119.35 (Officer D), Day 1.
[101] T175.39 (Officer D), Day 2.
[102] T115.24 (Officer D), Day 1.
[103] T116.36-37 (Officer D), Day 1.
[104] T116.42-117.35 (Officer D), Day 1.

48. As to the Salvation Army Incident, Officer D said he had no recollection of that Priority 2 job being broadcast at around 7:10pm; he had the radio on and could not see any reason why he would not have heard it, later stating: "perhaps I would have heard that, yes";[105] although Officer D then said: "my priority and allotted task was to the accident".[106]

49. As to why Officer D attended the Priority 3 motor vehicle accident rather than a Priority 2 incident (with an assault occurring), he initially said he was under "direction " to attend the accident;[107] Officer D later accepted that he had in fact volunteered to attend with the alcometer.[108] He also initially stated that he would have been quite close to the accident by 7:10pm.[109] Once it was pointed out that he then drove for a further 15 minutes to attend the accident in Newrybar, Officer D stated:

> It's a multiple faceted response to the task that I was set at that time. So ordinarily, and I'd even say without exception, or almost all the time, a priority 2 response is required of multiple police not just a single unit officer. That is a standard operating procedure that has been in place for my entire time in the police, and there's been probably a handful of jobs that I've attended to with a priority 2 response that I've attended them single unit.[110]

50. When questioned by his own counsel, Officer D later gave evidence that if he had actually heard the Priority 2 broadcast, it was "fair" to say that he would have given priority to that job.[111]

51. As to the suggestion that given the limited resources, Officer D should have doubled back to Ballina to deal with the Priority 2 job, leaving BLN14 to manage the accident, Officer D stated he didn't know where the location was, and noted also that there was only one informant; he considered his mindset would have been to collect Officer C and return to Ballina to the job.[112] Officer D accepted that it was an option for him to contact police radio and ask whether he should attend the assault in Ballina or attend the accident.[113] However, Officer D then queried whether he had even heard the broadcast (being at the "northern end of the command I was right at the extremity of the radio or the ability of the radio to function correctly";[114] although accepting that he had heard later broadcasts about the accident, Officer D reiterated: "… my experience in the field, was in places, at the extremities of the radio network, very hit and miss").[115]

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[105] T122.36 (Officer D), Day 1.
[106] T118.21-31 (Officer D), Day 1.
[107] T121.3-122.11 (Officer D) Day 1.
[108] T121.10-22 (Officer D), Day 1
[109] T123.1-16(Officer D), Day 1.
[110] T123.32-40 (Officer D), Day 1.
[111] T178.13 (Officer D), Day 2.
[112] T124. 24-35 (Officer D), Day 1.
[113] T125.14-18 (Officer D), Day 1.
[114] T125.23-27 (Officer D), Day 1.
[115] T126.14-16 (Officer D), Day 1. Officer D went on to state: "I'm just trying to provide context into what may else have occurred. It was very, very common, especially in my sector, which wasn't Ballina, to have sketchy radio operations throughout the whole sector, and we were very often recording and logging those black spots with the VKG operators": T126.24-29. He also confirmed that there were known black spots: T126.36. Officer D later gave evidence that the radio network has been upgraded significantly and he now works under a different set of operational conditions: T176.41-47 (Day 2).

52. Officer D thought it was "at best speculative" that if there had been a re-broadcast of the incident every minute (as the ROG SOPS require), he would likely have taken a different course.[116]

53. Officer D (who arrived on scene at the accident at around 7:25pm) parked his vehicle some distance behind Officer; he exited the vehicle and handed Officer C the alcometer; a tow truck came very shortly after; the vehicle was put onto the truck and they cleared the motorway.[117]

54. As to the second broadcast of the Salvation Army Incident (at 7:24pm), Officer D did not recall hearing it.[118]

Acknowledgment of Salvation Army Incident – 7:46pm

55. When the radio transmission at 7:46pm was read to him, Officer D recalled that he was to attend the Priority 2 job; he could not recall a specific conversation with Officer C on scene (although it seemed plausible there was one); he then followed BLN14 back to into Ballina travelling Code Blue.[119]

56. As to why he had travelled Code Blue, and not Code Red for a Priority 2 "bashing" of a woman, Officer D said he was following a senior officer to the job;[120] he was under direction and did not know where he was going; and there had only been "a single call and the time frame elapsed"; he further explained that in the main street of Ballina, it was quite often the case you would receive "multiple calls from multiple informants", suggesting the incident was "still ongoing or had more fluidity"; in Officer D's experience, false jobs or jobs that were not as described were often from a single caller.[121] Officer D accepted however, that the SOPS would ordinarily require a Code Red for a Priority 2 job, although stating "within the timeframe … as it's broadcast".[122] He explained that as time went on and no further calls were received, "that would lessen my willingness to attend a job like with code red".[123] Officer D rejected the suggestion that it was not a safe assumption that more than one call was required to indicate a serious incident (as happened in this case), stating:

> … No, I wouldn't agree with that. Unfortunately, in my experience, and thankfully, with respect to the deceased, this is an incident that has occurred that is not a commonplace incident and is not something that occurs on a regular basis. I've attended probably thousands of jobs that have not been as described by an informant, via a 000 call. I've attended probably hundreds of jobs where there was a single informant with no further calls, and when the job is attended to, no matter what the category, there isn't any - there's no information or person there to speak to that would - that would substantiate the caller's narrative of the call …[124]

[116] T127.15 (Officer D), Day 1.
[117] T131.7-17 (Officer D), Day 1.
[118] T131.22 (Officer D), Day 1; T178.32-43 (Officer D), Day 2.
[119] T133.3-22 (Officer D), Day 1.
[120] See also T136.8-10 (Officer D), Day 1. See also T179.21-41 (Officer D), Day 2.
[121] T133.26-134-11 (Officer D), Day 1.
[122] T134.15-19 (Officer D), Day 1.
[123] T134.22-40 (Officer D), Day 1.
[124] T135.15-26 (Officer D), Day 1.

57. Officer D did not identify any guidance in terms of the police manual or policy documents in support of his contention about the significance of one call only impacting upon the response to a priority call.[125]

Patrol of Holden Lane

58. Officer D followed BLN14 off the Pacific Highway through Ballina, along Cherry Street and then onto Holden Lane.[126]

59. Once in Holden Lane, Officer D initially stated that he was behind Officer C in BLN14, and that he "activated alley lights on the police vehicle I was in, which are lights which illuminate the left-hand/right-hand side 90-degree angle on the light bar there" and then proceeded slowly.[127] Officer D said he then stopped his vehicle on Holden Lane out the front of the backyard of Screenworks Australia and "either got out of my car or I drove right up on to the fence of that property and - and searched that rear yard of that house."[128]

60. Officer D was questioned as to whether he was sure of this evidence (which was not in his statement); he gave evidence to the effect that although not a clear recollection of searching the nominated area or where exactly he went, he recalled focusing on the yard which made sense because it was a residential premises, rather than a business premises.[129] There followed this exchange with the Commissioner:

> Q. Can I confirm with you, Officer D, given that yard was a focus, do you remember getting out of your car and looking?
>
> A. I would have to rely on my practice of getting out and searching yards. I don't search yards from cars, it's impossible. So - but I remember looking behind those two I remember there being sheds in the backyard and looking behind them. So - which would allude me to recall that I was actually out of the car, if that makes sense.[130]

61. On further questioning, Officer D confirmed searching the area around Stafford Lawyers/Screenworks Australia in Holden Lane, but not the specific address nominated by police radio, against stating: "I wasn't sure where it was"; he said he was following Officer into the laneway and had not been there before.[131] Officer D confirmed that he did not search the area behind the Salvation Army building at 73 Tamar Street.[132] There was no conversation with Officer C as to how the search was to be conducted but Officer D said it "made sense to me to commence the search on the right hand side of the lane … that's where I was orientated in the police vehicle … where I had greater visual access".[133]

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[125] T135.36-44 (Officer D), Day 1.
[126] T137.13-138.10 (Officer D), Day 1.
[127] T138.14-20 (Officer D), Day 1.
[128] T138.41-43 (Officer D), Day 1.
[129] T140.24-38 (Officer D), Day 1.
[130] T140.30-38 (Officer D), Day 1.
[131] T141.47-142.6 (Officer D), Day 1.
[132] T143.43 (Officer D), Day 1.
[133] T144.2-7 (Officer D), Day 1.

62. As to the contention that Officer D may have reconstructed his evidence based on usual practice, he stated:

> I wouldn't say it was a truth of the matter that I didn't get out of the car, categorically. I do remember looking behind those sheds and that's what's triggered - it's basically impossible to look behind those sheds from inside the motor vehicle. If you can see the parked car, the two parked cars at the back of the council building, as a reference point … -- the inability to search behind those two sheds from inside a police vehicle whilst you are on that laneway is nigh impossible.[134]

63. Officer D was then played CCTV footage from a premises (Meals on Wheels)[135] located on the left of the Screenworks Australia Building (being the yard area he asserted had been searched). Following further questions from the Commissioner as to whether his evidence might be mistaken given the CCTV, Officer D stated: "Oh, absolutely, Commissioner, that is possible, that I have a mis-recollection of it, but I do recall looking through that yard. … So maybe that's been extrapolated in my memory that I did a more thorough search than I did …".[136] Officer D ultimately accepted that he might be conflating his recollection with something else, and that the "CCTV does not do me any favours in relation to my recollection".[137] The following day under questioning from his own counsel, Officer D agreed that it was "highly probable" he had conflated his memory of searching that area with a search he had conducted on another occasion.[138]

64. Officer D confirmed that he did not search the back of the specific premises - the Salvation Army on Holden Lane - stating that he was not certain where the address was, that he "was under direction" and relied upon Officer C's knowledge as to the way the search should be conducted.[139]

65. Officer D accepted that he could have asked Officer C about which number 73 Tamar Street was.[140] There followed this exchange with Officer D and Counsel Assisting:

> Q. All right. So you made an assumption that the incident may have resolved, is that right, because of the time, the delay in attending?
>
> A. It could have resolved, it could have moved, it could have - there's a hundred different possibilities at that stage.
>
> Q. Well, there could have also been an injured woman in a fenced area behind or next to 73 Tamar Street; correct?
>
> A. That's plausible, yes.

[134] T144.46-145.10 (Officer D), Day 1.
[135] Exhibit 9C.
[136] T148.21-31 (Officer D), Day 1.
[137] T150.35-45 (Officer D), Day 1. See also T180.37-43 (Officer D), Day 2.
[138] T181.1 (Officer D), Day 2.
[139] T151.17-23 (Officer D), Day 1.
[140] T151.31-32 (Officer D), Day 1.

Q. Yes. And unless you get out of your vehicle and you search the specific address in VKG, you don't have a good opportunity of finding the woman that's been bashed, do you?

A. I think that would be highly subjective on the premises type, the time of day, the type of fencing you talk about, the location of the person that we're looking for. There's a hundred variables in that as well.

Q. Well, there's not a hundred variables if you get out of your car and you go to 73 Tamar Street and you have a look. There's not variables then, is there; there's just an address?

A. Yes.

Q. Yes.

A. That's correct.[141]

66. Officer D did not accept that appropriate police practice required him to exit his vehicle and search the side area (where the pool fence was located).[142] Officer D contended that he "may well" have been able to see beyond the pool fence, "depending on the position of the vehicle from inside with alley lights on".[143] On establishing the distance between Holden Lane and the pool fenced area to be approximately 10 metres, Officer D "reluctantly" agreed that he could not see into the fenced side area.[144] He did not accept that a proper search required him to look into the pool fence area, stating: "At no stage was … the side of the building ever mentioned or nominated".[145] He accepted, however, that incidents can be mobile ("100 per cent"), and that informants can be imprecise in giving information to '000'.[146] Given those matters, and whether it was proper police practice to get out of the car and at least look through the pool fenced area of the address nominated by police radio, Officer D stated: "No, I disagree. It's just - it's not police practice to walk the entirety around an address that was nominated for a search …"[147]

67. When questioned by his own counsel, Officer D stated that he had focussed on the area "behind" the Salvation Army shop as this was identified by police radio as the location of the assault; if the location had been "in and around" the Salvation Army, Officer D expected that he would have changed his approach to conduct a broader search which may have included looking over the pool gate or looking at the front of Tamar Street.[148]

68. Officer D did not canvass any residences on either side of the premises as "there was no-one around … there was no signs of life anywhere in that laneway".[149] He could not recall whether

[141] T151.44-152.24 (Officer D), Day 1.
[142] T156.18 (Officer D), Day 1.
[143] T156.29-32 (Officer D), Day 1.
[144] T158.25-34 (Officer D), Day 1.
[145] T158.43-44 (Officer D), Day 1.
[146] T159.1-5 (Officer D), Day 1.
[147] T159.12-17 (Officer D), Day 1.
[148] T182.45-22 (Officer D), Day 1.
[149] T161.20-23 (Officer D), Day 1.

he went around the front of the premises onto Holden Lane;[150] having not highlighted that matter in his statement, Officer D was "leaning towards" not having driven down Tamar Street.[151] Nor could Officer D recall whether there were any cars parked in the car park or not.[152] He accepted that as a general proposition, to be thorough in checking the car park, it was necessary to exit the vehicle and look behind any car or bin structure.[153]

69. As to a conversation with Officer C when they parked their respective vehicles some 100 metres down Holden Lane, Officer D recalled it was about whether he needed to remain in Ballina or return to his own station; he also recalled discussing the difficulties in raising the original informant (but could not recall the details).[154]

70. Officer D agreed that it was busy shift; that was his experience in policing over the last 15 years; he stated: "we can always use extra hands. We can always use an extra car crew …".[155]

71. Officer D did not recall any detectives from Strike Force Blaikie ever speaking to him about the response to the Priority 2, Salvation Army incident.[156]

Evidence of Officer C (BLN14)

Background

72. Officer C, a senior constable, attested from the academy in 1998; he is attached to Lismore Police Station in Richmond Police District (where he has worked since 2005, primarily in general duties).[157]

73. Officer C provided a statement in connection with Strike Force Blaikie (dated 4 January 2023);[158] and gave evidence during the public examinations on 4 December 2025.

Role of shift supervisor

74. Officer C had a "reasonable recollection of the events" having looked at his statement and other relevant documents.[159] He was working night shift from 6:00pm to 6:30am as shift supervisor; this role was basically to oversee the staff on shift and allocate duties, "… just maintaining the smoothness of the running of the shift, basically. Just overseeing such things as jobs and … ensuring cars attend and then if they do, when they do attend, that everything's done correctly and properly and recorded as such."[160] In rural areas like Ballina, it was

[150] T163.27-29 (Officer D), Day 1. Officer D later stated he could not "categorically deny" that he did not go around the front of Tamar Street, and may have doubled back on leaving: T183.41-47 (Officer D), Day 2.
[151] T188.2-26 (Officer D), Day 2.
[152] T185.43-186.1 (Officer D), Day 2.
[153] T187.20-24 (Officer D), Day 2.
[154] T163.34-164.21 (Officer D), Day 1.
[155] T165.33-166.4 (Officer D), Day 1.
[156] T164.34-38 (Officer D), Day 1.
[157] T191.28-45 (Officer C), Day 2.
[158] Exhibit 14C.
[159] T193.15-20 (Officer C), Day 2.
[160] T193.29-47 (Officer C), Day 2.

necessary for the supervisor to be mobile and back up the cars on occasion.[161] Officer C agreed it was the supervisor's role to prioritise the allocation of police resources within the Ballina sector.[162] He explained that on "most days" it was necessary to call on Lismore and "outstation" or minor stations to assist with the police response.[163] Officer C confirmed there were generally four officers on shift in Ballina: the station officer, the supervisor and two car crews (except on Friday and Saturday night).[164] Officer C (in marked car BLN14) reported to the Duty Officer, Officer E for the shift.[165]

Commencement of shift

75. Turning to the shift on 3 January 2023, Officer C recalled attending the self-harm job at 6:38pm; he was clear from that job by 7:06pm but AO18 remained on scene awaiting the ambulance.[166] At 7:01pm, a further mental health job (Priority 3 'concern for welfare') was then broadcast over VKG and Officer C asked radio to check whether it was suitable for ambulance to attend without police; the transcript suggested he was (already) juggling jobs (two Priority 3 jobs).[167] Officer C explained that Ballina in the summertime can be busy, or "hectic" (from mid-afternoon to 9 or 10pm) and then it slows down.[168]

Attendance at motor vehicle accident on Pacific Highway

76. The next job was the motor vehicle accident on the Pacific Highway; Officer C was taken to the transcript of his acknowledging the job, noting it was a priority road (a 110km zone).[169] Officer C thought he had upgraded from Code Blue to Code Red, travelling lights and sirens: he wanted to get there quickly to eliminate the chances of an accident; in 17 years of service at Ballina he had attended many accidents, including fatalities on the Pacific Highway; it was a high risk road where speed was a "big thing".[170] Officer C accepted however, that he did not travel Code Red given the timing of acknowledging the job at 7:03pm, and being on scene 18 minutes later; there was also nothing in the transcript advising Code Red (and generally he would call this over radio).[171]

77. As to the Priority 2 Salvation Army Incident, Officer C recalled hearing that broadcast enroute to the accident.[172] He believed he would have been assessing or thinking how he was going to respond, but could not say that he formulated a plan.[173] Officer C made the decision to continue to the accident as he thought it took priority at that stage, explaining:

[161] T194.3-17 (Officer C), Day 2.
[162] T194.21 (Officer C), Day 2.
[163] T194.25-30 (Officer C), Day 2.
[164] T195.3-14 (Officer C), Day 2.
[165] T195.15-22 (Officer C), Day 2,
[166] T197.18-198.12 (Officer C), Day 2.
[167] T198.17-199.10 (Officer C), Day 2.
[168] T199.8-18 (Officer C), Day 2.
[169] T199.22-200.25 (Officer C), Day 2.
[170] T201.4-28 (Officer C), Day 2.
[171] T202.7-28 (Officer C), Day 2.
[172] T203.5 (Officer C), Day 2.
[173] T203.15-19 (Officer C), Day 2.

> … in my mind, I would have weighed up the seriousness of both jobs. I believe that when I heard that broadcast, I was somewhere near - on the back of Lennox Head, on the Lennox - yeah, the Lennox bypass, which put me closer to - in location to the accident than returning to Ballina. And like I said, my concern was that potentially, a collision at 110 kilometres an hour could result in fatalities. I would have - I would have considered what VKG had said about the nature of the call, a female being bashed, them trying to recontact the informant to get additional information, the response or the manner in which the informant responded. And I - and at that point, I guess I - well, not "I guess"; I made the decision to continue to the accident as the priority.[174]

78. Officer C was not aware that "you're meant to drop jobs of a lesser priority to respond to a Priority 2"; he had not been trained in those terms and was not familiar with the Police CAD Incident Priority document (Exhibit 16C).[175]

79. Officer C gave evidence that he would have upgraded the accident on the Pacific Highway to a Priority 2 based on his triaging, even though no person was trapped or injured; it was often the case that on attending accidents, the information provided did not accord with the police radio information. He also agreed that informants can give imprecise information and that there needed to be a high index of suspicion around the description of things.[176] In any event, it was a risky scenario by virtue of the nature of Pacific Highway.[177]

80. Officer C accepted that it was open to send WB29 to the Salvation Army Incident Priority 2 job, stating: " With the benefit of reflection, hindsight, I - that would have been a rational and smart thing to do but I didn't do that. Why I didn't do that, I don't know.[178] He also said: "That is a course of action that I certainly could have chosen to do. Why I [did not do] that, I don't have an answer."[179]

81. It was also an option to ask highway patrol to attend (if they were available), or to contact the Duty Officer (although the Duty Officer generally monitors the radio).[180] He also noted that "the greater the length of time passes, that's when we start looking at other options. At this stage, only a short period of time had passed. So it wasn't something I suspect that I was even thinking about at that moment in time."[181] Also on reflection, Officer C accepted that he could have called on to radio and asked whether a Lismore crew could respond ("On reflection, in hindsight, maybe I could have done that quicker, earlier, but I didn't").[182]

82. Officer C gave evidence about the accident scene upon arrival: there was an obstruction to Lane 1, and "it was quite obvious to me that even my police vehicle was at risk".[183] He thought

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[174] T203.31-44 (Officer C), Day 2.
[175] T204.10-205.23 (Officer C), Day 2.
[176] T205.46-206.34 (Officer C), Day 2.
[177] T207.23-26 (Officer C), Day 2.
[178] T207.41-44 (Officer C), Day 2.
[179] T208.7-9 (Officer C), Day 2.
[180] T208. 13-32 (Officer C), Day 2.
[181] T208.36-40 (Officer C), Day 2.
[182] T209.15-17 (Officer C), Day 2.
[183] He explained that: "I'd actually parked it in such a fashion that it was - it was like a barrier between the traffic flow and the crashed vehicle which was obstructing the lane, and the cars coming around - it was a - you know, I guess I'd refer to it as a "blind corner". It wasn't, you know, like, a 90 degree turn but it was certainly cars were

there were two or three occupants of the car on scene, and had a vague recollection of another vehicle parked further up the road.[184] With benefit of the transcript of Officer C's broadcast at 7:21pm being read, he agreed that he was concerned about a partial obstruction to the road, and the speed of oncoming traffic and the potential for a collision.[185]

83. Officer C recalled the arrival of WB29 (Officer D) shortly after he requested his urgent attendance via radio.[186]

84. In relation to the second broadcast of the Salvation Army Incident, Officer C had no recollection of it, which was not unusual given he was out of his car, relying on a portable radio on the side of the Pacific Highway with traffic "whizzing past".[187] His focus was on the highway and ensuring he was not hit by a car; the radio broadcast would also have been obscured by the noise outside.[188] As to the second broadcast at 7.24pm, Officer C's attention was "definitely focussed on the accident."[189]

85. As to whether there were black spots in the area, Officer C stated:

> My honest answer to that would be no. Many years ago there was but radio generally is okay, in my opinion now. There is - even under the - well, the system that was in use in 2023, there were black spots in the East Ballina area, but I don't recall ever having or encountering radio issues up the M1.[190]

Acknowledgment of Salvation Army Incident – 7:46pm

86. Officer C contacted police radio at 7:42pm but was told to "stand by unless it's urgent"; he did not think he knew the status of the outstanding Priority 2 job at that time.[191] (Of note, BLN14 does not have an MDT).[192] He could not recall any discussion with Officer E before speaking to radio at 7:46pm (although Officer E recalled a conversation with him: see [117]), at which time he called back on from the accident, and asked about the outstanding job in "Fawcett Lane Ballina"; radio then corrected him about the outstanding Priority 2 job behind the Salvation Army. Officer C recalled that exchange.[193] Officer C gave evidence that he called back on once the accident was satisfactorily resolved, with the Priority 2 job still in the back of his mind at this time.[194]

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coming around there at 110. At the last moment they're veering to the right to clear the mess that was in front of them": T209.28-35 (Officer D), Day 2.

[184] T209.43-210.3 (Officer D), Day 2.
[185] T211.44-712.35 (Officer D), Day 2.
[186] T213.27 (Officer C), Day 2.
[187] T213.33-38 (Officer C), Day 2.
[188] T214.1-19 (Officer C), Day 2.
[189] T215.25-27 (Officer C), Day 2.
[190] T214.25-30 (Officer C), Day 2.
[191] T215.44-216. 3 (Officer C), Day 2.
[192] T217.19-20 (Officer C), Day 2.
[193] T216.22-217.15 (Officer C), Day 2.
[194] T243.20-27 (Officer C), Day 2.

87. Officer C believed that he was Southbound on the Pacific Highway at the time of the acknowledging the Salvation Army Incident (it was a 17 minute drive to the location).[195] He travelled Code Blue for a Priority 2 job given the length of time that had passed, there being only one call and because the majority of the trip was 110 km per hour; in contrast there was heightened risk for a Code Red response.[196] Officer C accepted that as to the aspect of receiving only one call, police may only ever receive one call about a serious assault, and that ongoing delay might mean someone was injured or dying.[197] There was this exchange with Counsel Assisting:

> Q. It's just not a safe assumption, is it, that one call means that an incident can be downgraded priority-wise?
>
> A. Not a safe assumption? I can see that - your logic there and it's not a statement I would disagree with. But on reflection, this incident, I triaged it and I believed at that time it didn't warrant me urgently responding.[198]

88. The incident type was broadcast as a 'concern for welfare' (rather than an assault); Officer C did not think that had the broadcast been for the incident type of 'Assault', 'Occurring now' it would have changed his mindset because the narrative for the CAD message did mention a bashing, so he would have processed it as an assault.[199]

89. Officer C could not say what would have occurred if the job was broadcast every minute after the initial broadcast: given what he was doing, he could not "guarantee" that he would have heard those calls; he did not know whether it would have changed his thinking, stating: "the fact that they [the dispatcher] call it more times is probably not going to change the content of the reported job", although he accepted it would bring it to his attention.[200] If called every minute during the period 7:10pm to 7:21pm, Officer C stated: "Well, I guess, yeah, I would have - if they were calling it every 60 seconds, I would have tried to do something to stop them from calling it."[201] However, he did not think had ever heard a Priority 2 job called every 60 seconds for a prolonged period of time.[202]

90. In responding to the Salvation Army Incident, for every job where it was potentially male/female, Officer C would "automatically assume that there's going to be a domestic component to it", and he probably thought that about this incident.[203]

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[195] TT218.32-44 (Officer C), Day 2.
[196] T218.47-219.15 (Officer C), Day 2.
[197] T219.18-29 (Officer C), Day 2.
[198] T219.31-36 (Officer C), Day 2.
[199] T219.47-220.3; T242.1-2 (Officer C), Day 2.
[200] T220.13-42 (Officer C), Day 2.
[201] T220.47-221.12 (Officer C), Day 2.
[202] T221.23-27 (Officer C), Day 2.
[203] T221.46-222.9 (Officer C), Day 2.

Arrival on scene and patrol of Holden Line

91. Officer C turned onto Cherry Street, and then right onto Holden Lane (travelling east to west);[204] he knew where the Salvation Army building was, having worked in Ballina for 17 years.[205] Officer C stated:

> … I turned on to Holden Lane and I was basically heading in a westerly direction. I knew that - well, the council's on the corner and I knew that there was a car park beside it and then the Salvation Army building. So basically I slowly - I slowed the police vehicle to, I would suggest, almost probably walking pace.
>
> … And then I proceeded very slowly along Holden Lane in a westerly direction. Now based on the content of that message [VKG communication] … my attention was basically drawn to the car park areas and Holden Lane itself …
>
> So I was basically looking or scanning basically the car parks at Holden Lane as I slowly made my way west …
>
> When I reached the point where I was almost on the car park itself for the Salvation Army building on my left, I come to a momentary stop, I looked at the car park, the back of the building, I looked along Holden Lane, I looked to my right, I saw nothing. I saw - when I say, "I saw nothing", I saw no-one, no person. The car park was empty. I could see the entirety of the car park. I could see the back of the building. I could see the fence to the left of the building. Paused there momentarily and then I started to move west at walking pace, again in the car, just doing that, basically, till I got to the end of the lane or got to the end of Holden Lane around Moon Street.[206]

92. That was the entirety of what Officer C did; he did not double back down the lane and check again; Officer D was behind him, and could be seen in his rear view mirror.[207] The vehicles had stopped out the front of the Salvation Army car park; Officer D was going slow.[208] Officer C confirmed that he did not get out of his vehicle at any point; as to the suggestion he should have done that, he stated:

> On reflection and with the benefit of hindsight, yes, I agree that maybe I should have got out of the vehicle. But purely my attention, or where I thought the job was, Holden Lane roadway, or the car park, I - nothing in that what I took in from that CAD job gave me the impression I should be searching behind a fence down the side of the Salvation Army building.[209]

93. Officer C could not see beyond the fence, which was at least 10 metres away.[210] As to whether an appropriate policing response required him to get out of the car and look around the area, he responded:

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[204] T222.15 (Officer C), Day 2.
[205] T222.24-26 (Officer C), Day 2.
[206] T222.36-223.22 (Officer C), Day 2.
[207] T223.25-45 (Officer C), Day 2.
[208] T224.9-20 (Officer C), Day 2.
[209] T224.23-32 (Officer C), Day 2.
[210] T224.35-47 (Officer C), Day 2.

> Like I said, my - what I took to be the job, and where it was, formed in my mind how I should react or, you know, make inquiries to ensure that there wasn't an incident there. And I looked in those locations. Nothing that was said made me think that I needed to get out of the car, check to see whether there was a gate in that fence or whether I could climb over it or whether I - I didn't even know what it was behind that fence. I know the roof line extended down. Yeah, so I don't think - the answer to your question is I don't think that there was - that procedurally, there was something that I didn't do that I should have done, if that makes sense.[211]

94. Officer C accepted that often informants do not provide exact or correct information, but stated " … I mean, what's to say that I shouldn't have been looking over the fences to the residential properties on my right? I mean, to argue or to put to me that just because the informant may have given incorrect information, I still can't see that, you know, it led me any closer to look where I should have look".[212] He continued: "I, in - with hindsight, and the benefit of hindsight and, you know, I probably - I wish I'd looked over that fence … But I didn't."[213]

95. As to why Officer C would not have taken a couple of seconds to look down the side gate of the specific address,[214] he explained his experience with Holden Lane as a thoroughfare; over many years he had been called to jobs where there was nothing there, and people were just transiting through ("… if the job had been at a residential address, in my mind then I'm sure that they would have remained", but because it was the lane, this contributed to his view people were transiting through).[215] Holden and Winton Lane were lanes that police are commonly called to.[216] Nothing made him think to check the exterior of the building.[217] He was not aware of the courtyard or area beside the building until led there by Mr Huber.[218]

96. In terms of canvassing nearby residents, Officer C explained that was something that would only be done if a crime had been detected.[219] Officer C did not know whether there was CCTV at the rear of the Salvation Army or not and did not look.[220] There was this exchange with Counsel Assisting (emphasis added):

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[211] T225.19-30 (Officer C), Day 2.
[212] T225.1-6 (Officer C), Day 2.
[213] T226.9-11; T227.3-8 (Officer C), Day 2.
[214] T226.21-227.28 (Officer C), Day 2.
[215] T242.21-22 (Officer C), Day 2. Officer C later explained in response to questioning by the Commissioner: "Moved on, yes, correct. They've moved - they've continued. It's - in 35 years of policing, it's not uncommon that people, males and females, couples, will be involved in a physical assault and it doesn't stay in one spot. I mean, you know, other than i like, I'm talking about outside of residences, of course. It's not uncommon to receive calls about people fighting in the street moving in this direction": T242.29-36 (Day 2).
[216] T243.5 (Officer C), Day 2.
[217] T227.32-228.11(Officer C), Day 2.
[218] T244.36-40 (Officer C), Day 2.
[219] He stated: "yes, not all jobs - with the luxury of time you would probably go knock on the door of all neighbours for every single job. I guess, or I believe, that based on the fact that there was the one call, the caller was not cooperative, the length of time that had passed, my - not assumption, but the forming of the opinion as to actually where this job was taking place in my mind based on what the CAD message or the radio VKG broadcast, I attended and I patrolled what I thought was where the job was. I saw nothing, located nothing. So in my mind, that certainly would not warrant, then, me going knocking to doors to say, "Did you hear something in the back lanes?": T228.20-41 (Officer C), Day 2.
[220] T229.45-47 (Officer C), Day 2.

Q. That's the point, though, isn't it: that if you'd parked the vehicle, walked into the car park, you could have seen if there was CCTV, you could have had a look down the lane. That's all of about a minute, can I suggest?

A. Oh, I don't disagree with you. I mean, like I said, to be honest, in - what's happened has - I've certainly had time to reflect on what's happened and I've certainly had time to reflect on what part I've played in what's happened, and I've reflected on the fact that if - things could have been vastly different if I'd actually done what you have just said. But unfortunately, on the night I didn't do that and, for the reasons that I've stated, and - well, this is where we are now.

Q. All right. So do I take it from that answer that if you got a job along those lines again, and if there was a nominated premises that said something like "Behind premises A", you would do things differently, is that what you are saying?

A. I would not disagree with that statement. I would say it's fair assumption that I probably would reconsider or have a more - what's the word? - I'd probably treat it differently, yes. I would take additional steps or at least consider whether it would be appropriate for me to take additional steps, get out, walk around, go stick my head over a fence.[221]

97. Officer C did not recall seeing Officer D getting out of his vehicle at any time.[222] He accepted Counsel Assisting's suggestion that it was good police practice to contact police radio at 7:55pm to confirm the details of the job.[223]

98. As to a "very short" discussion with Officer D at the end of Holden Lane, Officer C could not recall the full extent, beyond talking about the job.[224] He recalled the transmission updating radio (at 7:58pm):[225] see Annexure A at [12].

99. Officer C agreed (refreshed by the police radio transcript) there was no time pressure when he was in Holden Lane.[226] Officer C was also advised of an email from Officer E at the conclusion of her shift (at 12.14am, prior to Mr Huber attending Ballina Police Station) which noted: "*Poor [Officer C] at Ballina got smashed between 6 and 10pm. He did a great job down there. Lismore also had another run of mental health jobs*." Officer C agreed that it was a busy shift, particularly with a lot of mental health jobs; he accepted Officer E's characterisation, and although rating it high on a scale of being busy, it was not at '10'.[227] Although no longer working in general duties, Officer C stated that "general duties police are constantly chasing their tails".[228]

[221] T229.2-27 (Officer C), Day 2.
[222] T229.34-36 (Officer C), Day 2.
[223] T230.24-44 (Officer C), Day 2.
[224] T231.8-19 (Officer C), Day 2.
[225] T231.23 (Officer C), Day 2.
[226] T233.22-234.29 (Officer C), Day 2.
[227] T234.31-235.18 (Officer C), Day 2. He explained (at T235.14 to 18) that: "I only say that because I've worked shifts where you've had cars from Casino covering Lismore, Lismore covering Nimbin, Ballina down Lower Rivers, you know, Lismore in Ballina. It's the nature of the beast, unfortunately."
[228] T235.31-32 (Officer C), Day 2.

100. Officer C agreed that he knew Mr Huber (although not well) from a recent interaction involving arresting and charging him for assault; there was also an apprehended order naming Ms Lucena as the PINOP: see further Annexure A at [17] to [18]. [229] As to what steps Officer C would have taken had he seen Mr Huber, he stated:

> If I'd seen him there, I certainly would have stopped and "propped" him, because I - well, it's a business, first of all, at a minimum. "What are you doing here?" Especially if he was inside a fence, but even if he was outside the fence I probably, knowing who he was …[230]

101. He would have held a high index of suspicion about Mr Huber.[231] Officer C would also have entered the unlocked fenced area to have a look had Mr Huber been detected there; he had no question about his powers of entry to do that.[232]

Attendance of Mr Huber at Ballina Police Station – 12:45am, 4 January 2023

102. Officer C gave evidence about Mr Huber's arrival at Ballina Police Station around 12:45am saying in effect that "his missus" was dead; and also attending the scene at the Salvation Army, and going to the pool fence area.[233] In his statement, Officer C said that "almost immediately upon entering, I saw lying on the ground, face up on her back, was a female".[234] There was stuff scattered all over the ground, but "I could make out the shape or form of a person. It was pretty dark but we did have torches, and it was a female, yes".[235] Mr Huber did not ever point Ms Lucena's body out to police: "it was obvious … any person looking in there could see the rubbish or the clothing and items scattered. But you could also quite clearly see that there was a person there."[236]

103. Officer C remained on scene arranging for police and ambulance to attend and also dealing with crime scene duties until around 3:40am. He could not recall a specific discussion with Officer E, but stated: "we would have had a discussion".[237] It had not occurred to him the matter might be a critical incident until this was mentioned by the station officer who relieved Officer C at 3.40am; it surprised him that it was even considered as one.[238] There were no discussions with senior officers about the critical incident aspect; Officer C was never given a direction not to speak with other officers.[239] Officer C did not recall the content of a discussion with Superintendent Tanner, but was sure there would have been a discussion about the fact he had attended a job reported earlier at that location.[240]

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[229] T231.39-232.9 (Officer C), Day 2.
[230] T232.35-39 (Officer C), Day 2.
[231] T232.43 (Officer C), Day 2.
[232] T233.5-14 (Officer C), Day 2.
[233] T235.39-236.34 (Officer C), Day 2.
[234] T236.38-41 (Officer C), Day 2.
[235] T236.44-237.1 (Officer C, Day 2).
[236] T236.44-237.12 (Officer C), Day 2.
[237] T237.23-34 (Officer C), Day 2.
[238] T237.42-238.16 (Officer C), Day 2.
[239] T238.31-44 (Officer C), Day 2.
[240] T239.1-29 (Officer C), Day 2.

104. Detectives requested that Officer C prepare his statement straightaway (which he did on 4 January 2023 ie the night after).[241] He did not recall any interactions beyond that and did not think anyone had ever raised concerns about the patrol on 3 January 2023 with him.[242]

Reflections

105. As to systemic reflections, Officer C stated that although resourcing decisions are a matter for government, "it would be great to obviously have more staff".[243] In concluding his evidence, Officer C observed:

> … I mean, other than with the benefit of hindsight, I wish things had not happened the way that they did happen and I wish, you know, yet again, with the benefit of hindsight, maybe if I'd made, you know - how do I put it? Expanded my search or got out, looked over that fence, walked around the building, we may not be here. But unfortunately, that's with the benefit of hindsight. What's happened's happened and my condolences for the family of the deceased person...[244]

Evidence of Officer E – (Duty Officer/Richmond 10)

Background

106. Officer E attested from the academy in 1996; she was an inspector with Richmond Local Area Command (as it then was) from November 2014 to September 2019; from that time, she was a Chief Inspector and Duty Officer within Richmond LAC or PD.[245]

Role of Duty Officer

107. Officer E provided a 's 54 response' and 's 55 notice' to the Commission concerning relevant events.[246] She had a "quite good" recollection of the shift on 3 January 2023 (where she was rostered from 2pm until midnight).[247] Officer E was working out of her office in Lismore; she explained the role of the Duty Officer as being "responsible for the entire PD, so you've got 15 stations … [and] three 24-hour police stations [Ballina, Lismore and Casino]. The role is to check that you've got rosters filled and to monitor jobs as they go along."[248]

108. For the night shift on Tuesday, 3 January 2023, there were three supervisors at each of Lismore, Ballina and Casino.[249]

109. As to whether the Duty Officer would often leave the office, it depended on workload and the jobs that come in: if it was a busy shift and there were complex jobs, "you will leave the sector

[241] T239.42-240.5 (Officer C), Day 2.
[242] T240.15-41 (Officer C), Day 2.
[243] T241.6-7 (Officer C), Day 2.
[244] T241.10-28 (Officer C), Day 2.
[245] T249.47-250 (Officer E), Day 2.
[246] Exhibit 18C.
[247] T251.23-28 (Officer E), Day 2.
[248] T251.36-39 (Officer E), Day 2.
[249] T252.37 (Officer E), Day 2.

that you're in".[250] Officer E said that it was not particularly often and only in exigent circumstances that you would allocate a Lismore crew (for example) to assist Ballina.[251]

110. Whilst on shift as Duty Officer, Officer E would monitor the radio and her screen displaying the CAD system which showed the status of jobs at any point in time;[252] Officer E could click on the jobs and they would open up.[253] She could check on CAD to see where the car crews were at any time.[254]

111. In terms of a Priority 2 job, Officer E stated that it required a priority response, and can mean threats to life or property; it required an immediate response called a 'Code Red', where police travel lights and sirens (depending on the job, but generally police would respond in this way).[255] In contrast, a Priority 3 was a call for service but was not necessarily urgent.[256] Officer E was familiar with the NSWPF Police CAD Incident Priority classification; however, she was unsure whether general duties police were taught this system.[257] The best way to describe it was that if there were two tones on the radio, a priority response was required.[258]

112. During the shift, Officer E prepared a handover document for the incoming duty officer. She relevantly sent this document, copied to the senior leadership team, at 12:14am on 4 January 2023, with the covering email stating:

> Poor [Officer C] at Ballina got smashed between 6pm and 10pm. He did a great job down there. Lismore had another run of mental health jobs.[259]

113. Officer E explained that the reference in her handover note to speaking with Officer C, and to "FRPA met. Nil issues" concerned the First Response Policing Agreement. This is a contract between the NSWPF and the NSW Police Association which sets out how many cars and staff are to be available on any given shift. The staffing of four at Ballina was in accordance with this agreement.[260]

114. Officer E was questioned as to the jobs referred to in her 's 54 response' (which helpfully included the CAD incident reports for each), including the female self-harm incident (Priority 3) at 6:38pm, with the female located by 7:07pm; a concern for welfare at 7:01pm where no police were allocated (being caught up in the previous job); and then also at 7:01pm the accident on the Pacific Highway (Priority 3), which Officer E described as "upgraded" to urgent by BLN14 when he requested that WB29 respond Code Red.[261]

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[250] T252.42-45 (Officer E), Day 2.
[251] T253.4-7 (Officer E), Day 2.
[252] T253.15-254.5 (Officer E), Day 2.
[253] T254.36-37 (Officer E), Day 2.
[254] T261.28-30 (Officer E), Day 2.
[255] T255.4-6 (Officer E), Day 2.
[256] T255.10-11 (Officer E), Day 2.
[257] T255.21-256.4 (Officer E), Day 2.
[258] T256.9-10 (Officer E), Day 2.
[259] T256.26-257.13 (Officer E), Day 2.
[260] T257.41-258.44 (Officer E), Day 2.
[261] T258.13-260.1 (Officer E), Day 2 (although it was clarified that it was not upgraded to Priority 2 on the CAD job): T260.12-14.

Knowledge of Salvation Army Incident

115. As to the Priority 2 job for the Salvation Army, Officer E recalled hearing the job, but could not recall whether it was the first or second time: she did "distinctly remember … it being broadcast twice" whilst sitting at her desk.[262] At this time, Officer E was speaking to the informant (and father) for the female self-harm job.[263] From the description of the Salvation Army Incident, Officer E did not understand that it was a domestic incident, but rather a concern for welfare; it could also have been assault (and being near the Ballina CBD, could be alcohol-related).[264]

116. Officer E later thought she may not have heard the initial broadcast at 7:10pm, being on the phone at this time and not looking at the CAD dashboard on her screen; the phone call to the informant's father was not a short phone call, given the circumstances.[265] Officer E did hear the rebroadcast at 7:24pm; at that point, she made inquiries about other rostering options, including speaking with the Supervisor at Lismore. She could not recall how long that call was but asked him to check how many police were working at Ballina; Officer E responded: "We may need to deploy Lismore crews, once they're back on, down to there"; and then she began to "kit up".[266] Officer E accepted that some of the Lismore crews were dealing with P4 matters around this time, being "follow up" matters which Officer E thought were domestic (for example, taking reports or serving an ADVO).[267] Officer E was later unsure when she had the conversation with the Lismore supervisor in the context of evidence indicating the text exchange with that officer was at 7:42pm (ie sometime later).[268]

117. Officer E pointed to other Priority 3 jobs coming in prior this.[269] After putting her gun belt on and kitting up, and getting into the car, Officer E recalled a short conversation with Officer C to the effect: "How are you going with that job which is on the highway?" And I believe it's at that point that he says to me, "We're about to come back on". And that's when I say, "No, it's all good, I think they're about to have two car crews available."[270] Officer E said she was conscious of the outstanding Priority 2 job and was thinking "What are we going to do with this job?"[271] She continued on to state: "On its face it's a serious job. The unfortunate thing is there was only one phone call … you would normally have multiple phone calls".[272] Officer E stated that such assumptions are often made in terms of how many calls are received for jobs; she agreed however that (as in this case), you might only get one call for a serious incident.[273]

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[262] T260.30-38 (Officer E), Day 2.
[263] T261.43-261.7 (Officer E), Day 2.
[264] T271.28-40 (Officer E), Day 2.
[265] T262.47-264.4 (Officer E), Day 2.
[266] T264.14- 37 (Officer E), Day 2.
[267] T264.41-265.22 (Officer E), Day 2.
[268] T265.41-266.22 (Officer E), Day 2.
[269] T266.31- 267.8 (Officer E), Day 2.
[270] T267.15-26 (Officer E), Day 2.
[271] T267.40-41 (Officer E), Day 2.
[272] T267.45-268.7 (Officer E), Day 2.
[273] T268.22-34 (Officer E), Day 2.

118. In the context of the Salvation Army Incident being the only Priority 2 job that came in between 6:38 and 7:41pm (when two Priority 2 jobs followed in quick succession), there was this exchange with Counsel Assisting:

> Q. So looking at it now, this was a job that should have received greater priority than being attended to some 35 minutes after the broadcast?
>
> A. I think with the resources that we had and the amount of jobs that we had that were coming in, we did the very best that we could.[274]

119. As to potential systemic issues concerning resourcing, Officer E said that January can be a busier time; although it might be assumed that Tuesday night was not busy, "this was an exceptionally busy shift";[275] Officer E explained that resources were exhausted after the New Year's Eve/Day period (which many officers had worked, including herself): so as duty officer, she was trying to triage things to deal with jobs in a timely manner.[276] As to other options, a station officer would never leave a 24-hour police station; highway patrol were not rostered and it would have been unusual to ask Tweed-Byron Highway Patrol to attend a job in the Richmond PD.[277] Officer E also explained that CKI22 was dealing with a stolen motor vehicle/domestic job which was not ideal given she was an alpha unit; CKI22 did not call back on until 7:55pm.[278]

Officer E kits up and heads out – 7:40pm

120. Once in the police vehicle from around 7:40pm, Officer E attended a Priority 2 job at Goonellabah for a few minutes; she then intended to head into Ballina, but there was another job requiring assessment as to whether a rescue call out was required.[279] At 7:55pm, Officer C broadcast being on scene on police radio; Officer E recalled hearing him say he was there: she stated "so in my mind it's like, okay, I've got a car crew there. I recall shortly after that, Woodburn 29 was also there. Because they were both alphas. And then I recall a short time later that 14 called back on."[280] Officer E also recalled checking in via radio whether BLN14 needed a hand, and Officer C responding that they did not.[281]

Expectations as to nature of police patrol for Salvation Army Incident

121. As to Officer E's expectations regarding the police response to the Salvation Army job, she expected they "would attend, that they would examine the area, whether that be from the vehicle or on foot, and that then they call back on and provide me with the information, because I'm not there"; and further that "… if they're satisfied that they can see clearly what they need

[274] T268.43-47 (Officer E), Day 2.
[275] T269.11-15 (Officer E), Day 2.
[276] T269.22-34 (Officer E), Day 2.
[277] T269.39-270.17 (Officer E), Day 2.
[278] T270.25-271.15 (Officer E), Day 2. She went on to explain that: "Yeah, so we have a single unit policing policy, and so generally, you would not go to something that has - and it doesn't have to just be a domestic, but generally after the hours of darkness, even though it's daylight saving, it's nor preferable that you would go, because obviously there's heightened emotions." T271.18-23 (Day 2).
[279] T272.27-275.25 (Officer E), Day 2.
[280] T275.25-32 (Officer E), Day 2.
[281] T275.34-276.14 (Officer E), Day 2.

to see and they're satisfied, then I'm satisfied, unless there's something glaringly that jumps out ...".[282]

122. Officer E accepted that informants can be imprecise in their description of things to '000'; there should be a high index of suspicion about the accuracy of descriptors such as "behind", "around" or "next to".[283] However, she did not expect the officer to walk up to the gated area, as that was "within the boundaries of the Salvation Army", the two officers were very experienced and she trusted their assessment.[284]

123. Officer E gave evidence that it was not her expectation (even today) that operational police responding to a CAD job in the terms of the Salvation Army Incident would get out of their vehicle and scope the area, including looking down to the gated area.[285] Her expectation "would be that they would search so that they're satisfied, so that then, in terms, I'm satisfied, that there's nobody laying behind the Salvation Army."[286] In her view, operational police are entitled to rely on the specific information provided by an informant (notwithstanding that they can be loose with their language).[287]

124. The officers could canvass residents either side, but Officer E said she would not expect that of police given "the number of priority jobs we have every shift".[288] She also stated … there's probably no clear rules in the police about how far you - about what you do with one phone call, how far you canvass, how far you get out of the police car and how far you walk. There's a lot of discretion there in terms that the person themselves who attends has to be satisfied."[289]

125. However, Officer E accepted that the capacity to hear verbal cues or sounds of distress or argument could be impacted if an officer was just in a vehicle driving past; stopping the vehicle and getting out, one could hear more clearly over the noise of an engine and also the radio.[290] At the Salvation Army setting, getting out of the vehicle, walking around, looking down the side (and for any blood), looking to see if there was CCTV could all be done in a matter of minutes.[291]

Events following Mr Huber's attendance at Ballina Police Station

126. Following notification of Ms Lucena's death at around 12:50am on 4 January 2023, Officer E spoke with Officer C (by phone) about the Salvation Army job, and the connection with Mr Huber's confession.[292] Officer E did not ask Officer C about what searching he had done in response to the Priority 2 job.[293] She considered the matter could possibly be a critical incident

[282] T277.26-278.1 (Officer E), Day 2.
[283] T278.6-13 (Officer E), Day 2.
[284] T278.39-47 (Officer E), Day 2.
[285] T284.16-19 (Officer E), Day 2.
[286] Ibid.
[287] T284.29-35 (Officer E), Day 2.
[288] T285.7-13 (Officer E), Day 2.
[289] T285.25-30 (Officer E), Day 2.
[290] T286.10-44 (Officer E), Day 2.
[291] T287.3-6 (Officer E), Day 2.
[292] T287.38-288.18 (Officer E), Day 2.
[293] T288.23-26 (Officer E), Day 2.

"because it's a death and resulting from a police operation".[294] Officer E could not recall telling Officer C that, but driving home to Ballina she spoke with another officer (probably the Station Officer) and said: "Look, don't isolate yourselves but don't speak about it because it could potentially be a critical incident", and asked for that to be passed on.[295] Back at Ballina, within a couple of hours, Officer E confirmed compliance with her direction.[296]

127. At around 1:02am, Officer E attended the scene; she spoke with Superintendent Tanner and told him there had been a DV homicide, and said "Look, there's some complexities around it. We had a call for service and it took us some time to get to the job … He asked why it took some time to get to the jobs and I explained the other jobs that we had going."[297] Officer E agreed there would have been a discussion about workload at that time.[298]

128. Officer E was shown a SITREP dated 4 January 2023, which she read over and affirmed the accuracy of;[299] she accepted that a reference to Police being "delayed in their response by other Priority 2 incidents occurring in the area at the time" was misleading on its face (the other jobs being Priority 3 incidents).[300]

129. Finally, Officer E confirmed that she had provided information to Supt. Tanner to inform an email he sent at 3.25am on 4 January 2023,[301] and that they would have spoken prior to the email being sent.[302] A second email sent by Supt. Tanner at 3:11pm on 4 January 2023, forwarded to Officer E at 7:44pm for information, was not based on discussions with her during the day.[303]

130. No officer from Strike Force Blaikie ever spoke with Officer E about the initial response to the Salvation Army Incident; nor did any senior officer seek her views on whether the matter was a critical incident.[304] However, Officer E discussed this issue with Supt. Tanner (which was not unusual) "to provide all the information for full transparency to go up the chain."[305]

131. Officer E concluded her evidence by acknowledging the tragic circumstances of Ms Lucena's death.[306]

[294] T288.30-37 (Officer E), Day 2.
[295] T288.43-289.2 (Officer E), Day 2.
[296] T293.40-43; T294.4-30 (Officer E), Day 2.
[297] T289.9-21 (Officer E), Day 2.
[298] T289.36-37 (Officer E), Day 2.
[299] T290.43-291.13 (Officer E), Day 2; Exhibit 19C.
[300] T291.44-292.4; T293.22-23 (Officer E), Day 2.
[301] Exhibit 20C.
[302] T294.39-295.45 (Officer E), Day 2.
[303] T296.17-297.2 (Officer E), Day 2.
[304] T297.9-18 (Officer E), Day 2.
[305] T297.23-29 (Officer E), Day 2.
[306] T298.17-20 (Officer E), Day 2.

Evidence of Superintendent Scott Tanner, then Commander of Richmond Police District

Background

132. Supt. Tanner attested from the academy in 1993; he worked in general duties from 1994 to 2010; from 2010 to 2018, he worked as a general duties inspector and duty officer.[307] Supt. Tanner was then the Superintendent and Commander of New England PD from February 2018 to August 2020; and later the Superintendent and Commander of Richmond PD from August 2020 to April 2025.[308] He is currently the Commander of Liverpool Police Area Command.[309]

133. Supt. Tanner provided a 's 54 response' and 's 55 notice' to the Commission,[310] and also gave evidence on 5 December 2023.

Experience with critical incident declarations

134. Supt. Tanner provided an overview of his experience with critical incidents, including training as part of the promotion to Superintendent, and on completing the P1179 declaration form (Exhibit 5), being a presentation from Professional Standards Command.[311] Supt. Tanner has relieved as an Assistant Commissioner on various occasions, and has used the P1179 form to declare critical incidents (some five or six) in that capacity.[312] Supt. Tanner had not had cause to declare a "public interest", (s 111(1)(b), *LECC Act*) critical incident.[313] He had completed the P1179 form for a non-declaration: he recalled one occasion where there was a delay in understanding the level of injury of a person; once satisfied that the matter did not meet the requirements, he completed the non-declaration form.[314]

135. Supt. Tanner noted in terms of critical incident declarations, it is "not always clear cut"; even where an Assistant Commissioner was "bouncing around for consideration" (or advice) a possible critical incident,[315] completing the P1179 provides a clear record of the Region Commander's thinking (including for use before the Commission, or in a coronial matter).[316]

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[307] T304.28-38 (Supt. Tanner), 5 December 2025 (**Day 3**).
[308] T304.43-47 (Supt Tanner), Day 3.
[309] T305.4 (Supt. Tanner), Day 3.
[310] Exhibit 22C.
[311] T305.34-307.1 (Supt. Tanner), Day 3.
[312] T307.4-15; T312.10 (Supt. Tanner), Day 3.
[313] T307.47 (Supt. Tanner), Day 3.
[314] T308.23-38 (Supt. Tanner), Day 3.
[315] This process would normally be between the Superintendent and the on-call inspector for the region (the Professional standards Manager); they would take that back to the Assistant Commissioner, who might then contact the Superintendent directly or it might come back down the chain. The ultimate decision is made by the Assistant Commissioner: T311.6-27 (Supt. Tanner), Day 3.
[316] T308.45-310.19 (Supt. Tanner), Day 3.

136. Supt. Tanner had a "good" recall given the terrible events of 4 January 2023.[317] He was at home, asleep and received a call from either Officer E or the Crime Manager advising that:

> … a person had walked into the Ballina police station and said that he thought his wife was dead. Then they have attended to what is now known a Holden Lane, and gone into the side of the … Salvation Army building, and located a female deceased. They did tell me at that stage that police had been called there earlier in the night for a person assaulting or a male assaulting a female.[318]

137. It was a brief conversation (minutes only);[319] Supt. Tanner then prepared to attend the scene; enroute, he spoke with the on-call region officer, and told her what he knew. The focus at that time was on a potential murder and not the earlier police operation.[320] He arrived sometime around 1:30am. Once on scene, Supt. Tanner spoke with Officers C and D together as from memory (although this was not clear),[321] as both were holding crime scene.[322] Supt. Tanner recalled that BLN14 (an experienced officer) took the lead in the conversation; he had asked about the delay from the time the job came in to when they got there, and they explained that they had been at Alstonville and then a motor vehicle accident on the M1.[323]

138. BLN14 gave the following account of what happened on arrival in Holden Lane:

> So they told me that they both got there separately and they drove up each end of Holden Lane. I believe they said they put their alley lights on looking - or just on dusk, being daylight saving, and they did not see anyone. And I believe Ballina 14 said that if - there was only one call and if it had still been going on, they would have expected more calls to have come in.[324]

139. Supt. Tanner's 's 54 response' referred to the officers telling him that on attending Holden Lane, "… they drove around the car park and up and down Holden Lane but did not see anybody";[325] from this, Supt. Tanner understood that the officers had driven around two car parks, the one in the Salvation army, and the larger council chambers car park further up.[326] He did not recall understanding or asking if the officers patrolled the front (that is, on Tamar Street).[327] Supt. Tanner believed that the officers told him they did not get out of their vehicles at any point: he did not think anything of this at the time.[328]

140. Supt. Tanner understood that the officers patrolled "up and down", and into both car parks; that accorded with his expectation of a proper response, but even if they had just driven along

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[317] T314.17-18 (Supt. Tanner), Day 3.
[318] T315.21-28 (Supt. Tanner), Day 3.
[319] T315.31 (Supt. Tanner), Day 3.
[320] T316.4-317.3 (Supt. Tanner), Day 3.
[321] T317.33-37 (Supt. Tanner), Day 3.
[322] T316.40-47 (Supt. Tanner), Day 3.
[323] T317.7-13 (Supt. Tanner), Day 3.
[324] T318.43-319.2 (Supt. Tanner), Day 3.
[325] T319.21 (Supt. Tanner), Day 3.
[326] T319.34-320.46 (Supt. Tanner), Day 3.
[327] T320.3-9 (Supt. Tanner), Day 3.
[328] T321.20-24 (Supt. Tanner), Day 3.

Holden Lane, that would suffice as it was quite an open area.[329] He thought that was an appropriate response on the information at the time.[330] The discussion with the officers was no longer than five minutes.[331]

141. Supt. Tanner agreed that he was very experienced in general duties.[332] He accepted that many jobs have limited information, and can be open to interpretation; also, informants may not be precise about a location, and incidents at a location can be mobile (and "could end up anywhere").[333] From his understanding, Supt. Tanner thought that given the timing (close to an hour from the time of the initial call to when they got on scene) "they've made an appropriate look, and an appropriate patrol".[334]

142. Supt. Tanner said that "priority 2s come in a lot of different forms and fashions",[335] and there is an ability for police to downgrade a job to a priority 3 (as where there are five competing priority 2 jobs).[336]

143. However, Supt. Tanner was not aware of the police (VKG) radio transmissions (audio or transcript) for the relevant time period;[337] he looked at the chronology on the CAD job for the Salvation Army Incident.[338] He was not otherwise familiar with ROG SOPS for broadcast timing (ie 90 seconds for the first broadcast, and every one minute thereafter).[339] It was not consistent with his understanding (although Supt. Tanner said he would hear that in Liverpool if they are broadcasting jobs, they would seek a direction from Liverpool 14 (the supervisor), asking whether to downgrade it or allocate or to otherwise keep calling it).[340]

Prioritisation of jobs

144. In response to being taken through the details of the motor accident on the Pacific Highway, (Priority 3), Supt. Tanner accepted that although there was no obstruction, "being familiar with that area, any accident on the M1 needs to have a swift response, because of the risk that it has to other members of the public. You know, you've got vehicles doing 110 plus on the highway."[341] Supt. Tanner did not understand that WB29 was attending the accident because he had an alcometer, stating: "I understood that he was going there to help him with traffic control, and I would expect that, you know, any accident on the M1, trying to do it by yourself is near impossible."[342] As Superintendent at Richmond PD, Supt. Tanner had "absolutely" attended fatalities on the Pacific Highway himself.[343]

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[329] T321.28-42 (Supt. Tanner), Day 3.
[330] T321.47-322.3 (Supt. Tanner), Day 3.
[331] T339.3-4 (Supt. Tanner), Day 3.
[332] T322.13 (Supt. Tanner), Day 3.
[333] T322.19-30 (Supt. Tanner), Day 3.
[334] T323.32-38 (Supt. Tanner), Day 3.
[335] T323.44-45 (Supt. Tanner), Day 3.
[336] T324.1-17 (Supt. Tanner), Day 3.
[337] T325.34 (Supt. Tanner), Day 3.
[338] T325.39-44 (Supt. Tanner), Day 3.
[339] T326.7-13 (Supt. Tanner), Day 3.
[340] T326.40-327.4 (Supt. Tanner), Day 3.
[341] T327.34-37 (Supt. Tanner), Day 3.
[342] T328.38-41(Supt. Tanner), Day 3.
[343] T332.5 (Supt. Tanner), Day 3.

145. Supt. Tanner disagreed that when the Priority 2 job came over the radio, the appropriate course was to send one of BLN14 or WB29 to attend the job – he would not send a single unit officer to what appeared to be an assault occurring because that was unsafe, and there were policies around that (the "single unit policy").[344] There "should" always be two officers attending an assault, based on their experience, understanding of the location and of who was involved.[345]

146. Supt. Tanner stated that this was the type of job Highway Patrol might attend if they were working;[346] however, Supt. Tanner understood they were not on duty that night (from his review of the rosters); in fact, there were no ancillary units working that night (ie detectives or the proactive crime team).[347]

147. As to understanding how a Priority 2 job about a female being bashed was not prioritised above a Priority 3 job, Supt. Tanner explained it thus:

> Yes. I think by labelling it, we're probably downplaying the risk of that incident on the M1. Whilst, yes, it would come across as a P3, because there's nobody injured, there's no obstruction, things like that, being a high-volume road, any distractions on the side of the road, whether it's a car into a tree that people will see going past, poses a significant risk. So I think the judgment call is basically up to the officer, you know, it is their experience. I had two very senior officers, very experienced officers -- and I believe that the decision they made was a decision that was acceptable.[348]

148. Supt. Tanner clarified that he was not suggesting the motor vehicle accident on the Pacific Highway was a Priority 2 job, but rather that "it's not a definitive scale. It certainly has to be a sliding scale based on that officer's experience of the area and --- risk".[349]

Expectations as to nature of patrol for the Salvation Army Incident

149. When taken to the CAD job for the Salvation Army Incident, and the reference to: "Behind Salvation Army [Building] 73 Tamar St, Moon St, Ballina … Male stated a female being bashed behind Salvation Army building",[350] Supt. Tanner accepted that "behind the Salvation Army" could be the perimeter of the building, and that one would seek to see the boundaries.[351]

150. In circumstances where there was a fence approximately 8 to 10 metres from where the cars were patrolling on Holden Lane, Supt. Tanner expected at the very least that the officers would drive into the car park.[352] He agreed that by getting out of the vehicle, one could look around to see whether there was any blood; listen to any sounds down the side of the building and that an officer would be better placed to make an assessment by getting out of the vehicle.[353] That

[344] T329.4-22 (Supt. Tanner), Day 3.
[345] T329.26-31 (Supt. Tanner), Day 3.
[346] T327.44-47 (Supt. Tanner), Day 3.
[347] T328.27-34 (Supt. Tanner), Day 3.
[348] T330.5-18 (Supt. Tanner), Day 3.
[349] T330.24-32 (Supt. Tanner), Day 3.
[350] T33.34-46 Supt. Tanner), Day 3.
[351] T334.9-19 (Supt. Tanner), Day 3.
[352] T335.36-336.7 (Supt. Tanner), Day 3.
[353] T335.12-20 (Supt. Tanner), Day 3.

could be done in a minute or two.[354] Supt. Tanner accepted that shining a torch down the gated area that could not be seen from Holden Lane would take thirty seconds.[355]

151. As to lessons learnt for general duties and whether there was an expectation for them to get out of their vehicle and scope the scene for a couple of minutes, Supt. Tanner stated (emphasis added):

> I go back to the fact that - what was based in the CAD message, they've based their response on that … And if they were satisfied they didn't see a female being bashed behind the building, you know, close to an hour later, then their response was appropriate on the night with what they had. <u>As a lessons learnt absolutely, these two officers almost certainly - and as an organisation, possibly reinforce, that, you know, we need to be a bit more intrusive when we don't find what we're looking for … As you're saying, get out of car, search around, shine torches, things like that but …</u>

152. Although Supt. Tanner reiterated his view that the responses on the night were adequate,[356] he accepted that there was a lesson to be learned in terms of the need for general duties police responding to an incident like this to be more thorough.[357]

153. Supt. Tanner recalled speaking with Officer E on scene about what else had happened that night; he obtained an overall picture of Ballina and Lismore (noting that "on occasions, when Ballina are run off their feet, we will deploy Lismore staff down to assist"). He was told "they had quite a busy shift that night as well".[358]

154. Supt. Tanner was not aware of a CAD Incident report that indicated Lismore 15 was dealing with a Priority 4 matter (being an administrative task) at 7:12pm (that is two minutes after the Priority 2 came in).[359] Lismore 15 was a single unit officer, so Supt. Tanner would only expect that car to attend to back someone else up.[360] A further Priority 4 matter that Lismore 14 attended from 7:01pm to 7:06pm was noted (again, a single officer); Supt. Tanner noted that sometimes crews would change cars through the night.[361] As to the review set out in his email of 3.11pm, Supt. Tanner confirmed that he only reviewed Priority 2 and 3 jobs, not Priority 4; he agreed, however, that it was a relevant circumstance ("absolutely") that there were Priority 4 jobs; it raised the potential (at least) that Lismore 15 could have backed up WB29 to attend the Priority 2 job (for example).[362]

Communications with A/AC Chapman

155. Supt. Tanner explained that once on scene, he sent A/AC Chapman some images by text, with a message along the lines of: "You wouldn't have seen where the person was located due to

[354] T335.30-33 (Supt. Tanner), Day 3.
[355] T336.37-40 (Supt. Tanner), Day 3.
[356] T338.22-23 (Supt. Tanner), Day 3.
[357] T338.42 (Supt. Tanner), Day 3.
[358] T339.22-23 (Supt. Tanner), Day 3.
[359] T340.27-44 (Supt. Tanner, Day 3).
[360] T341.46-19 (Supt. Tanner), Day 3.
[361] T341.24-41 (Supt. Tanner), Day 3.
[362] T342.27-343.1 (Supt. Tanner), Day 3.

where it was";[363] he also had a discussion with A/AC Chapman, and went through the whole even from "go to whoa", discussed aspects of the police response and whether it did met the critical incident guidelines.[364] At that time, A/AC Chapman was not satisfied that it met the criteria, and Supt. Tanner agreed (although it remained under active consideration given it was early in the incident).[365]

156. Next, Supt. Tanner returned to Ballina Police Station and then reviewed the CAD message, did some background checks and prepared an email he sent at 3.25am.[366] The purpose of the email was twofold: as commander, he was briefing up about a serious crime (a homicide); but he was also asking questions about whether the police response was appropriate or could be deemed a critical incident.[367] Supt. Tanner had obtained the CAD log for the Salvation Army Incident from a VKG supervisor at 1.44am, and been provided with that information, which he included in the email.[368]

157. After sending the email, Supt. Tanner went back to the scene to check on the welfare of staff, and then went home, and had a little sleep, returning around midday.[369] After an update on the investigation from the officer in charge, Supt. Tanner rang AC Chapman and relayed that information.[370]

158. Supt. Tanner could not recall a specific call at 9:15am with AC Chapman, but agreed he would have said that he was satisfied that police attended as quickly as they could; he could not recall stating they had "patrolled the front and rear" with nil find, but certainly the rear.[371]

159. Prior to the 3.11pm being sent, Supt. Tanner was asked to do a review of the workload at the time to "further inform [AC Chapman] about her decision-making whether to call it a critical incident or not".[372]

Teams meeting with A/AC Chapman and Deputy Commissioner Pisanos

160. Supt. Tanner recalled having a 'Teams' meeting with Deputy Commissioner Pisanos and A/AC Chapman that day, but was fatigued and did not recall the timing. The purpose of the meeting was to tell him about the "horrendous matter", and also "inform him about the decision-making around critical incident or not" (which was an important function of the meeting);[373] he explained that it was to "satisfy [DC Pisanos] that our thought patterns aligned with what he thought and the information that we had. So it was a review [as to whether or not it was a

[363] T350.26-351.4 (Supt. Tanner), Day 3.
[364] T351.20-24 (Supt. Tanner), Day 3.
[365] T351.30-44 (Supt. Tanner), Day 3.
[366] T352.5-17 (Exhibit 22C)
[367] T352.30-45 (Supt. Tanner), Day 3.
[368] T353.10-31 (Supt. Tanner), Day 3.
[369] T354.43-355.11 (Supt. Tanner), Day 3.
[370] T355.14-356.14 (Supt. Tanner), Day 3.
[371] T365.27-33 (Supt. Tanner), Day 3.
[372] T356.12-28 (Supt. Tanner), Day 3.
[373] T359.3-360.7 (Supt. Tanner), Day 3.

critical incident]".[374] The meeting was "probably around a half hour mark".[375] There was discussion about the criminal and coronial investigation, and "there would have been" discussion about a DV homicide review, although Supt. Tanner stated "that doesn't involve me", as it was conducted by State Crime Command.[376] He was unfamiliar with the scope of such a review.[377] Supt. Tanner was not asked to arrange or speak to people conduct the DV Homicide Review.[378] He did not speak to the on-call homicide consultant at any point (that was not his role).[379] Following this meeting it was decided that Supt. Tanner would do a further review of the workload and staffing.[380]

161. The results of Supt. Tanner's review were then set out in his email of 3:11pm.[381]

162. Supt. Tanner initially stated that he never obtained or reviewed the statements of Officer C or D;[382] he did not recall being told do that by A/AC Chapman, nor in fact doing it, but accepted that he "may well have" been directed or asked to do so.[383] He would have done it if asked, but had no recollection of it; if there was nothing in the statements that changed his view from the original email, he may have called A/AC Chapman to say "there's nothing out of the ordinary.[384]

163. As to the SITREP sent on 4 January 2023 at 6:53pm, Supt. Tanner accepted that the reference to "Police were delayed in their response by other priority 2 incidents occurring in the area at the time" was inaccurate.[385]

Communications with Acting Assistant Commissioner David Driver (Professional Standards Command)

164. Supt. Tanner recalled speaking with Acting Assistant Commissioner Driver (**A/AC Driver**) of PSC on 5 January 2023. A/AC Driver rang him and there was a discussion about the critical incident aspect; A/AC Driver was sent Supt. Tanner's two emails and Supt. Tanner then explained the reasoning (ie why it was not a critical incident). A/AC Driver was satisfied with that response.[386] Supt. Tanner was confident he would have spoken about these discussions with A/AC Chapman.[387]

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[374] T356.32-357.33 (Supt. Tanner), Day 3.
[375] T357.38 (Supt. Tanner), Day 3.
[376] T359.3-6 (Supt. Tanner), Day 3.
[377] T357.37-358.32 (Supt. Tanner), Day 3.
[378] T358.36-44; T359.30-39 (Supt. Tanner), Day 3.
[379] T359.10-13 (Supt. Tanner), Day 3.
[380] T360.13-16 (Supt. Tanner), Day 3.
[381] T360.29-365.1 (Supt. Tanner) Day 3 (noting that Supt Tanner sought to provide further interpretation and extrapolation about the response of the Lismore crews who were apparently attending to Priority 4 jobs at various times).
[382] T366.2-6 (Supt. Tanner), Day 3.
[383] T366.21-28 (Supt. Tanner), Day 3.
[384] T367.33-37 (Supt. Tanner), Day 3.
[385] T371.15 (Supt. Tanner), Day 3.
[386] T372.31-734.22 (Supt. Tanner), Day 3.
[387] T374.26-30 (Supt. Tanner), Day 3.

165. Also on 5 January 2023 around 10am, Supt. Tanner recalled speaking with A/AC Chapman and Supt. Greg Thomas about an independent review by homicide of the police actions, and that this "could potentially also be seen as another layer of independence from the decisions or the information that I provided to Ma'am Chapman about the critical incident".[388]

166. It was A/AC Chapman and Supt. Thomas who would have arranged with the homicide squad to do an independent review; Supt. Tanner had no power or authority to do so, as it would have to come from the region.[389]

Significance of statement of Ms Hudson-Moon

167. The statement of Lesley Hudson-Moon taken on 5 January 2023[390] (as to her witnessing a man standing in the side area next to the Salvation Army at 7.20pm whilst walking her dog) was never brought to Supt. Tanner's attention. However, he "absolutely" thought it would have been significant for his purposes, stating "that's the first I've heard of that".[391] The statement was an important document.[392] Supt. Tanner was otherwise aware of the statement from Mr Leadbetter (see [42] above).[393] If provided with the statement of Ms Hudson-Moon, Supt. Tanner could have undertaken inquiries with the OIC about Mr Huber's movements and whether he may have been on scene at 7:55pm.[394]

168. For completeness, Supt. Tanner opined that in response to the information conveyed by police radio about the Salvation Army Incident, had the officers decided to get out of the car looked through the pool fence and seen Mr Huber, they would have had the power to enter (on the basis of investigating or preventing a breach of the peace or investigating a crime); also on the basis of s 9(1)(b) in *Law Enforcement (Powers and Responsibilities) Act 2002*.[395] Officer C would also have had the power to investigate a potential domestic violence offence, given his awareness of the charges against Mr Huber.[396]

Consideration of matter as critical incident

169. As to the timing of when it was determined that the matter was not a critical incident, Supt. Tanner thought this occurred sometime after 6 January 2023.[397]

170. When asked why a critical incident should not be declared if a region commander is giving anxious consideration to the matter, with the option to later revoke, Supt. Tanner explained that: "… declaring a critical incident also places a lot of stress and pressure on the police that are involved … And that's got to be balanced up with the public interest and all those other

[388] T374.37-375.1 (Supt. Tanner), Day 3.
[389] T375.13-34 (Supt. Tanner), Day 3.
[390] Exhibit 23C.
[391] T376.39-377.2; T376.16-47 (Supt. Tanner), Day 3.
[392] T378.3 (Supt. Tanner), Day 3.
[393] T379.6-7 (Supt. Tanner), Day 3.
[394] T385.7-27 (Supt. Tanner), Day 3.
[395] This is an emergency power where a police officer may enter a premises if they believe on reasonable grounds that a person has suffered significant physical injury: T398.41-399.7 (Supt. Tanner), Day 3.
[396] T398.20-24 (Supt. Tanner), Day 3.
[397] T387.3-9 (Supt. Tanner), Day 3.

guidelines … I guess it's the assertion that they've done something wrong".[398] There was both stigma and a cumulative effect.[399] He stated:

> You know, someone who's been in the cops for, you know, a long time might have been through numerous of these. So, personally, I would not err on the side of "Hey, let's just do it and then downgrade it"; I would wait until I'm completely satisfied that it does meet the criteria and then you are not placing that undue stress on those police.[400]

171. However, Supt. Tanner also agreed that in relation to a delay in calling a critical incident, the impact on the investigation could include the impact on memory, crime scene and canvassing;[401] capturing for example CCTV from local businesses; and also drug and alcohol testing;[402]

172. As to the kinds of things Supt. Tanner would turn his mind to in relation to the "public interest" category in the guidelines (s 111(1)(b)), he stated:

> So I think if it's - I guess it's about a high profile person involved, you know, such as a member of parliament or, you know, someone who is well known. If there is a clear failure by police to do something, then certainly that would meet that public interest test. Or in other occasions it's been done about a particular group in the community, whether that's by race or demographic, etcetera.[403]

Definition of "police operation" for purposes of a critical incident

173. When questioned by his counsel, Supt. Tanner provided an understanding of the definition of a police operation to the effect that it was "more along the lines of a coordinated response … more than just a normal day-to-day role or function that the police are performing. It's more of something that takes a bit of coordination";[404] he therefore considered that general police attending a domestic was not an operation but "a function".[405] When taken to the definition of a "police operation" in the *LECC Act* by Counsel Assisting (namely, "any activity engaged in by a police officer while exercising the functions of a police officer other than an activity for the purpose of a search and rescue operation"), Supt Tanner accepted that was not in accordance with his understanding.[406]

Reflections (including on systemic issues)

174. As to whether the public scrutiny of police (including through the work of the Commission) impacts the willingness of people to join the Police Force, Supt. Tanner stated:

> Absolutely, Commissioner. You may or may not recall I was down here for a previous matter some time ago, where four of my police were found no misconduct. All four have now exited. One has lost his marriage. He's in a real bad way. So, you know, no-one asks

[398] T387.32-38 (Supt. Tanner), Day 3.
[399] T388.3 (Supt. Tanner), Day 3.
[400] T388.3-9 (Supt. Tanner), Day 3.
[401] T395.11-16 (Supt. Tanner), Day 3.
[402] T388.47-389.33 (Supt. Tanner), Day 3.
[403] T394.8-15 (Supt. Tanner), Day 3.
[404] T393.13-43 (Supt. Tanner), Day 3.
[405] T393.28-37 (Supt. Tanner), Day 3.
[406] T397.21-42 (Supt. Tanner), Day 3.

us to do this job, I'm not asking for sympathy or anything like that, but it does play a big part.[407]

175. In relation to systemic issues, Supt. Tanner stated as follows:

> I don't want the community to think there are not police out there available to respond, okay, so that is a very important point I want to make. But it is no secret, and this is an open forum and everyone is aware of it, that there is a shortage of people wanting to join the police. We have the positions available, 2,500, close to 3,000.
>
> Community expects a lot of their police, and rightfully so, but in communities - in regional communities, the ability to have police on every street corner or to respond to every job within minutes is limited by a number of factors, namely, having the people filling those positions. So that's really critical. I just want to make the point that I'm not being critical of the organisation for that. It's a world-wide phenomenon that people aren't joining the police, okay.
>
> But probably the most important point I want to make is that, you know, to Ms Lucena and her family, this is an absolute tragedy, you know, and as a commander, I take these things very personally, when a person is subjected to this horrific crime. …
>
> So I really want to just pass on my thoughts to the family, that we all grieve the loss of someone in those circumstances. So that's all I wanted to say on that.[408]

Submissions

Timing of police response

176. The 'Ballina sector' shift on 3 January 2023 started off as busy; the limited resources at Ballina were quickly tied up with the mental health incident involving a female about to self-harm diverting AO18 from 6:38pm until 8:00pm (ish). Consequently, there was only Officer C (BLN 14), as the supervisor, and Officer D (WB29), who were available to respond to incidents in the area.

177. There followed the Priority 3 motor vehicle accident on the Pacific Highway broadcast at around 7:03pm and acknowledged by both BLN14 and WB29 shortly after. WB29's stated purpose over the radio was to attend to provide BLN14 with an alcometer, rather than for officer safety (noting that information broadcast about the accident did not suggest that it was serious on its face). WB29's initial evidence that he was directed to attend with the alcometer would not be accepted (see [49]). However, it would be accepted that as the Pacific Highway is a priority road with vehicles travelling at 110km per hour and a history of fatalities, any obstruction can pose a significant risk to motorists. There was also compelling evidence from BLN14 (who had attended many fatalities on that road: see [76]), WB29 (at [46]) and also Supt. Tanner as to the risk to officer safety in a single officer attending such an incident (see [147]). And of course once on scene, it became apparent to Officer C in BLN14 (as is clear from his transmission at 7:21pm), that the road was in fact partially obstructed, albeit not

[407] T391.10-16 (Supt. Tanner), Day 3.
[408] T390.9-35 (Supt. Tanner), Day 3.

initially advised in the first police broadcast; for that reason, he asked for WB29's attendance to be expedited: see [82]-[83].

178. It was some 7 minutes after the Pacific Highway motor vehicle accident that the Priority 2 Salvation Army Incident was first broadcast. It was a higher priority job indicating a female was being assaulted ("bashed") in that moment; it required an urgent police response. BLN14 gave candid evidence as to hearing the first broadcast at 7:10pm but could not say that he had formulated a plan about how to respond ([77]).

179. Officer C told the Court (with confidence) that there were no blackspots that might have impacted transmission of the broadcast on the M1 (at [85]). On that basis, WB29's evidence to the effect that he may not have heard the first broadcast for the Salvation Army Incident would not be accepted (at [51]).

180. As to whether frequent re-broadcasting of the Salvation Army Incident (had that occurred as required by the ROG SOPS) may have impacted on the response, Officer C stated that he thought he would have done something to try to stop them (police radio) from calling it (see [89] above). That is, the job would have been front of mind. It should also be recalled that a Priority 2 job is broadcast with the distinctive two-tone alert on each occasion, which highlights its urgency.

181. Officer C as the supervisor for the Ballina sector, gave frank evidence about not having directed WB29 to attend the Salvation Army Incident, which he thought was an option (see [80]); nor did he consider other options (such as requesting a Lismore crew to attend: [81]). Knowing the location as he did, Officer C did not raise concerns about Officer D being an alpha unit (and he could at least have undertaken a risk assessment).

182. Officer E (who would ordinarily monitor the radio) was distracted with the call to the father of the informant for the mental health incident that AO18 were attending (see [115]-[116]); she may have otherwise heard the broadcast and identified the resourcing issue that presented (particularly had there been more frequent broadcasts of the Salvation Army Incident). Additionally, had there been a specific call to Officer C, he would have been required to formulate a plan to respond to the Priority 2 job (or otherwise contact Officer E to her assistance).

183. Ultimately then, there were a number of factors that led to the non-prioritisation of the urgent, Priority 2 Salvation Army job:

    a. *First,* the non-compliance with the ROG SOPS as to the frequency of re-broadcast, and relatedly, the failure to escalate the job with the supervisor (as detailed above);

    b. *Second*, the assessment of Officer C that a motor vehicle accident on the Pacific Highway presented a significant risk to motorists (often beyond what may appear from the initial details of the job); relatedly, there is an officer welfare issue attending such an incident alone; that evidence has some force and would be accepted;

c. *Third,* Officer C did not give consideration to resourcing options to enable an urgent police response to the Salvation Army Incident (for example, potential highway patrol vehicles or Lismore crews that might attend);

d. *Fourth*, once on scene, Officer C (understandably) did not hear the second and third re-broadcasts for the Salvation Army Incident and was caught up attending to the accident (as was WB29); however, he sought to respond to the Priority 2 job once clear from the accident as it was "still in the back of his mind" (see [86]); and

e. *Fifth*, Officer E was otherwise diverted by the mental health matter until at least the second broadcast (see [116]);

f. *Sixth*, a clear theme of the evidence was that the matter assumed less priority for all involved with it because there was a single call only: this influenced both Officer D (see [56]) and Officer C [87]) in determining to travel Code Blue instead of Code Red when acknowledging the job at 7:46pm. Generally, a Priority 2 incident would require lights and sirens (see [111]). However, Officer C to his credit (and in contrast to Officer D at [56]), readily accepted that the fact one of call only was not a safe assumption or basis upon which to downgrade an incident: see [87]). Otherwise, it may also be accepted that travelling Code Red elevates the risks to officers and the public, and that this should only occur where in fact warranted. The operation of the "single call only" heuristic is addressed at [199] to [200] below.

184. In the circumstances, whilst the prioritisation of the two competing incidents was wrong with the benefit of hindsight, it could not be said that any officer was attempting to do other than execute their duties with good faith; the decision-making can also be understood in the context of the dangerous nature of the Pacific Highway and the risk to motorist and relatedly, officer safety in attending an accident scene alone, however minor.

185. Otherwise, emphasis should also be placed on the compelling contemporaneous evidence as to the busy shift on Tuesday, 3 January 2023 in the form of Officer E's email to the incoming Duty Officer to the effect that *"Poor [Officer C] got smashed between 6pm and 10pm. He did a great job down there .."*: see [99]. Importantly, that email was sent prior to any knowledge of Ms Lucena's tragic death.

Nature and adequacy of police response at Holden Lane

186. Once on scene at Holden Lane at 7:55pm, some 9 minutes after acknowledging the job, which suggests that BLN14 and WB29 were already southbound on the Pacific Highway at this time (noting the location is ordinarily a 17 minute drive from the accident), Officer C took appropriate steps to confirm the known information with police radio (ie "what did the caller exactly say? There's no indication whether it's a house or on the street"); at this time, police radio made it clear that the informant was not cooperative (having hung up and sworn at the '000'operator): see Annexure A at [10].

187. The patrol of Holden Lane consisted of BLN14 and WB29 driving slowly from east to west along the street, with WB29 having the alley lights of his truck illuminated; the vehicles

stopping "momentarily", looking to the Salvation Army building and car park on the left, and then continuing on to the end of Holden Lane, around Moon Street: [91]. There was no driving into the car park, nor alighting from the vehicle at any time; nor was there any patrol of the front of the Salvation Army building (being the address, 73 Tamar Street): (*cf* the suggestion by Officer D: see [68] above).

188. Officer C, again to his significant credit, accepted that with the benefit of hindsight he ought to have gotten out of the vehicle; however, he explained that nothing in the CAD message had identified the need to search down the side of the Salvation Army building: see [92] to [94].

189. Given his significant local experience, Officer C also explained that Holden Lane was a thoroughfare, and that people would frequently transit through that area; the fact it was not a residential address also influenced his thinking; nor was he even aware of a "courtyard style" area next to the Salvation Army building until later shown this by Mr Huber: see [95]. These factors further inform and explain the failure to search the side area.

190. Officer C's evidence would be accepted: he was thoughtful, honest and forthright in his account.

191. Officer D, however, presented as defensive and aspects of his evidence were unsatisfactory. This included Officer D's initial account of leaving his police vehicle to search the backyard of the Screenworks Australia premises; this evidence was not contained in his statement prepared three days later; nor was the search shown in CCTV footage;[409] the evidence was also later retracted when Officer D was questioned by his own counsel: see [63]. Evidence of leaving the vehicle to search that yard would not be accepted. The Commission would also reject the suggestion that Officer D, an experienced police officer, was reliant on Officer C as to the way the search of the area should be conducted: see [64] to [65]; and also Officer D's initial account that he "may well" have been able to see beyond the pool fence (which was some 10 metres away from Holden Lane: see [66]); this was plainly contradicted by Officer C (see [96] and photographs in evidence).[410]

192. Officer E, for her part, has extensive experience in the Richmond PD, and was doing her best to manage the competing demands of the shift, which became sufficiently busy that she had to 'kit up' herself and enter the field to help out. Officer E made contemporaneous notes regarding her decision-making in the hand-over document: see [112]. Although apparently, considering the patrol by Officers C and D to be acceptable even today, Officer E agreed with the benefits of police leaving their vehicle in terms of an appreciation of the scene (including in terms of visual and audio cues): see [125].

193. Accepting the explanations provided by Officer C as to his approach to the patrol as honest, in all the circumstances, a thorough police response to the Salvation Army Incident (Priority 2 job) involved further steps being taken, given the following factors:

[409] Exhibit 9C.
[410] See for example, Exhibit 11C, p [8641022].

a. *First*, informants frequently give imprecise information to '000' about the locations or description of incidents: for that reason, a high index of suspicion is necessary;

b. *Second*, without leaving the vehicle, important visual or auditory cues that can be detected from a foot patrol may be missed – for example, sounds such as groaning, talking (see Officer E at [125] above), or evidence on scene, such as signs of a struggle, blood on the ground etc: see in this regard, evidence of Supt. Tanner at [150]);

c. *Third*, incidents are often mobile (see for example, Officer D at [66]; and Supt. Tanner at [141]): for this reason, it cannot be assumed that a victim and/or assailant will remain in precisely the same area as an informant reports; this does not mean that attending police are required to check all surrounding locations, but it does underscore the need to properly scope the identified address (*cf* for example, Officer's D evidence at [65]): at least it can then be said the victim is not at the reported address with a reasonable level of confidence;

d. *Fourth*, a proper 'scope' of the area behind the Salvation Army building – which included a quick walk around the car park, and a 'look' down the side gate area which area could not be seen from Holden Lane would not have a taken more than a few minutes; it was also possible to quickly walk past the front of the building (which would have enabled a peer through the slatted wooden fence, as Ms Hudson-Moon did);[411] there could also have been calling out to anyone nearby to see if there was a response;

e. *Fifth,* given two officers were in attendance, issues of officer safety did not preclude a search or scope of the scene as identified at (d) above;

f. *Finally* and relatedly, there was no time pressure on the attending police at 7:55pm (as was accepted by Officer C): see [99].

194. Had a more extensive search been undertaken, it cannot be known what would have occurred: there is speculation in the counterfactual as to whether the officers would have encountered Mr Huber at that time (including, for example, the possibility that Mr Huber may have hidden from police, and that Ms Lucena may have made no noise); however, there is also a distinct possibility that Mr Huber may have been heard or seen by police (given the evidence of Ms Hudson-Moon and Mr Leadbetter: see [41] to [42] above). Had this occurred, Officer C gave compelling evidence that he would have questioned Mr Huber ("stopped and propped him") and that he would have had a high index of suspicion about Mr Huber: see [100] to [101] above

195. Ultimately then, there was a missed opportunity to conduct a thorough search of the nominated address, in circumstances where a serious assault of a female had been reported "behind the Salvation Army" building in Ballina (it being accepted that informants often give '000' imprecise information as to locations and also that incidents can be mobile). Learnings in this regard are accepted by at least Officer C, Supt. Tanner (at [151]), and AC Cotter (at [352]).

[411] See Exhibit 11C, pp [8641043-8641044].

196. However, it cannot be said that had such a search been undertaken, Ms Lucena's life would have been saved. That cannot be known and may ultimately be thought unlikely. The manner and cause of Ms Lucena's death will be the subject of close examination during the coronial inquest (see s 81 of the *Coroners Act 2009*), noting also the complexity of the expert evidence on that matter, which led to Justice Rothman's finding that it is likely Ms Lucena died at or about 7.25pm, but also that it "may be she died just after 9.30pm": see Annexure A, at [23] to [24].

Systemic issues relating to timing and nature of police response

197. Given the evidence summarised in detail above, the following systemic issues ostensibly influenced the police response.

198. *First,* there was an apparent re-prioritisation of motor vehicle accident by Officer C in his own mind, given his significant experience on the Pacific Highway; however, his thinking in that regard was not articulated over police radio (noting that he had the authority to upgrade the priority of incidents) or discussed with Officer E: see [79]. Additionally, Officer C stated that he had not been trained to the effect that "you're meant to drop jobs of a lesser priority to respond to a Priority 2": see [78].

199. *Second,* as noted above, each of the general duties officers (and indeed, also the SCOs) were operating on the basis of a heuristic bias (that is, a form cognitive bias or mental short cut that can result errors) to the effect that one call makes it less likely that the event is serious or ongoing. Indeed, Officer D stated that as time went on and no further calls were received, it would lessen his willingness to attend a job like the Salvation Army Incident, 'Code Red'; and in fact, Officer C broadcast this expressly ("Well radio, we've only had the one call, if so, then I'll be blue and probably 10 minutes": see Annexure A, at [9]). As poignantly demonstrated by this case and accepted by all officers (except Officer D: see [56])), that assumption is simply not safe. It may be unsafe because for example: a) an area has less passers-by at particular point in time; b) people witness things and do not contact police (as with Ms Hudson-Moon and Mr Leadbetter); or c) a person may be assaulted so seriously that they are unconscious and thus do not make noise that attracts attention.

200. Whilst there may be certain value in such an approach for *competing* Priority 2 matters which must be prioritised, that approach was not apt for this matter. To the extent it informed their thinking, nor was it a reason for Officers C and D not to leave their vehicles.

201. *Third*, there is a potential issue relating to the use of MDTs in general duties vehicles. When Officer D was working in Ballina, sometimes the MDT was so problematic it got to the stage that some days he would not "even bother logging on", and would instead use radio as the form of communication.[412] Officer C did not have access to an MDT, as it is not placed into the supervisor's vehicle; he otherwise described MDTs as "a bit of a hit and miss thing. I think that's got to do with age and the technology that we use, in fact, I think we use hand-me-down stuff from the highway patrol …".[413] Whilst Officer C's preference may be to use radio, the

[412] T177.11-16 (Officer D), Day 2.
[413] T217.31 (Officer C), Day 2.

MDT provides a form of visual cue as to outstanding jobs (noting that Priority 2 incidents show up as red): it seems highly desirable that they are contained in all vehicles.

202. *Finally*, and importantly, given the limited information obtained by the telephonist from the informant, there was no basis to categorise the incident as a "domestic violence" assault; nor was there any evidence suggesting that the matter was taken to be domestic violence and treated less seriously as a consequence (see eg: at [115]).[414]

1(d): Decision by NSW Police Force Officers not to declare a critical incident in relation to the death of Lindy Lucinda, and any review of that decision

Evidence of Acting Assistant Commissioner Tracey Chapman (Region Commander)

Background

203. Superintendent Tracey Chapman, at the relevant time an Acting Assistant Commissioner (**A/AC Chapman**), has been the commander of Lake Macquarie Police District since November 2023; prior to that, she was the Commander of the Hunter Valley Police District from March 2021 to November 2023. She attested from the academy in 1995.[415]

204. From 1 January 2023 for a two-week period, A/AC Chapman was acting as Assistant Commissioner in the role of Northern Region Commander (handing back the role to AC Peter McKenna on 15 January 2023).[416] A/AC Chapman explained that the role of Northern Region Commander is "predominantly to oversee and oversight the policing operations across the northern region in this instance"; it covers from Gosford or Brisbane Water police district through to Tweed-Byron police district."[417] The Region Commander is responsible for declaring critical incidents.

205. A/AC Chapman provided two 's 54 responses' and a 's 55 notice';[418] she also authored a 'Godfrey Report' dated 26 June 2023.[419]

Experience with critical incidents

206. A/AC Chapman first learned about the NSWPF Critical Incident Guidelines (**Guidelines**) in 2010 when she transferred to the Northern Region office as an inspector and HR manager for the region; in an on-call capacity, she received phone calls in relation to critical incidents and briefed the region commander.[420] A/AC Chapman has since been involved with the Guidelines in various capacities, including as a Superintendent and Acting Assistant Commissioner. She did not receive training regarding documentation to be completed for a critical incident either

[414] Although Officer C thought given it was a male/female incident, there may be a domestic component to it (at [90].
[415] T408.39-409.8 (A/AC Chapman), Day 3.
[416] T409.23-32 (A/AC Chapman), Day 3.
[417] T409.37-43 (A/AC Chapman), Day 3.
[418] See Exhibit 25C (Response dated 14 November 2025); and Exhibit 26C (Response dated 1 December 2025)
[419] Exhibit 27C.
[420] T413.3-10 (A/AC Chapman), Day 3.

as a Superintendent or A/AC (including the P1179 form).[421] Whilst an inspector, A/AC Chapman had completed 'non-declaration' P1179 form on behalf of the region commander (although could not recall when).[422]

207. A/AC Chapman has not been involved with or heard of a critical incident being declared under the "public interest" limb in s 111 of the *LECC Act*.[423]

208. As to erring on the side of caution by declaring a critical incident and then revoking it if later if necessary, A/AC Chapman did not have a view either way: it would "depend on the circumstances".[424]

209. During her time as Acting Assistant Commissioner, A/AC Chapman took contemporaneous diary notes (usually as events occurred)[425], she also commenced a 'hand back' document on the day she started relieving (such that the notes were completed around the time the job occurred).[426]

Notification of homicide

210. At 1.21am on 4 January 2023, A/AC Chapman was at home in bed and was phoned by the on-call region officer;[427] she was made aware there was a DV homicide, some of the circumstances and was advised that Supt. Tanner was attending the scene.[428] A/AC Chapman could not recall speaking with Supt. Tanner or receiving a text message from him with photographs of the scene.[429]

Return to the office and events of 4 January 2023

211. By 5:27am, A/AC Chapman was at work and had sent Supt. Tanner's email of 3:25am to the staff officer for Deputy Commissioner Pisanos.[430] After receiving the email, A/AC Chapman "certainly wanted to understand what car crews were doing during that period of time between the original call and when police attended", and the reasons for the delay.[431]

212. At 7.40am, A/AC Chapman had an in-person discussion about the matter with Detective Superintendent Greg Thomas (the Operations Manager for Northern Region) (**D/Supt. Thomas**) for about 20 minutes;[432] her diary notes included the following (emphasis added):

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[421] T413.44-414.1; 415.5 (A/AC Chapman), Day 3.
[422] T414.15-29 (A/AC Chapman), Day 3.
[423] T415.28 (A/AC Chapman), Day 3.
[424] T416.10-30 (A/AC Chapman), Day 3.
[425] T417.46-418.1 (A/AC Chapman), Day 3.
[426] T417.30-34 (A/AC Chapman), Day 3.
[427] See further Exhibit 35C being the notes of Inspector Jones.
[428] T420.1-7 (A/AC Chapman), Day 3.
[429] T420.45-421.14 (A/AC Chapman), Day 3. A/AC Chapman had checked her current phone and there were no current messages from Supt. Tanner; this suggested that she had changed phones since that time: T421.47.
[430] T425.2-13 (A/AC Chapman), Day 3.
[431] T425.19-21; T425.35 (A/AC Chapman), Day 3.
[432] T424.26-27 (A/AC Chapman), Day 3.

> Discussion Thomas re: homicide. Closest substantive CM – [crime manager] is O'Reilly at MNC [Mid North Coast]. Do I want to send him for a day to look at it? Want to understand level of involvement/consultation from homicide. If they are covering 7pm-midnight actions, satisfied another oversight not required. Initial review by Superintendent Tanner. Clarity required on Time of Death from PM. Homicide involvement. Caller follow-up? Walk through with officers attending at 8pm.[433]

213. The reference to the "walk through" was "what the circumstances were for the officers", that is, for Supt. Tanner to understand what had occurred, rather than an actual walk-through.[434]

214. A/AC Chapman explained that Operations Manager, D/Supt. Thomas had direct contact with the State Crime Command (**SCC**) and the homicide squad; he was responsible for organising the region response in terms of resources. He was also significantly experienced in the region role, and A/AC Chapman discussed consideration of a critical incident with him at that time. They discussed that it did not meet the circumstances, and A/AC Chapman wanted to "understand the level of involvement, consultation from homicide" and whether it would cover the police actions. She expected D/Supt. Thomas to clarify that given his contact with SCC and the homicide squad.[435]

215. At 9:15am, there was a call between A/AC Chapman and Supt. Tanner where they discussed his email setting out certain information regarding the attendance of police at the scene.[436] A/AC Chapman's diary note records the following (emphasis added):

> 9.15am. [Phone call] Tanner – satisfied police attended as quickly as they could. Have patrolled front & rear with nil find. Victim later located with assistance from POI through 2 gates (side area) where donation etc are. Superintendent Tanner attended scene & indicates difficulty locating her due to environment. Male caller also homeless & not yet located. Witnesses have heard arguing post police attendance.[437]

216. On the basis of this note, A/AC Chapman understood that there had been a patrol of the front and rear of the premises; this understanding was never corrected. Although at some point, A/AC Chapman had reviewed a map of the Salvation Army building in Ballina, she could not recall having a conversation or view about whether the officers went into the actual car park.[438]

217. As to whether A/AC Chapman needed to understand the steps taken by the attending police, she stated:

> Well, I needed to have an understanding of, yes, the broader circumstances, the minutiae detail, perhaps not. But I don't recall specifically asking about the car park. I may have. I don't - I simply don't have a recollection.[439]

218. At some point, A/AC Chapman became aware that the officers had not left their vehicles (she could not recall when, but expected this was in the first few days): she wanted to understand

[433] Exhibit 25C, p 792.
[434] T426.2-4 (A/AC Chapman), Day 3.
[435] T423.17-44 (A/AC Chapman), Day 3.
[436] T422.10-12 (A/AC Chapman), Day 3.
[437] T426.30-40 (A/AC Chapman), Day 3.
[438] T426.46-427.33: T430.23-25 (A/AC Chapman), Day 3.
[439] T427.44-47 (A/AC Chapman), Day 3.

whether or not that was reasonable.[440] A/AC Chapman believed she saw one statement (for Officer C) at which point she would have become aware that he did not leave his vehicle.[441] She believed there was a conversation with Supt. Tanner about that at some point, but could not recall the details and did not have a note.[442] A/AC Chapman was not concerned by the statement of Officer C, as he had explained the circumstances, his view of the car park, lighting and based on a map, "I expect that it's reasonable that they could see into that car park"; there was one report of the female being assaulted "that in itself can be unusual. You would sometimes expect more than one, when you have someone being assaulted in a public place". A/AC Chapman was therefore satisfied with the explanation in the statement.[443]

219. However, A/AC Chapman accepted that there may only ever be one call from a member of the public about a serious incident; it was not safe to assume that because there was one call only, it was not a serious matter.[444]

220. As an aside, the circumstances relating to the information known about the Salvation Army Incident were outlined to A/AC Chapman in the context of whether there was a power to enter an unlocked fenced area at the side of the building; A/AC Chapman stated: "Unless there were some further - something further in the course of the conversation with that person, I don't necessarily think - you still don't necessarily have power to enter private property."[445]

221. At 10:55am, A/AC Chapman spoke with D/Supt. Thomas regarding the homicide 'sitrep', and the need for further detail, including the initial '000' call amongst other matters.[446]

Teams meeting with Deputy Commissioner Pisanos and Supt. Tanner

222. At 1:10pm, A/AC Chapman's diary referred to a meeting with DC Pisanos; this was held on 'Teams', and attended by A/AC Chapman, Supt. Tanner, DC Pisanos (and potentially others, including Inspector Matthew Crotty,[447] A/AC Chapman's staff officer at that point).[448] As to what was discussed, DC Pisanos was given an overview of what was known at that the time; there was some discussion about media, and the plan moving forward; A/AC Chapman did not have a specific recollection of a critical incident being discussed. Contrary to Supt. Tanner's evidence, she did not agree that one main purpose of the meeting was to discuss whether the matter should be declared a critical incident; however, if that was discussed, there was no expectation that one should be called.[449] A/AC Chapman was confident that DC Pisanos had not expressed a contrary view about calling a critical incident: this would have led to further

[440] T428.4-15 (A/AC Chapman), Day 3.
[441] T428.19-25 (A/AC Chapman), Day 3.
[442] T428.44-46 (A/AC Chapman), Day 3.
[443] T429.18-30 (A/AC Chapman), Day 3.
[444] T429.34-38 (A/AC Chapman), Day 3.
[445] T433.38-41 (A/AC Chapman), Day 3.
[446] T434.16-42 (A/AC Chapman), Day 3.
[447] It was later clarified by email that this was an error, and that the staff officer was Detective Inspector Ranald Urquhart; A/AC Chapman was unsure whether he was present during the meeting: Exhibit 40C.
[448] T435.42-436.8 (A/AC Chapman), Day 3.
[449] T436.26-427.6 (A/AC Chapman), Day 3.

discussion and notes.[450] A/AC Chapman could not recall if Supt. Tanner was tasked to review the workload of Ballina and Lismore as a result of this meeting.[451]

223. At 3:11pm, Supt. Tanner sent the email with the outcome of his review to A/AC Chapman, DC Pisanos, D/Supt. Thomas, the OIC and Crime Manager. A/AC Chapman (ultimately) agreed that information from statements obtained from two workers from the Salvation Army (that is, "[t]hese two workers last saw the POI at 9.30pm last night. When they arrived they heard the female yell out to the POI alerting him to the presence of these two workers"), was "important information" for consideration.[452]

Supt. Tanner's review of the workload and staffing levels

224. As to Supt. Tanner's review of the workload, A/AC Chapman did not have "significant concerns" as to the staffing levels and workload. She could not otherwise indicate whether she had "concerns" ("it's difficult to be clear about what was in my mind at the time I read this …").[453] A/AC Chapman thought she had understood from the email that there was only one Priority 2 job during the period 6:38 to 7:41pm; a Priority 2 job would "ordinarily be an urgent response".[454] A/AC Chapman did not recall asking Supt. Tanner any questions about his review; she did not look at any of the incidents herself, and relied upon his summary.[455]

225. More generally, as to A/AC Chapman's experience listening to the police radio (ie per the Lake Macquarie channel), she did not consider that an unanswered Priority 2 job would be called every 60 seconds (and was not aware of the ROG SOPs requiring that).[456]

Request for independent DV Homicide Review

226. On 5 January 2023 at 10am, A/AC Chapman's diary included the following note (emphasis added):

> 10am - Present for [phone call] with Thommo/Tanner. Questioned whether we had specifically requested an independent review by Homicide of Police action (Homicide consultant had indicated this). Confirmed that as part of decision making my view included Homicide reviewing evidence/info and should include that within their scope & report any concerns independently. Also requested Tanner review officers' statements covering the initial attendance.[457]

227. A/AC Chapman recalled this phone call in the region commander's officer on speakerphone. She "questioned whether "we" had specifically requested an independent review process by homicide; she expected that D/Supt. Thomas had stated: "Homicide consultant indicated this", as he was the liaison with SCC.[458] A/AC Chapman also stated:

[450] T437.20-27 (A/AC Chapman), Day 3.
[451] T437.46-438.13 (A/AC Chapman), Day 3.
[452] T439.47 (A/AC Chapman), Day 3.
[453] T440.27-37 (A/AC Chapman), Day 3.
[454] T441.23-28 (A/AC Chapman), Day 3.
[455] T441.40-T442.4 (A/AC Chapman), Day 3.
[456] T442.31-443.3 (A/AC Chapman), Day 3.
[457] T444.15-26 (A/AC Chapman), Day 3.
[458] T444.31-40 (A/AC Chapman), Day 3.

> And I reaffirmed or confirmed that part of decision-making includes a view that homicide review that evidence and include it within their scope. Should there be concerns, it can be escalated independently of what else was occurring, such as the homicide investigation more.[459]

228. As to how the homicide review of police action was to be formalised, A/AC Chapman stated:

> So it was my understanding that the homicide review process included a review of previous interactions with police, etcetera, and those particular parties. I don't - I'm not aware of whether they have a scope document or not but quite clearly I asked for that to be included in their review process.[460]

229. A/AC Chapman could not say how the need for the review had been communicated, but thought it was through D/Supt. Thomas, who had the connection to SCC.[461]

230. A/AC Chapman was not updated by the officers undertaking the DV Homicide Review about their findings as to the initial police response.[462]

231. With respect to Supt. Tanner's review of the officers' statements, A/AC Chapman stated: "…I don't have a note but it would be my understanding we had a conversation and he raised no concerns about the statement."[463]

232. At 2:51pm on 6 January 2023, Supt. Tanner in fact sent A/AC Chapman a copy of the statement of Officer C by email, stating: "Ma'am, Attached is the statement by [Officer C] as discussed. Thanks".[464]

Discussion with Professional Standards Command

233. A/AC Chapman could not recall any discussion with A/AC David Driver from PSC at any stage on 5 January 2023; nor did she make any notes of such a discussion.[465]

Handback to AC McKenna

234. A/AC Chapman explained that the format of the "hand-back" document was created by AC McKenna; she went through it during the course of the two-week period of relieving and added information as relevant to the handover.[466] This document recorded the following (emphasis added):

> <u>There would be a DV homicide review and I requested the scope of the review include the activities between 1900 call and the time the POI enters the station. I was of the view that a further independent review was not required</u>. Requested [Superintendent] Tanner to

[459] T444.43-445.2 (A/AC Chapman), Day 3.
[460] T445.8-12 (A/AC Chapman), Day 3.
[461] T445.27-33 (A/AC Chapman), Day 3.
[462] T447.46-448.2 (A/AC Chapman), Day 3.
[463] T446.11-13 (A/AC Chapman), Day 3.
[464] Exhibit 36C, p [8648190].
[465] T435.1-18 (A/AC Chapman), Day 3.
[466] T448.9-13 (A/AC Chapman), Day 3.

provide a full review of the activities of attending police and any attempt to get to the side of the premises or follow up with informant/caller at the time.[467]

235. A/AC Chapman expected that the issue may have been "live" at the time she wrote it, given the "tense" used; she had asked Supt. Tanner to review the activities and they were the two things she had asked about, stating: "… by those notes I would suggest that I wanted to understand whether they had gotten to the side of the premises or you know, gone looking in that direction. My understanding is they didn't".[468] A/AC Chapman stated that she had wanted to consider this in all the circumstances, as it was "an information gap".[469] As to the reference to following up with the informant or caller, she had also wanted to understand "whether they'd attempted to call back" (but not necessarily the officers).[470]

236. A/AC Chapman explained that she did not have a conversation with AC McKenna about the matters in the document: there was a gap as Supt. Tanner took over for a two-week period thereafter.[471]

237. As to the reference to "[Superintendent] Tanner has reviewed statement of attending police and satisfied with their actions when first attending the job", A/AC Chapman agreed this suggested Supt. Tanner had reported the outcome of the review back to her and was satisfied; A/AC had also received Officer C's statement and could have indicated if she had a different view.[472]

Godfrey Report dated 7 June 2023[473]

238. After being taken through the content of this report, A/AC Chapman accepted that there was no reference in the document to police not alighting from their vehicles during the patrol at 7:55pm.[474] A/AC Chapman did not accept that detail ought to have been included in the Godfrey report on the basis that she was not asked for all the circumstances relating to police, and considered that the correspondence did not require this.[475]

239. As to whether it was accurate, as stated in the Godfrey Report, that during the course of the morning of 4 January 2023 "this incident was not raised with me with respect to a critical incident consideration by any officers", A/AC Chapman explained that she had not been *formally* requested to consider whether the matter was a critical incident (although there were numerous conversations about it).[476] However, A/AC Chapman accepted that the matter was under live consideration by her.[477]

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[467] T449.40-450.3 (A/AC Chapman), Day 3.
[468] T450.10-22 (A/AC Chapman), Day 3.
[469] T450.42-44 (A/AC Chapman), Day 3.
[470] T451.7-19 (A/AC Chapman), Day 3.
[471] T451.42-452.2 (A/AC Chapman), Day 3.
[472] T452.4-35 (A/AC Chapman), Day 3.
[473] Exhibit 27C.
[474] T453-454.18; T456.42 (A/AC Chapman), Day 3..
[475] T456.46-457.21 (A/AC Chapman), Day 3.
[476] T455.7-36 (A/AC Chapman), Day 3.
[477] T455.36 (A/AC Chapman), Day 3.

240. In relation to A/AC Chapman's rationale for not declaring a critical incident, the report noted that she did not consider the s 110 criterion were met; as to the "public interest" ground, A/AC Chapman referred to the inquiries undertaken by Supt. Tanner regarding the initial delay following his "thorough and detailed review of CAD and all activities being undertaken at the time by rostered police";[478] she also referred to the briefing by Supt. Tanner as to the initial attendance of police in terms of the location of the victim and environment making it difficult to locate the victim.[479]

241. With respect to the entry that: *"I also requested that [Supt. Tanner] ensure the DV homicide review by State Crime Command include assessing all matters including the lead up to locating the victim",* A/AC Chapman stated that was her recollection when she wrote the document six months later; she could not accurately recall if it was in fact Supt. Tanner or D/Supt. Thomas.[480] A/AC Chapman confirmed that "all matters" included any deficiencies in the police response.[481] The report also stated: "On this basis I was satisfied that there would be suitable independent review and any matters arising would be treated if appropriate under Part 8A of the Police Act. I maintain this position*."*[482]

242. A/AC Chapman was not convinced that she had seen the article attached to the Commission's letter (which was the genesis of the Godfrey Report); she accepted having some awareness of the underlying incident, however.[483] She explained her present view that whilst the incident referenced in the Commission's letter had some similarity "it was glaringly different on a number of fronts" because the victim was the caller (in contrast to an anonymous informant); there was a longer delay and then 20 hours before the victim was discovered; regional versus metropolitan resourcing and that it was a priority 3 job (although A/AC Chapman accepted that a delay to a Priority 2 job was of greater concern than a delay to a Priority 3, all things being equal).[484]

Non-completion of P1179 Form

243. A/AC Chapman accepted that she had given deep consideration to whether the Salvation Army Incident should be called a critical incident.

244. She thus accepted that the P1179 'non-declaration' and the reasons for her decision should have been completed, and that there were benefits to such documentation (including relying upon such a document in giving evidence).[485] A/AC Chapman also agreed with the suggestion of further training for superintendents (who may relieve as Assistant Commissioners) to receive further training about the non-declaration documentation requirements.[486]

[478] T456.1-10 (A/AC Chapman), Day 3.
[479] T456.20-32 (A/AC Chapman), Day 3.
[480] T457.23-44 (A/AC Chapman), Day 3.
[481] T458.12 (A/AC Chapman), Day 3.
[482] T458.15-19 (A/AC Chapman), Day 3.
[483] T459.8; T460.30-32; T461.29 (A/AC Chapman), Day 3.
[484] T461.47-463.11 (A/AC Chapman), Day 3.
[485] T463.29-40 (A/AC Chapman), Day 3.
[486] T464.2-14 (A/AC Chapman), Day 3.

Nature of a DV Homicide Review

245. A section 55 notice issued to the Commissioner of the NSWPF (and responded to by Detective Sergeant Grant Davidson of the Domestic & Family Violence Command). That officer advised that as at January 2023, "reviews of domestic violence homicides were suspended pending the establishment of the Domestic & Family Violence Registry (DFVR) in September 2023".[487] Prior to this suspension, Regions conducted reviews using the 'Domestic Violence Homicide Review' completed by the Region Strategic Intelligence Manager. No guiding document for these reviews apparently existed (or could be found) as at 3 January 2023. In any event, given the suspension of reviews in January 2023, no review was conducted into the homicide of Ms Lucena.[488]

246. A new process now exists for Domestic Violence Reviews (although the guiding documents are under review), as outlined in the notice.[489]

Evidence of Detective Senior Constable Shaun McKay

247. On 8 December 2025, Detective Senior Constable McKay (**DSC McKay**), the OIC for Strike Force Blaikie, provided a 's 54 response', together with documents pursuant to a 's 55 notice'.[490]

248. DSC McKay relevantly stated that beyond ascertaining the identity of the original informant, he did not recall any member of the NSW Police Force requesting a review of '000' calls in relation to the investigation into Ms Lucena's death, nor a review of the initial police response.[491]

Evidence of Acting Assistant Commissioner David Driver

249. On 24 November 2025, A/AC Driver provided a 's 54 response', together with documents pursuant to a 's 55 notice'.[492] In short, A/AC Driver believed that he received a call from A/AC Chapman on 4 January 2023 (he could not when); she advised of the incident and the circumstances, and stated that she did not believe the matter was a critical incident but wanted to hear his thoughts. A/AC Driver considered the matter, and outlined the view that he did not consider the matter to be a critical incident, as it did not meet the criteria in s 110 of the *LECC Act*, and there did not appear to be "other grounds" sufficient to warrant the declaration of a critical incident.[493] (As noted at [233] above, A/AC Chapman did not recall any conversation with A/AC Driver).

[487] Exhibit 42C*, Section 55 Notice to Produce per Detective Sergeant Grant Davidson, dated 19 December 2025, p [8644232].
[488] Ibid.
[489] Ibid.
[490] Exhibit 34C.
[491] Ibid, p [8629898].
[492] Exhibit 33C.
[493] Ibid, p [8634874].

250. A/AC Driver subsequently spoke with Supt. Tanner on 4 or 5 January 2023; he also reviewed Supt. Tanner's two emails; based on this information and the discussion with Supt. Tanner, A/AC Driver was satisfied that the matter was not a critical incident.[494]

Evidence of Deputy Commissioner Paul Pisanos

251. On 24 November 2025, DC Pisanos provided a 's 54 response', together with documents pursuant to a 's 55 notice'.[495]

252. DC Pisanos recalled speaking with A/AC Chapman on 4 January 2023 regarding the content of her "email briefing", whether she required further assistance or resourcing, and that her and Supt. Tanner were reviewing the local police response (which was a work in progress at that time). Beyond that, DC Pisanos highlighted that it is the role of the Region Commander to make decisions around whether or not to declare a matter a critical incident.[496]

Evidence of Assistant Commissioner Joseph Cassar

Background

253. AC Joseph Cassar is the current Commander of the Southern Region (having served in that role since January 2024); he was Commander of Professional Standards Command from May 2022 to February 2024; prior to that, he was Southern Region Commander for a three year period. AC Cassar attested from police in 1987; he served in general duties, was designated as a detective in 1994, and then spent time in the major crime squad, and later the homicide squad. By 2010, he was the Superintendent in charge of the Cabramatta Command; and later became the Shoalhaven and then Wollongong Commander; in 2017 he was promoted to Assistant Commissioner.[497]

254. On 8 November 2025, AC Cassar provided a 's 54 response',[498] and produced documents pursuant to a 's 55 notice'.[499] AC Cassar gave evidence in a public hearing on 8 December 2025.

Mandate of Professional Standards Command (PSC)

255. AC Cassar provided an overview of the role of the PSC within the NSWPF, being the subject matter experts and owners of professional standards and anything that goes with it; they are also the corporate owners of the NSWPF Critical Incident Guidelines. PSC sets the standard for performance, conduct and integrity within the agency and has an important advisory and consultancy function for critical incident matters; and also developing best practice policies

[494] Ibid, p [8634875].
[495] Exhibit 32C.
[496] Ibid, p [8641793].
[497] T472-473 (AC Cassar), 8 December 2025 (**Day 4**).
[498] Exhibit 28C.
[499] Exhibit 29C.

and processes.[500] PSC also function as an important contact point between the NSWPF and integrity bodies such as the Commission.[501]

Completion of P1179 form re declaration of critical incidents

256. AC Cassar estimated he had probably declared around 15 critical incidents as Region Commander.[502] When consideration was given to whether or not a matter was a critical incident, AC Cassar accepted that the P1179 should be completed.[503] He could not recall how many non-declarations he had completed, but it was in the single figures.[504]

257. As to completion of the P1179 form and whether AC Cassar would do it personally, he noted the structure with the region which includes an inspector in the role of a Professional Standards Manager (**PSM**), (being the "conduit" to obtain all the correct information[505] and the region subject matter experts on call).[506] AC Cassar explained (in terms of his experience), the PSM are usually the first port of call, and have a high level of understanding about the Guidelines; the PSM might provide a referral, explain what has occurred and there would be a discussion about whether it meets the critical incident threshold; it may be "black and white", but there may instances where further inquiries are made (for example regarding the status of injuries or whether a person will survive).[507] AC Cassar stated that "if it's grey and I don't declare it, then I'll do a s 1179 …", as where more information was required.[508]

258. As to storage of the P1179 forms, AC Cassar (as Region Commander) assumed[509] that the forms go back to the PSM, who then escalates them to the "right location"; however, he could not say where that was,[510] beyond expecting that they may be "escalated" to PSC and not just "filed locally".[511] AC Cassar was not otherwise aware of the process regarding such forms,[512] although "it's an electronic document and it is stored … within the organisation".[513] AC Cassar did not recall accessing these forms during his two years at PSC.[514]

259. AC Cassar agreed that as the "subject matter experts", it was important for PSC to have access to the P1179 (including the non-declarations),[515] to identify trends in decision-making[516] and for their review, consideration and analysis.[517]

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[500] T476.15-478.7 (AC Cassar), Day 4.
[501] T478.1 (AC Cassar), Day 4.
[502] T478.19-20 (AC Cassar), Day 4.
[503] T478.36-41 (AC Cassar), Day 4.
[504] T478.46-479.22 (AC Cassar), Day 4.
[505] T481.12-15 (AC Cassar), Day 4.
[506] T481.39-40 (AC Cassar), Day 4.
[507] T479.26-480.34 (AC Cassar), Day 4.
[508] T481.44-482.7 (AC Cassar), Day 4.
[509] T485.12-31 (AC Cassar), Day 4.
[510] T482.35-41 (AC Cassar), Day 4.
[511] T483.1-9 (AC Cassar), Day 4.
[512] T484.24-38 (AC Cassar), Day 4.
[513] T485.34-39 (AC Cassar), Day 4.
[514] T483.26-35 (AC Cassar), Day 4.
[515] T483.13-22 (AC Cassar), Day 4.
[516] T483.41-43 (AC Cassar), Day 4.
[517] T485.2 (AC Cassar), Day 4.

260. When taken to the P1179 form (Exhibit 5), AC Cassar agreed that the form was to be completed where there was "consideration" as to whether or not to declare a critical incident.[518] He also agreed it was an important document providing a clear and auditable record of the Region Commander's decision to declare and not declare, a critical incident.[519]

261. AC Cassar was not aware of any training given to Assistant Commissioner's regarding completion of the P1179 form;[520] nor had he personally received any reminders about the need to complete Part 3 (the non-declaration part).[521]

"Public interest" critical incidents

262. As to declarations of "public interest" critical incidents, AC Cassar referred to declaring one very recently concerning the discovery of a 48-year old woman outside Lake Illawarra Police Station.[522] AC Cassar stated this was "… the most recent one. I couldn't think of any other ones, not at this time".[523] He was taken to the February 2024 Guidelines (p 5), which identifies the following considerations:[524]

> The Region Commander may also make this declaration if they have "other grounds for considering it is in the public interest to do so" (s111(1)(b)). This may include where an incident could attract significant attention, interest or criticism and the public interest is best served by investigating the incident as a critical incident.[525]

263. AC Cassar then explained his thinking as to declaring the matter a "public interest" critical incident (subject to a suppression order).[526]

264. As to whether there was scope for the Guidelines to indicate the types of matters that have been declared "public interest" critical incidents, AC Cassar stated:

> That's a double-edged sword. If there is the opportunity for personal engagement where they can do - have the opportunity for exploratory questions, I think that's possibly - yeah, it's a good thing. But if it is a documented, like, dot point as to why or why not, I think the risk there is there's a lot of information that may not be contained in that document. So I would hate to see a mindset, say, that they are relying on this example. And that's why it's - that whole function of the determination or not determination is very complex, as a region commander, and I certainly don't take that lightly.[527]

265. However. AC Cassar agreed that given the rarity of "public interest" critical incidents (namely 3 out of 297 incidents 2017), it may assist to provide some examples. He added: "But it has to be … tempered with the broader sense of exploring the whys and why nots."[528]

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[518] T486.33 (AC Cassar), Day 4.
[519] T486.39-44 (AC Cassar), Day 4.
[520] T487.33 (AC Cassar), Day 4.
[521] T488.16-19 (AC Cassar), Day 4.
[522] T489.33-490.2 (AC Cassar), Day 4.
[523] T490.36-37 (AC Cassar), Day 4.
[524] T493.20 (AC Cassar), Day 4.
[525] Exhibit 30C, p 5.
[526] T493.29-494.494.26 (AC Cassar), Day 4.
[527] T496.23-33 (AC Cassar), Day 4.
[528] T497.9-17 (AC Cassar), Day 4.

To benefit from the proposal, there should almost be a series of prompts to "think about these options" and have further discussions.[529]

Response to the Commission's correspondence and AC Cassar's review – June/July 2023

266. AC Cassar (then the Commander of PSC) was on leave at the time of Ms Lucena's death, returning to his role in late January 2023; Superintendent Driver was acting in his role during this period.[530]

267. On or around 7 June 2023, AC Cassar received the letter from the Commission addressed to PSC which stated the following:

> On behalf of our Chief Commissioner I am writing to formally request a copy of the Critical Incident Declaration/Non Declaration By Region Commander form (P1179), which may have been completed in relation to an incident which occurred in Ballina in January 2023. If there was no consideration given to whether the incident should have been declared a critical incident, I request advice as to whether consideration ought to have been given to making a declaration.[531]

268. The letter referred to an ABC News Report concerning the death of Tatiana Dokhotaru, and stated: "Without further information it is difficult to reconcile the decision not to declare a critical incident in the Ballina matter, with a decision to declare a critical incident in the Liverpool matter."[532]

269. Noting the Godfrey Report,[533] AC Cassar explained that the matter had been escalated to him; he thought the best person to provide advice as to declaring or not declaring was AC McKenna, as the substantive region commander; he forwarded it accordingly.[534] AC Cassar had no recollection of discussing the matter with A/AC Chapman (and in fact thought AC McKenna was going to provide the response);[535] however, there may have been discussions with staff within PSC (as would be standard).[536]

270. In evidence, AC Cassar clarified that he did not know the Salvation Army location in Ballina; nor had he pulled up a map because: "… my role wasn't to investigate the matter", it was primarily to respond to the correspondence and review other available material – being the CAD, Guidelines and AC Chapman's response.[537] He did not review the crime scene photos as that was not part of his function.[538] Nor was it part of AC Cassar's review to consider other competing Priority 2 jobs.[539]

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[529] T497.9-17 (AC Cassar), Day 4.
[530] T498.39-499.20 (AC Cassar), Day 4.
[531] Exhibit 29C, p [8632637].
[532] Ibid, p [8632638].
[533] Ibid, p [8632644].
[534] T500.24-40 (AC Cassar), Day 4.
[535] T501.30-37 (AC Cassar), Day 4.
[536] T501.41-502.8 (AC Cassar), Day 4.
[537] T502.42-503.1 (AC Cassar), Day 4.
[538] T507.31-32 (AC Cassar), Day 4.
[539] T507.37-45 (AC Cassar), Day 4.

271. In giving evidence, AC Cassar was not aware of whether the relevant CAD incident was a Priority 2 or Priority 3 job; it was unclear whether he was aware of that detail in conducting his own review.[540]

272. As to the nature of AC Cassar's 'review', he accepted that it was limited, explaining:

> … when I say "my review" -- there's no structured review process in professional standards command when we talk about declarations or non-declarations. A reason - when I say "reviewed", I reviewed the response. So bearing in mind the catalyst was 's letter for a copy of the 1179, I then took it upon myself to look at the response provided by Assistant Commissioner Chapman and other supporting documents that I've referred to.
>
> So I'm not reviewing the whole investigation. That is not my - I didn't see that as my function. I just wanted to see - I just wanted to be convinced that the course of action taken by this region commander and the explanation that was provided is consistent with the guidelines.
>
> So I didn't go into details of checking crime scene logs, statements, talking to police or anything like that. That's not my function.[541]

273. AC Cassar accepted from A/AC Chapman's response that she had turned her mind to whether or not the matter was a critical incident (and apparently accepted that this constituted "consideration" of that matter).[542]

274. AC Cassar also accepted that the review conducted by Supt. Tanner was not independent give that he was the commander of the Richmond PD.[543]

275. In relation to whether the Godfrey Report should have included details about attending police not leaving their vehicles (noting reference to the difficulties for police in identifying the location of Ms Lucena), AC Cassar stated that he would not expect that detail from the Region Commander; she provided advice and a response, and AC Cassar was "satisfied that she had taken appropriate action", stating: "It's not up to me to look at what the police did or didn't do".[544] He later stated:

> The objective was for me … to respond to [the Commission's request for the P1179], and then she's provided us a response, and then I wanted to satisfy myself, as a commander of PSC, that she was acting within the, I suppose, the directions or the guidance of the critical incident guidelines, and I was satisfied with that.[545]

276. AC Cassar was not aware of the fact that police had not left their vehicles at the time of completing his review (and thought perhaps he had learnt that later from the media).[546]

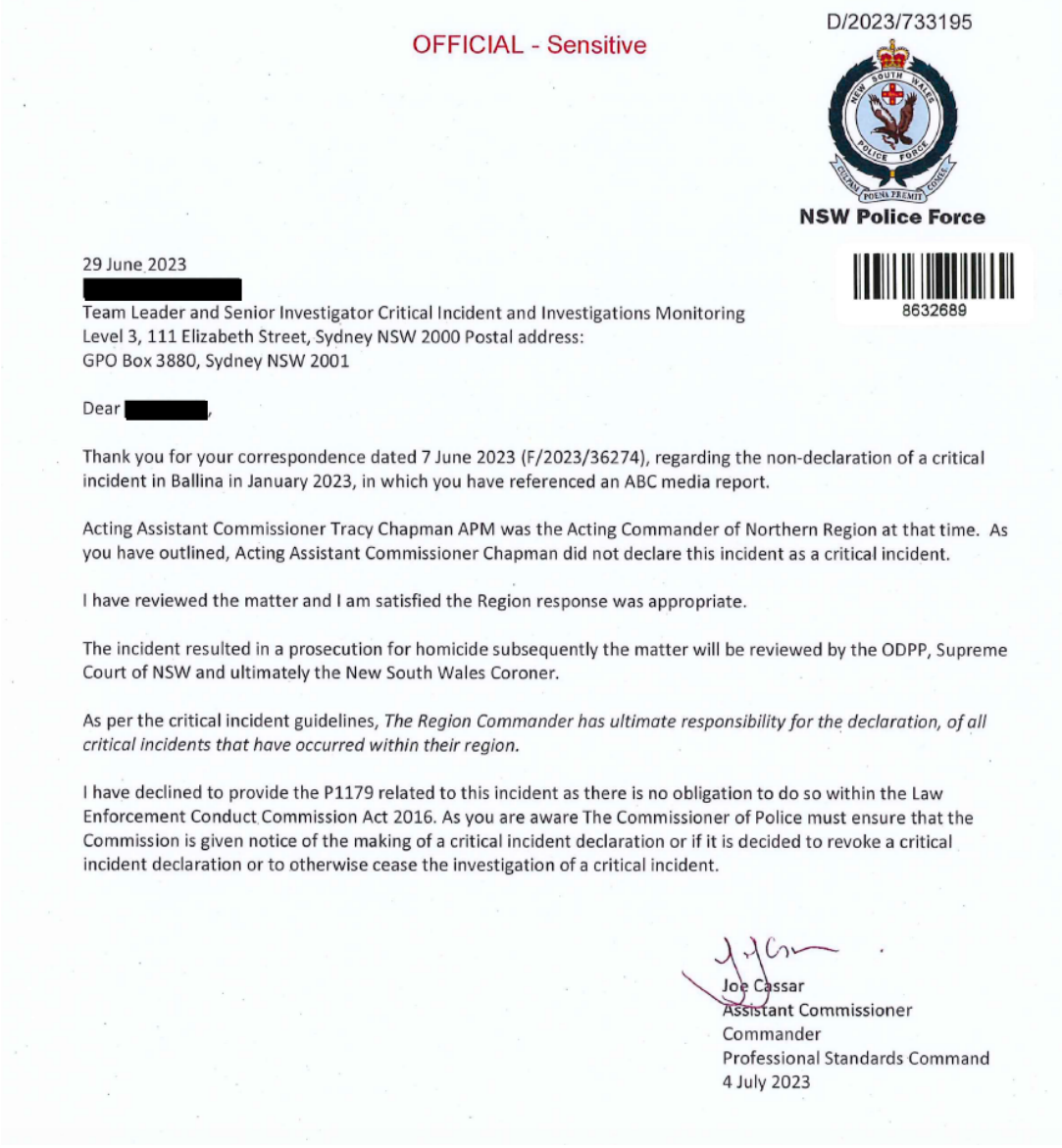
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[540] T503.4-504.16 (AC Cassar), Day 4.
[541] T508.8-26 (AC Cassar), Day 4.
[542] T505.27-46 (AC Cassar), Day 4.
[543] T506.36-508.1 (AC Cassar), Day 4.
[544] T508.34-8 (AC Cassar), Day 4.
[545] T509.20-26 (AC Cassar), Day 4.
[546] T513.35-44 (AC Cassar), Day 4.

277. With respect to A/AC Chapman's reference to the DV Homicide Review by SCC, it was the first time he had heard of this; he had not come across the process whilst at PSC.[547] AC Cassar did not follow up the outcome of that review; it was no part of his function to do so: the catalyst was the call for a P1179, "not to conduct a full investigation" as to why the region commander did or did not declare a critical incident. AC Cassar did not see it as his function as PSC Commander to "pull apart" the process of a fellow Assistant Commissioner.[548]

AC Cassar's letter to the Commissioner – 4 July 2023

278. AC Cassar's response to the Commission was as follows:[549]



OFFICIAL - Sensitive

D/2023/733195

NSW Police Force

8632689

29 June 2023

[redacted]
Team Leader and Senior Investigator Critical Incident and Investigations Monitoring
Level 3, 111 Elizabeth Street, Sydney NSW 2000 Postal address:
GPO Box 3880, Sydney NSW 2001

Dear [redacted],

Thank you for your correspondence dated 7 June 2023 (F/2023/36274), regarding the non-declaration of a critical incident in Ballina in January 2023, in which you have referenced an ABC media report.

Acting Assistant Commissioner Tracy Chapman APM was the Acting Commander of Northern Region at that time. As you have outlined, Acting Assistant Commissioner Chapman did not declare this incident as a critical incident.

I have reviewed the matter and I am satisfied the Region response was appropriate.

The incident resulted in a prosecution for homicide subsequently the matter will be reviewed by the ODPP, Supreme Court of NSW and ultimately the New South Wales Coroner.

As per the critical incident guidelines, *The Region Commander has ultimate responsibility for the declaration, of all critical incidents that have occurred within their region.*

I have declined to provide the P1179 related to this incident as there is no obligation to do so within the Law Enforcement Conduct Commission Act 2016. As you are aware The Commissioner of Police must ensure that the Commission is given notice of the making of a critical incident declaration or if it is decided to revoke a critical incident declaration or to otherwise cease the investigation of a critical incident.

Joe Cassar
Assistant Commissioner
Commander
Professional Standards Command
4 July 2023

279. As to review by the ODPP, Supreme Court of NSW and the Coroner, AC Cassar was conveying that there was an independent body looking at the information, and giving comfort from that

[547] T514.7-47 (AC Cassar), Day 4.
[548] T515.5-24 (AC Cassar), Day 4.
[549] Exhibit 29C, p [8632689].

perspective.[550] AC Cassar accepted however, that neither the Supreme Court or DPP have a mandate in relation to systemic issues that may arise with respect to police practice (as occurs in a critical incident investigation); there would also be a significant delay before any coronial process considered systemic issues.[551]

280. As set out above, AC Cassar stated in the response to the Commission's letter: "I have declined to provide the P1179 related to this incident as there is no obligation to do so within the *[LECC Act]*". In fact, no P1179 form was ever completed. AC Cassar explained his response by stating: "So there was no request as to whether a P1179 had been completed in this letter. She just asked for a copy of the P1179".[552] That is, he was not asked whether a P1179 was completed;[553] if that had been asked, AC Cassar said he "would have included that in my response".[554]

281. There followed this exchange with Counsel Assisting:

> Q. Why wouldn't you say, "There is no P1179 in relation to this incident"?
>
> A. I didn't - I - I believe I answered the question that was in the correspondence.
>
> Q. Can I suggest to you that that formulation is misleading and it's misleading in this respect: it suggests that a P1179 related to the incident exists –
>
> A. No, that wasn't my intention.
>
> Q. -- do you accept that? It may not have been your intention but do you accept now how that formulation is apt to mislead?
>
> A. Oh, I still don't believe it's misleading. Because I - I was thoroughly aware that if you wanted the documents - and there was no follow-up over the last two years from the agency, the Law Enforcement Conduct Commission agency, to ask - to further request detailed information in regards to this matter; it was just that one correspondence. Two years later I receive a 54 and a 55.
>
> Q. Sure. That's a separate matter to what you've written there, can I suggest? And what you've written there conveys the strong indication that there is "the P1179 related to the incident" in existence?
>
> A. No, I don't agree with that.[555]

Submissions

Consideration of critical incident

282. A/AC Chapman clearly gave close consideration to whether or not the circumstances relating to initial police response to the Salvation Army Incident constituted a critical incident. As the

[550] T517.38-518.1 (AC Cassar), Day 4.
[551] T518.6-519.3 (AC Cassar), Day 4.
[552] T520.22-24(AC Cassar), Day 4.
[553] T520.33 (AC Cassar), Day 4.
[554] T51.21-22 (AC Cassar), Day 4.
[555] T521.40-522.18 (AC Cassar), Day 4.

matter did not fall under any of the s 110 criterion, the "public interest" basis was the most likely category.

283. The matter was evidently under discussion in the days that followed, including between A/AC Chapman and Supt. Tanner (who had also discussed the issue directly with Officer E), and also squarely in the Teams Meeting with Supt. Tanner, A/AC Chapman and DC Pisanos on 4 or 5 January 2023. In this regard, Supt. Tanner's recollection that an important function of this meeting was to discuss whether or not the matter was a critical incident would be accepted (see [160] *cf* [222]):

284. Supt. Tanner at least, discussed the circumstances of the matter with A/AC Driver, then acting as Commander of PSC, which was a constructive process. A/AC Chapman had no such recollection, and although A/AC Driver recalled speaking with her, no notes of any discussion were produced; it could not be accepted that this in fact occurred (given A/AC Chapman's tendency to make notes of relevant meetings; nor did she accept such discussion having taken place: see [233]).

285. To inform the issue of staffing levels and workload in the Richmond Police District command, Supt. Tanner conducted a review based on the CAD job for the Salvation Army Incident, together with the CAD logs for the other jobs and the roster. Whilst this was a fair place to commence such a review, there were limitations in that:

    a. Supt. Tanner did not look at Priority 4 or 5 incidents (which if done contemporaneously, may have informed his assessment of available resources, including Lismore crews that could have potentially assisted with a response, at least by way of 'back-up');

    b. Supt. Tanner did not have access to the police radio transcript or audio of the VKG recordings (which would have provided greater context for the various responses to the jobs); and

    c. the scope of Supt. Tanner's review (understandably) did not canvass broader systemic issues relating to the ROG SOPS.

286. Additionally, Supt. Tanner understood that the patrolling police had driven *into* the car park behind the Salvation Army building, and also patrolled "up and down" Holden Lane; this information was incorrect: see [139] to [140]; contemporaneous notes taken by A/AC Chapman also record Supt. Tanner stating that the officers had patrolled "front & rear with nil find": see [215] (which was again inaccurate).

287. Nor in undertaking his review was Supt. Tanner made aware of the statement of Lesley Hudson-Moon, accepted by him as significant for the purposes of his review: see [167].

288. Thus, whilst Supt. Tanner was seeking in good faith and with due diligence, to provide A/AC Chapman with all the necessary information to inform her decision about whether or not to declare a critical incident, there were inaccuracies or omissions in his data set (as indicated

above); nor could it be said that his review was independent, given he was effectively reviewing resourcing and the response of his own Police District (see AC Cassar, [274]).

289. Additionally, whilst the view appears to have been taken that it was defensible for the attending officers not to leave their vehicles in conducting the patrol, that aspect was not clearly articulated in any of the contemporaneous documentation: for example, Supt. Tanner's email of 4 January 2023 at 3.25am notes the arrival of police at 19:55 and states: "Patrol of area does not locate any person … Location of body is at side of the building behind 2 gates and no lighting available. The area is strewn with clothing and other donated items. Without POI indicating where body was no person would have seen it".[556] Nor was this aspect subsequently made clear in the Godfrey Report prepared by A/AC Chapman, who referred to difficulties in police locating Ms Lucena, but not to the fact of the attending police not leaving their vehicles (see [238]).[557] That aspect is an unfortunate omission from the documentary trail informing the decision not to declare a critical incident, given it was a matter that would evidently be of concern were the matter to come under public scrutiny.

290. Otherwise, as stated, it was the evidence that both Supt. Tanner and A/AC Chapman (as well as other senior officers) gave continued consideration to whether the matter constituted a critical incident declaration. That was certainly appropriate. It also appeared that there was consistency in the view that the matter was not a critical incident (ie views of A/AC Driver, D/Supt Thomas and DC Pisanos). A/AC Chapman accepted that such consideration meant that she should have completed Part 3 of the P1179 Form, which was an appropriate concession: see [243] to [244].

291. The evidence of Supt. Tanner, and AC Cotter would be accepted to the effect that there are sound reasons not to 'declare and later revoke' a critical incident where a matter is in the 'grey zone' (that is, where the decision is not clear cut). That is because of the stigma or significant welfare impact upon police, with the implication that police "have done something wrong", a consequence that tells against erring on the side of declaration: see Supt. Tanner at [170]; and AC Cotter at [331].

Determination not to declare critical incident

292. A/AC Chapman's decision not to declare the matter a critical incident (likely after 6 January 2023: see [169]), although the precise timing cannot be known, given there is no clear record), was certainly open to her. It is a matter of discretion for the Commissioner's delegate (relevantly, the Region Commanders).

293. However, the difficulties that arise in the present circumstances are these:

a. As noted above, the contemporaneous documentation of the assessment by Supt. Tanner and A/AC Chapman does not refer to the fact of the officers not leaving their vehicles yet simultaneously relies upon the difficulties of locating Ms Lucena as a relevant circumstance;

[556] Exhibit 22C, p [8641384].
[557] Exhibit 34C, p [8632646-8632647].

b. Supt. Tanner's review was not informed by all relevant information (as noted above);

c. Supt. Tanner's review did not meet the criteria of being independent, given his role as Commander of Richmond PD;

d. A/AC Chapman evidently placed significant reliance upon her understanding that there would be an independent DV Homicide Review undertaken by SCC: see [226]-[234]. Beyond her diary notes (the content of which is repeated in later documentation), there is no record as to the nature and scope of this review, nor the person responsible for it. The OIC, DSC McKay was not aware of any such review (at [248]); and in fact, DV Homicide Reviews were suspended as at January 2023, and one was not conducted into Ms Lucena's death: see [245]. Nor was the status or outcome of this review apparently ever followed up (which ought to have revealed that no such review was extant). Ultimately then, there was no independent review as envisaged by A/AC Chapman.

294. The corollary of not declaring the matter a critical incident, although A/AC Chapman identified that an "independent review" of the initial police response was required including to "assess all matters including the lead up to locating the victim",[558] was that there was no oversight by the Commission nor any involvement by PSC. These are two important safeguards that protect police against the public perception of a "cover-up" (as agreed by AC Cotter: [328]).

295. One lesson to be distilled is that where a Region Commander is in the territory of considering that an independent review of police action in connection with a death or serious injury is warranted, that factor alone that tends in favour of a declaring a critical incident; a DV Homicide Review is no substitute (as was accepted by A/AC Chapman).[559]

AC Cassar's review and letter of 4 July 2023

296. It may be accepted that AC Cassar, in conducting his review for the purposes of responding to the Commission's letter of 7 June 2023, relied upon the content of the Godfrey Report prepared by A/AC Chapman, together with the CAD Incident log. Given the limited mandate of his review (and noting that he was effectively reviewing the actions of a peer Assistant Commissioner), the limited nature of that review can be understood, and accepted.

297. However, in AC Cassar's letter to the Commission dated 4 July 2023 (extracted at [278] above), it ought to have been appreciated that the formulation of "I have declined to provide the P1179 related to this incident as there no obligation to so …" was apt to mislead. Whilst it may be accepted that was not AC Cassar's intention (noting that he would certainly appreciate the importance of accurate communication with the Commission), the ordinary reading of that sentence is the clear suggestion that a P1179 was in existence. As it happens, no such form existed: that fact could (and should) have been plainly stated. It is regrettable that it was not.

[558] Tab 34C, p [8632647].
[559] See Exhibit 26C, p [8647109].

C. POTENTIAL MISCONDUCT, SYSTEMIC ISSUES AND AREAS FOR AGENCY IMPROVEMENT

No evidence of misconduct

298. No submissions are advanced as to any circumstances constituting or potentially amounting to police misconduct, administrative officer misconduct, serious misconduct or agency maladministration.

299. The evidence did not rise to that level.

300. Rather, the evidence taken during the public examinations (and summarised in detail in Part B above) demonstrated hard working and professional members of the New South Wales Police Force undertaking their roles and responsibilities to the best of their respective abilities and in good faith, at times under significant pressure. It also warrants emphasis that general duties officers, in particular, are usually the first responders to a multiplicity of risky scenarios, as was most recently tragically illustrated by the events at Bondi Beach on 14 December 2025.

Systemic issues and areas for agency improvements

301. Notwithstanding, certain systems issues and areas for potential improvement were identifying during the public hearings. These are addressed below.

Radio Operations Group policies and procedures

Concerns regarding the "Shared Offsider" Dispatch Assist model

302. Evidence was given by Ms A to the effect that listening to the channel in the dispatch assist role is absolutely critical;[560] she could manually change the channel (ie stop listening to one channel, and listen to the other), but there was "absolutely" the capacity for information to be missed in this model.[561]

303. Ms A was not sure how long the shared offsider role had operated but thought it had evolved in the last 5 to 10 years.[562] She frankly stated that the shared offsider role, "best case scenario, shouldn't be happening …". There was this exchange with Counsel Assisting (emphasis added):

> A. … You've then got two people that would normally look after one channel looking after two. So in my situation, where I was offsiding for two channels, I was looking after an area from north of Forster right through to the Queensland border, which is a massive area of radio traffic.
>
> Q. Yes.
>
> A. So --

[560] T31.26-42 (Ms A), Day 1.
[561] T31.46-32.19 (Ms A, Day 1).
[562] T32.29-47 (Ms A), Day 1.

Q. And that increases risk, does it, to put yourself in that position?

A. Absolutely. You miss radio broadcasts, you could miss a - often miss a car crew calling urgent if they're in strife, and just the workload, and again, because your workload's so big on the screen, you can miss jobs, and then there's just the workload in itself can delay you in making those broadcasts.[563]

304. There was also this exchange (emphasis added):

Q. In your view, when you're undertaking the dispatch assist role, and you are monitoring two channels simultaneously, do you think you can do that safely?

A. No.

Q. Why?

A. Because my sole attention is not on one channel, and things can go on on the other channel that I'm not listening to or privy to, where the dispatcher may need help. And quite often, they don't have time to ask for help. So it's not possible to do it safely, I don't believe.[564]

305. Ms A agreed with Counsel Assisting's characterisation that the dispatcher assuming the dispatch assist was dealing with things and when there was otherwise no time to communicate, was potentially a recipe for disaster.[565]

306. In terms of the error that may have occurred at 7:05pm in opening the incident, this was less likely to have occurred if Ms A had only been dealing with one channel; possibly there may also have been a broadcast sooner (although she could not say either way, as the channel was busy and they were dealing with other jobs).[566]

307. Ms A told the Commissioner that:

> … the best way for us to do our job is to have… two people on a channel as a dispatch and dispatch assist for the entire shift, with what I'll call spares or telephonists in the room to then come in and take over when they're on meal or crib breaks. That has changed exorbitantly from when I first started.[567]

308. In Ms A's experience (over the last few decades), policing is becoming more complex (including in terms of mental health jobs); this means more work for police in the field, and more work for radio dispatchers and dispatch assists; however, there is less resourcing within the ROG. Ms A proffered the following reflection:

> … I just think that policing as a whole, in my opinion, and just talking with people that I work with, is that it's starting to be dealt with as a business, as opposed to an emergency

[563] T65.9-34 (Ms A), Day 1.
[564] T55.13-24 (Ms A), Day 1.
[565] T55.26-41 (Ms A), Day 1.
[566] T66.20-34 (Ms A), Day 1.
[567] T66.40-45 (Ms A), Day 1. See also Ms A's evidence as to when things changed at T67.4-16.

> service, and that it's - and that's why we're restricted with numbers of staff and I think that for us to keep the police safe out on the road, we need to be at full strength and we're not, we rarely are; and that the rostering needs to reflect the numbers that need to be on the floor …

309. Ms A referred to the high burnout, stress and turnover of staff.[568]

310. Mr B shared the concerns of Ms A regarding the shared offsider model, stating:

> I don't think that's ideal. I have done that. You can't listen to - you can only listen to one channel at a time. It makes it very difficult if you have both channels, and then if you need to speak on one channel, you have to turn the other channel off, otherwise it goes over that channel and the dispatcher on that channel might be speaking. So it's definitely not ideal.[569]

311. At times, Mr B had spoken to supervisors to say, "it's not working or it's too busy for that."[570] He considered that it "definitely creates risk", namely that "[t]hat something's missed. That it can burn people out, put people under more pressure than they really should be under."[571]

Merging of channels

Although not relevant to the circumstances of the Salvation Army Incident, Ms A raised (in the context of increasing workload), the practice of merging channels: that is, where you have one dispatcher looking after two channels. Ms A thought the practice should never happen.[572]

312. Ms A said that concerns about the practice of merging channels had been raised "regularly", but she thought it just "falls on deaf ears". She continued on to state "… it's not only just for the police in the field, it puts them at risk tenfold, it's also putting us at risk for burnout and for not being able to cope. And that's becoming more evident as time goes on" (emphasis added).[573]

313. Mr B stated that the merging of channels "is quite common"; it definitely happens several times a week, generally at quieter times through the middle of the night and early morning.[574] The merging of channels means that a dispatcher has a much larger geographical area, more population and more police resources.[575] Mr B was concerned by the practice of merging, stating:

> It concerns, me yes … It puts a lot more pressure on the person dispatching and the dispatch assist, to be able to control that area. There's more jobs to look at, there's more police

[568] T68.25-41 (Ms A), Day 1.
[569] T84.36-42 (Mr B), Day 1.
[570] T84.46-T85.1 (Mr B), Day 1.
[571] T85.9-14 (Mr B) Day 1.
[572] T65.13-14 (Ms A) Day 1.
[573] T65.47-66.5 (Ms A), Day 1.
[574] T80.9-16 (Mr B), Day 1.
[575] T80.27-28 (Mr B), Day 1.

resources to deal with, there's more air traffic. You're basically doubling the air traffic from what you would normally have or expect.[576]

314. Mr B thought that the merging of channels was placing greater strain on dispatch staff, and anecdotally, leading to increased burnout: in the last five years, it was the hardest he had worked.[577]

315. Mr B said that there is increasing complexity to working as a communications officer, including because of technology (for example, triangulation for missing persons, which require constant updates); the job was "more challenging, more workload", including now that "everyone has a mobile phone now, there is just more jobs".[578] Yet there had not been a corresponding increase in resourcing at the Newcastle ROC; nor for police on the street, in Mr B's experience.[579]

Issues with the CAD System

316. Ms A frankly explained that she believed she had accidentally clicked on the Priority 2 job when searching for other information, which then led to the job falling out of the 'unviewed' list, and onto the dispatchers broadcast/acknowledged list.

317. As noted above, Ms A understood from general talk that this problem had been raised within ROG,[580] but understood it was a CAD issue, stating:

> So we're still using the CAD system that was introduced back in 2007, which is quite antiquated, and I my understanding is it costs a lot of money to make those upgrades and changes.[581]

318. For his part, Mr B gave candid evidence that the CAD system was no longer fit for purpose, having been in operation since 2007. He stated:

> Generally, I think there is too many jobs for that purpose now. My understanding, when it came in - I think it came in in 2007 … It could have been a little bit before or a little bit after … And it was a UK-based system that the police bought and it was designed for smaller areas, so not doing - not to have the job volume that we have.
>
> … So when it is busy, you can't see every job. You can get all the jobs to come up on that screen but that screen can get full too and you still have a scroll bar. But the priority jobs do tend to stay up there, but once you go into another job to look at it, that's gone.
>
> … I think it's past its use-by date and especially when channels are merged, that's full. You can't even see all the cars that are on scene at different jobs, which is part of our role, is to -- -- monitor where those cars are on scene. The prompt box, where you get prompts to say

[576] T80.34-39 (Mr B), Day 1.
[577] T81.1-5 (Mr B), Day 1.
[578] T81.30-82.13 (Mr B), Day 1.
[579] T82.17-21 (Mr B), Day 1.
[580] T53.3-4 (Ms A), Day 1. Ms A also stated: "I mean, the other thing, too, is I suppose we just accept that that's just the CAD system and that's just the way things are, and we just have to deal with it" : T53.3-7.
[581] T53.32-35 (Ms A), Day 1.

> that there's an update to a job or something's changed within the job that you need to click on, it then opens the job and you have to then try and work out what's changed, that prompts box also ends up with a scroll bar when there's a lot of prompts. And that prompt box is - that's probably lower on the list of things to do, but it does have to be done, and that's where the welfare checks for officers on scene are at, come up, as well. So that can get very full and time-consuming to go through and acknowledge all those prompts as well.[582]

319. Ultimately, Mr B agreed that there was an urgent need for an appropriate system to manage the complexity and volume of the dispatcher's job, stating:

> I believe there's one in the works. I was of the understanding that there was going to be one very close to being released but I don't think that's happening as quick as they had anticipated. So we're still using a system that's considerably old, 20 years, pushing close to 20 years old.[583]

320. As a design feature for any new system, Mr B offered that: " it would be nice if there was an area somewhere where just all priority jobs could be that was a lot easier to see."[584]

Recommendations

321. The foregoing evidence provides a sound and pressing basis for a recommendation to the NSW Police Force in the following terms:

Recommendation 1

That having regard to the evidence revealed by the public examinations in Operation Almas, the New South Wales Police Force conduct an urgent review into the following matters:

a. use of the "shared offsider" dispatch assist model, including the risks associated with a dispatch assist being unable to listen to both channels simultaneously and the associated risk of missing key information (particularly during busy shift periods);

b. whether the CAD System remains fit for purpose, given the increased workload and complexity of current policing (including in terms of the functionality and display features for dispatch), and if not whether any interim steps can be taken to improve functionality until the CAD System is replaced;

c. the adequacy of resourcing at the Newcastle Radio Operations Centre; and

d. whether the Radio Operations Group Standard Operating Procedures are achievable and fit for purpose, particularly in relation to the repeat broadcasting of Priority 2 incidents every 60 seconds.

[582] T101.26-102.16 (Mr B), Day 1.
[583] T102.22-27 (Mr B), Day 1.
[584] T102.35-36 (Mr B), Day 1.

Critical Incident Declarations

Assistant Commissioner Peter Cotter, Professional Standards Command (PSC)

322. As the current head of PSC, AC Cotter provided thoughtful and constructive evidence to inform the issues under consideration, particularly from the perspective of potential systemic reforms.

Background

323. AC Cotter attested from the academy in 1984 and is in his 42nd year of policing. He has significant experience as a criminal investigator (including with the homicide squad); he was also the Commander of the Homicide Squad for 2 years from 2010 to 2011; he has served a Region Commander of the Central Metropolitan Region (for 3 months in early 2022) and as Region Commander of Southern Region (from April 2022 to January 2024); since January 2024, AC Cotter has been the Commander of the Professional Standards Command.[585]

324. Additionally, AC Cotter has significant practical experience in the conduct of critical incident investigations (as a Senior Critical Incident Investigator), and also in declaring such incidents whilst a region commander.[586]

325. AC Cotter prepared both a 's 55 response' and produced documents in response to a 's 55 notice' dated 2 December 2025.[587]

Role of PSC

326. AC Cotter agreed that (amongst other matters), one of the essential functions of PSC is to provide advisory, consultancy and review services for investigations, critical incidents and complaint management; and to develop reference materials, standard operating procedures, policies and training that support professional standards and the application of best practice.[588] PSC also have corporate ownership of the Guidelines. The Guidelines have been the subject of review over the last 12 months, but AC Cotter had identified additional things arising from his review of this matter and potentially related recommendations, for consideration.[589] The Guidelines were previously reviewed (in a cosmetic sense) in January 2024, and prior to that in 2019: they are not reviewed annually, but rather when there is a "significant body of work" or need for an update, or deep reflection (as in this case).[590]

327. As to the role of PSC in relation to a critical incident, it is to ensure good communications between PSC in terms of senior investigators (whether from homicide or in the field) with the Commission or in the coronial jurisdiction; to ensure there are "no corners cut", that things are documented and recorded and that there is a veil of independence, transparency and probity

[585] T534.23-535.15 (AC Cotter), Day 4.
[586] T547.26-548.39 (AC Cotter), Day 4.
[587] Exhibit 31C.
[588] T536.23-537.20 (AC Cotter), Day 4.
[589] T538.3-8 (AC Cotter), Day 4.
[590] T538.15-28 (AC Cotter), Day 4.

around the investigation.[591] The PSC "review officer" has a central role in monitoring the integrity of probity concerns, identifying conflicts of interest, and ensuring the investigation is of the highest standard.[592] A review officer has an important function in identifying any deficiencies in a critical incident in terms of systems, policies and procedures (which is not the ordinary mandate of a homicide investigation).[593] AC Cotter also agreed that the critical role PSC plays, combined with the Commission's oversight of critical incident investigations, provides a safeguard against public perceptions of "cover-up".[594]

DV Homicide Review

328. AC Cotter had not heard of a DV Homicide Review as an independent review of police operations.[595]

Benefits of critical incident model of investigation

329. AC Cotter agreed that benefits of the critical incident investigation model – as compared with a DV Homicide Review process – include the mandatory drug and alcohol testing; directions to involved officers not speak about their evidence; and an emphasis on policies, procedures and systemic improvements;[596] there were also the benefits of impartiality and independence.[597]

330. As to the scenario where a Region Commander may be considering a matter in the "grey zone", in terms of welfare being a key consideration that might tend against declaring and then revoking a critical incident, AC Cotter stated:

> The welfare of our police is omnipresent, and I put that absolutely on the podium. But that has to be absolutely balanced, though, with the probity of an investigation...[598]

> It is a really – it is a really hard precipice sometimes to walk for region commanders. But if there has to be an err on any side of caution, it has to be for transparency, impartiality, probity and integrity.[599]

Consistency in critical incident declaration decision-making by Region Commanders

331. AC Cotter agreed that consistency in decision-making in relation to critical incident declarations (and non-declarations) is desirable ("… obviously we want consistency").[600] Such consistency was also concordant with (former) Commissioner Scipione's Critical

[591] T539.1-17 (AC Cotter), Day 4.
[592] T539.22-35 (AC Cotter), Day 4.
[593] T540.8-18 (AC Cotter), Day 4.
[594] T540.27-32 (AC Cotter), Day 4.
[595] T540.37-44; T541.23-28; T541.38-42 (AC Cotter), Day 4.
[596] T546.18-38 (AC Cotter), Day 4.
[597] T546.43-547.20 (AC Cotter), Day 4.
[598] T548.46-549.2; T549.9-12 (AC Cotter), Day 4
[599] T549.24-27 (AC Cotter), Day 4.
[600] T550.29-57 (AC Cotter), Day 4.

Incident Policy Statement (from January 2016),[601] which sentiments remain applicable to the current critical incident environment.[602]

332. In his evidence, AC Cotter highlighted that a Region Commander has a number of people available to him or her in the chain of command (including the PSM, the Superintendent, and a Deputy Commissioner), and that "you would hope that the collective body of those people will thrash things out, will discuss it, will have real conversations around what has occurred".[603] He emphasized that it was "important to talk early and talk often because things can change".[604] AC Cotter opined that robust discussions between senior police was a very wise course of action, informing the best decision-making.[605]

P1179 Form (Exhibit 5)

333. AC Cotter provided a copy of a memorandum from Assistant Commissioner Talbot (then the Commander of PSC) dated 25 September 2018 which introduced the P1179 Form (then known as a P1147) to all Region Commanders.[606] The memorandum indicated that the form was developed to ensure consistency in the information provided to the Commission, including the rationale and reasons for the decision made (including not-declaring).[607] He thought it was of equal if not greater importance to spell out clearly what had been considered and to provide some reasoning in circumstances of non-declaration.[608]

334. AC Cotter agreed that the P1179 provides an auditable trail of the Region Commander's thinking for not declaring a critical incident (with the consequence that the Commission has no monitoring capability, where such non-declarations are made).[609]

335. It was explained that P1179 forms do not go to PSC: they remain with the Region Command, "most likely" within the professional standards portfolio led by the PSM. The forms are not collated in any central repository, to AC Cotter's knowledge.[610]

336. As to the suggestion by Counsel Assisting that the forms should be collated by the Region Command but also by PSC to ensure there is a comprehensive record of all P1179 declarations so any trends can be identified, AC Cotter stated that there was no "pure opposition" to that suggestion, but that there should be change and agreement by the executive as to that change occurring…".[611]

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[601] EXHIBIT 31C, p [8629656].
[602] T552.17-44 (AC Cotter), Day 4.
[603] T551.7-28 (AC Cotter), Day 4.
[604] T551.30-33 (AC Cotter), Day 4.
[605] T551.37-38 (AC Cotter), Day 4.
[606] Exhibit 31C, p [8629611].
[607] T554.24-27 (AC Cotter), Day 4.
[608] AC Cotter stated: "But it is important, in our line of work, in our level, on matters of importance, to give a clear decision and then give some type of supporting reasoning to that, whether it is to do or not to do": T554.42-555.7 (AC Cotter), Day 4.
[609] T555.17-18.
[610] T555.24-32 (AC Cotter), Day 4.
[611] T556.8-22 (AC Cotter), Day 4.

337. AC continued on to explain that in terms of PSC collating P1179 forms (both declared and non-declared) to provide a quality assurance process, there would need to be the "remit to do it … because without the remit, it's just a warehouse".[612] He agreed there would need to be some guidance and guidelines about what to do with forms (that is, "where our role begins and ends in that review").[613] Presently, there is no structure or imprimatur for AC Cotter to do anything with the forms, if collated by PSC.[614] AC Cotter accepted the merit in PSC undertaking a review of critical incident declarations over a particular year to see if there was consistency or outliers.[615]

338. AC Cotter also agreed that there was benefit in a quality assurance process to ensure consistency in decision-making as between different regions (together with the Deputy Commissioner).[616]

339. AC Cotter stated that because PSC does not collate the P1179 forms "my command is blind to the fact whether one is completed or not upon a non-declaration."[617]

340. There is no training provided for Assistant Commissioners or Superintendents in relation to critical incidents (and thus, the importance of completing the non-declaration P1179 forms); the training that is run is primarily for investigators and SCIIs.[618]

Review of the Critical Incident Guidelines

341. With respect to completion of the P1179 form, AC Cotter stated that the Guidelines need a "shake-up" in terms of making reference to the need to complete the form: both when declaring and not declaring (that is, "make a decision, time and date stamp it and give some reasons for it").[619] Additionally, AC Cotter referred to the need for the Guidelines to be "tidied up", and to include a "checklist so it's distinct from the guidelines, which is the principal document, and the checklists for the respective roles and responsibilities".[620] AC Cotter envisaged taking the Regional Commander Guidelines,[621] and developing that into a more prescriptive set of things that must be done, stating "I think there needs to be absolutely more assistance provided to those region commanders from us". The current Guidelines, to his mind, did not meet expectations.[622]

342. As to other areas to improve the Guidelines, AC Cotter identified that there should be a chronological 'step-by-step' process outlined for the Region Command (in the form of a cheat sheet). AC Cotter was contemplating a "wholesale review" of the Guidelines, considering that they need "a fresh set of eyes and a fresh set of prescription that is more helpful than perhaps

[612] T557.1-6 (AC Cotter), Day 4.
[613] T557.11-18 (AC Cotter), Day 4.
[614] T557.45-558.1; T566.27-44 (AC Cotter), Day 4.
[615] T567.12-25 (AC Cotter), Day 4.
[616] T557.34-43; T558/20-24 (AC Cotter), Day 4.
[617] T558.31-32 (AC Cotter), Day 4.
[618] T558.38-46 (AC Cotter), Day 4.
[619] T559.5-17 (AC Cotter), Day 4.
[620] T559.23-29 (AC Cotter), Day 4.
[621] Exhibit 31C, p [8629671].
[622] T559.43-11 (AC Cotter), Day 4.

where they are at the moment."[623] Additionally, there was utility in ensuring a "one-stop shop", by combining all the relevant resources into one document;[624] AC Cotter stated:

> I think there needs to be a little bit of old-school thought pattern in it and make it a holistic document which sets out the who, the what, the when, the why for all the people involved to give absolute clarity in that one-stop shop, one document, checklists for ticking purposes, literally, assigned to them.[625]

343. Statistics compiled by the Commissioner indicate that since 2017, there have been 3 "public interest" critical incident declared, out of a total of 297; AC Cotter agreed that this indicated such declarations were very rare.[626]

344. As to the "grey zone" where a Region Commander was considering making a s 111(1)(b) "public interest" critical incident declaration and the suggestion that this is where the most help will be needed, AC Cotter agreed; he also thought that the definition of 'public interest' "needs to be fleshed out".[627] He stated:

> I don't know about a set of prescriptive examples, but I'm certainly open - I think we are certainly open as an organisation to reviewing a very - a very healthy definition for what "public interest" is, bearing in mind the Act itself, owned by LECC, isn't helpful in defining it at all, and it's not necessarily the legislator's role either, but it doesn't help - there is no help given there either.[628]

345. As to the concept of declaring and revoking later for matters in the "grey zone", AC Cotter noted that critical incidents "do have some stigma associated with them … The attrition rate to our officers involved, or witness, and to the families of them … We've got to declare them when they should be declared. That's what we've got to get better at".[629] AC Cotter agreed that greater assistance could be provided to Region Commanders and others regarding "declaring right" for public interest critical incidents.[630]

Media reporting on similar domestic violence incidents

346. AC Cotter was taken to certain articles which raised inconsistency in declaring critical incidents for other domestic violence matters involving calls to police, relative to the death of Ms Lucena.[631]

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[623] T560.34-39; T563.35-38 ("… we have some work to do to go back and reflect and review this document and the checklists, or whatever we want to call them, and have a better document which helps all our people make the best decision they can") (AC Cotter), Day 4.
[624] T560.47-561.17 (AC Cotter), Day 4.
[625] T562.25-30 (AC Cotter), Day 4.
[626] T563.40-564.11 (although AC Cotter had identified a few additional matters), (AC Cotter), Day 4.
[627] T564.31-32 (AC Cotter), Day 4.
[628] T564.35-42 (AC Cotter), Day 4.
[629] T565.25-567.7 (AC Cotter), Day 4.
[630] T566.14-17 (AC Cotter), Day 4.
[631] T568.3 (AC Cotter), Day 4.

347. Specifically, AC Cotter was taken to an *ABC* article dated 19 August 2023, entitled "Drew Douglas died in Sydney after a delayed police response. New figures highlight a growing problem",[632] which included the following:

> For priority two calls, the average response time has also increased slightly, from 10 minutes and 50 seconds in the 2019/20 financial year, to 11 minutes and four seconds last year.[633]

348. As to whether AC Cotter (in his capacity as Commander of PSC) was aware of the reporting of this nature raising concerns about delayed police response to '000' calls, he stated: "

> …I know it's been a topic of discussion and intent to respond as quickly as we can, with benchmarks, corporate benchmarks, of under 10 minutes I know, for, you know, all jobs, but certainly priority 2s.[634]

349. AC Cotter was also taken to an article from *The Australian*, "'Critical Incident' declared in NSW town of Casino, woman found dead", dated 29 June 2024,[635] which included the remarks of AC McKenna regarding a '000' call being made to police shortly after 1.30am, but police only acknowledging the call at 2.25am. AC McKenna stated the following in relation to calling a critical incident investigation:

> That has given me enough concern to ask for an independent review ... what was that delay and whether it was justified or otherwise," he said on Saturday afternoon.
>
> "What (police) were doing prior to that and what other jobs there were will form part of that investigation."[636]

350. AC Cotter accepted that such articles underscored the importance of consistency in decision-marking for critical incident investigations.[637] He accepted that Ms Lucena's death was an outlier as to time delays in relation to those articles, and that Supt. Tanner's review (as set out in his emails) was not independent of the Command (although suggested that both Supt. Tanner and AC Chapman had turned their mind to that issue). AC Cotter accepted however, that neither had reviewed the VKG transcript/audio recordings nor the issues of compliance with ROG SOPS, which is something a critical incident would explore.[638]

Reflections

351. As to reflections and learnings, AC Cotter made the following useful observations, which are worth extracting in full:

> Policing is hard, policing is busy, and there's a lot going on a lot of the time. I know that's a very sweeping statement. But it is a truism and I think it was a truism on this particular night in the Ballina Richmond area and north and south of it.

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[632] Exhibit 6.
[633] T568.17-569.18 (AC Cotter), Day 4.
[634] T569.23-28 (AC Cotter), Day 4.
[635] Exhibit 7.
[636] T570.38-571.27 (AC Cotter), Day 4.
[637] T571.32 (AC Cotter), Day 4.
[638] T577.36-573.11 (AC Cotter), Day 4.

What I will say is that from my reading, every officer, whether they be in the radio room at Newcastle, manning the car crews, turning up and dealing with the crime scene and the murder that they discovered - every one of those officers went about their duty with good faith and were doing their best.

Perfect is always the enemy of good. Were some of the things that occurred on that night absolutely perfect? In my opinion, and clearly on reflection by the organisation, probably not perfect. But there was certainly no malice, dereliction of duty or anything else, in my opinion.

They all tried. They were all working. They were all busy in various ways. Walk a mile in the shoes of that radio room, there were double beeps, there were jobs north, south, east and west of that coast up in that northern area. And unfortunately, things do get missed. I understand there were time frames not met in the original calling of the job, the subsequent callings of the job via the KPIs and the framework that is set.

…

So what I'm saying is we understand it is a realism to say that when police respond to incidents on the highway, officer safety is important too. You've got to balance that, again, against a woman getting the hell bashed out of her, if you believe the description, and I do.

Probably a lot of people would look at that again and maybe make a different decision, split the car crew, whatever, even though they're in separate cars. But they still did their best with no ill intent.

And then when they did respond, again, could they have done more? I think anyone would say yes, they could have. What more could have looked like, to give themselves an equal opportunity or more of an opportunity to investigate, discover, still might have ended up with the same outcome. So there are little - I don't say "little" in a demeaning or undermining way. There are little failings across but everyone tried their best to do what they had in front of them for their own safety and ultimately for the safety of Ms Lindy Lucena, who unfortunately nobody could save because of the actions of Mr Huber, who has been convicted, as we know.

This is a hard business and again, I just hope - I just hope - I don't see, if I look at it through my lens, I don't see any misconduct. I see areas where we can obviously patch up, bolster - some of that falls to me, some of that falls to the organisation and some of that falls to, yes, the policies and the procedures and some of the systems that we need to absolutely make sure that we classify jobs properly when they come in and that we do have a bit of a hard line with - if it's a 2, it's a 2 unless there's absolutely strong underscoring reasons which flip that.

And I do believe that we - when we respond to jobs, yes, I think we have to be really vigilant that we have to put ourselves in the shoes of the community watching us, that we will get out and do the very best job we can.[639]

[639] T573.34-35 (AC Cotter), Day 4.

Recommendations

Training and guidance on completion of P1179 forms and review of NSW Police Force Critical Incident Guidelines

352. In summary, the foregoing evidence indicates a need for further training and guidance for Superintendents who relieve as Assistant Commissioners in the Region Commander role as to the requirement to complete the P1179 upon *consideration* as to whether to declare a matter a critical incident.

353. Creditably, A/AC Chapman accepted that in the circumstances, she ought to have completed the P1179 form: see [243] to [244].

354. Further, AC Cotter identified the need to provide additional guidance for Region Commanders in the NSW Police Force Critical Incident Guidelines, to give a more prescriptive overview of what steps they are required to take.

355. That evidence would be accepted as grounding the following recommendations:

Recommendation 2

That the NSW Police Force provide training for Superintendents and Assistant Commissioners in relation to the declaration of critical incidents, including as to the importance of completion of the P1179 form and the definition of "police operation" in the *Law Enforcement Conduct and Commission Act 2016.*

Recommendation 3

That the NSW Police Force review the NSW Police Force 'Critical Incident Guidelines' (dated February 2024) including:

a. to provide clearer guidance as to steps to be undertaken by Region Commanders in declaring a critical incident and as to the requirement to complete the P1179 form upon *consideration* of whether to declare a critical incident (including in circumstances of non-declaration);

b. as to inclusion of an appropriate form of 'checklist' for the roles and responsibilities of relevant officers (including Region Commanders);

c. that the checklist include, where relevant, consideration of the actions of the Radio Operations Group, and not only the response of operational police; and

d. to provide further guidance on the "public interest" category of critical incidents (per s 111(1)(b) of the *Law Enforcement Conduct Commission Act 2016*), for example, by providing a summary of the types of matters that have previously been the subject of the "public interest" critical incident declarations.

Collation and review of P1179 forms by Professional Standards Command

356. As set out above, presently, the P1179 forms are not collated by PSC.

357. Both AC Cassar and AC Cotter agreed that as PSC are the subject matter experts, there is merit in that Command have access to the P1179 forms (which include non-declarations), so as to provide a form of quality assurance in decision-making, and to identify and consider trends: see [258] to [259]; [336] to [338]. AC Cotter highlighted the need for PSC's remit or mandate to be clearly identified however, lest PSC become a mere "warehouse" for such forms (at [337]).

358. Given this evidence, the following recommendation is proposed:

> **Recommendation 4**
>
> That the New South Wales Police Force put in place systems and procedures to enable the Professional Standards Command to obtain access to and collate P1179 'Critical Incident Declaration/Non-declaration by Region Commander' forms, including for the purposes of ensuring consistency in decision-making across the NSW Police Force; identifying trends in operational policing response and providing a form of quality assurance in the declaration of critical incidents.

D. CONCLUSION

359. In concluding these submissions, Counsel Assisting and those instructing her offer their heartfelt condolences to Ms Lucena's family, friends and loved ones for their incalculable loss.



Emma Sullivan

Barrister

Forbes Chambers

29 December 2025

ANNEXURE A: SUMMARY OF KEY FACTS RELATING TO INITIAL POLICE RESPONSE

Events from 7pm on 3 January 2023

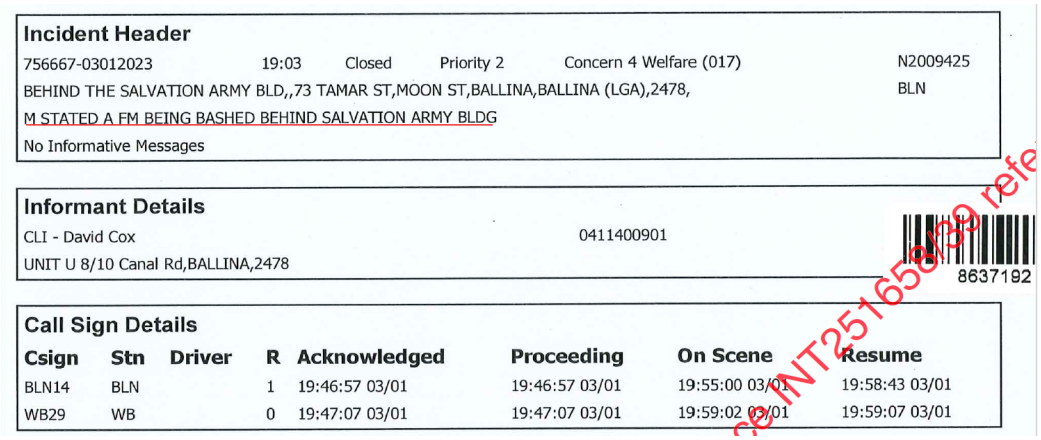
1. At approximately 7pm on Tuesday, 3 January 2023, the NSW Police Force received a '000' call from a then unknown male informant who reported "there's a man bashing the hell out of his woman at the back of the Salvation Army in Ballina". The Telstra operator stated to the Policelink Telephonist: "He said someone was beating the hell out of his woman"[640]

2. At around 7.03pm, the Police Link telephonist then called back the informant and there followed this exchange:

> *Telephonist: Your phone dialled 000. Could you repeat?*
>
> *Informant: Yeah, I'm just letting you know, there's a woman getting bashed behind Salvation Army in Ballina and that's all I got to say I don't want to be reported or anything.*
>
> *Telephonist: Yes.*
>
> *Informant: But just giving a heads up. I told Youse where and what.*[641]

3. At 7.03pm, the Telephonist entered the incident into the CAD System [Computer Assisted Dispatch]. Given the limited information provided, two further calls were made to the informant, who did not answer.

4. The information was categorised by the Telephonist as a Priority 2, 'Concern for Welfare' incident. The relevant CAD Incident Header information was as follows:



Incident Header

756667-03012023	19:03	Closed	Priority 2	Concern 4 Welfare (017)	N2009425
BEHIND THE SALVATION ARMY BLD,,73 TAMAR ST,MOON ST,BALLINA,BALLINA (LGA),2478,					BLN
M STATED A FM BEING BASHED BEHIND SALVATION ARMY BLDG					
No Informative Messages					

Informant Details

CLI - David Cox 0411400901

UNIT U 8/10 Canal Rd,BALLINA,2478

8637192

Call Sign Details

Csign	Stn	Driver	R	Acknowledged	Proceeding	On Scene	Resume
BLN14	BLN		1	19:46:57 03/01	19:46:57 03/01	19:55:00 03/01	19:58:43 03/01
WB29	WB		0	19:47:07 03/01	19:47:07 03/01	19:59:02 03/01	19:59:07 03/01

ce INT25165 of 39 refe

5. At 7.10pm (some 7 minutes after the call was first entered into CAD), the **initial broadcast** for the 'assault' incident behind the Salvation Army in Ballina was made over police radio on Channel P. It was preceded by the two tone beeps, in accordance with procedure.

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[640] Exhibit 2..
[641] Ibid, p 2.

Radio (@3:10:30): Two beeps Ballina car behind the Salvation Army building. 73 Tamar Street, cross Moon Street. Male stated a female's being bashed behind the Salvation Army building. Informant then terminated the call. On call back attempted, he stated, 'I've told you where it is. I don't want to be involved'. Swore the operator and hung up. On second call back, there's no answer.

6. No crew acknowledged the Salvation Army Incident at this time. The crews in the Ballina sector were attending to other jobs in the broader area, including a mental health/self-harm incident (which tied up the crew in AO18), and an accident on the M1, near Newrybar (which was a Priority 3 job broadcast at 7.03pm, and acknowledged by Officers C and D shortly after).

7. At 7.24pm, the Salvation Army incident was re-broadcast by the dispatcher.

Radio @03:24:30: Two beeps. Still standing by for a Ballina car for this concern for welfare behind the Salvation Army. 73 Tamar Street cross of Moon St Ballina. Male stated a female being bashed behind the Salvation Army building.

8. At 7.34pm, there was the third (and final) broadcast for the Salvation Army Incident.

9. At 7.46pm, BLN 14 containing Officer C (the shift supervisor who had attended the incident on the M1 highway), asked about the outstanding Ballina job.

BLN14 (@03:46:15): Yeah radio, just letting you know that we're back on, Woodburn 29 and I are back on from that job on the Pacific Highway. Traffic lanes are clear now, that vehicle's been moved off the road. Is that job in Fawcett Lane, Ballina, still outstanding?

Radio: I don't know about Fawcett Lane, but we've got a Priority 2 behind the Salvation Army, 73 Tamar Street cross Moon Street. That's outstanding.

BLN14: Yeah, I'm just thinking where the Salvation Army is. I think it's the place I'm speaking of. Well, I'll head there and have a look.

Radio: Okay, code of response and ETA? BLUE and 10 - why blue? BLN14: Well radio, we've only had the one call, if so, then I'll be blue and probably 10 minutes.

Radio: Blue and 10 it is. Woodburn 29, are you going to go as well?

WB29: Yes affirmative.

10. By 7.55pm, both crews had arrived at Holden Lane, the rear of the Salvation Army premises. Shortly after arrival at Holden Lane, there was an exchange between Officer C and police radio as follows:

BLN14 (@3:54:41): Ballina 14

Radio: Ballina 14

BLN14: I'm at the rear of the Salvation Army on Tamar Street. It's actually going to be Holden Lane, I was close. What did the caller exactly say? There's no indication whether it's a house or on the street.

Radio: Standby. Okay, so it just said behind the Salvation Army at 73 Rivers Street.

Male stated a female was being bashed behind the Salvation Army building. The informant then terminated the call. On callback he stated, 'I've told you where it is, don't want to be involved' and swore at the 000 operator and hung up. Second callback and third callback were not answered. The call was made from a mobile phone registered to a David Cox of a Ballina address.

BLN14: Copy, and you said River Street, so Salvation Army's on Tamar or River?
Radio: Oh sorry, the Salvation Army behind 73 Tamar Street, cross of Moon.

BLN14 (@3.56.04): Yeah copy that. That will make it Holden Lane and I know where the building is so we're just patrolling that lane now.

11. There was a patrol of Holden Lane as detailed above:

12. At 7.58.25pm, Officer C broadcast an update on police radio, as follows:

BLN14 (@03:58:25): Back on the air from Holden Lane, nothing sighted. There is numerous residents here. I'm sure we would have got more calls if there was something going on in the street there.

Radio: Copy.

Woodburn 29, did you make it there?

WB29 - I was behind - back on too

WB29: Yeah, I was behind 14. I'm back on too.

13. By around 7.59pm, both officers called back on and went about their duties, including attending to other incidents.

Events of Wednesday, 4 January 2025

14. At 12.30am, on 4 January 2023 (that is, some 4 and half hours after the initial '000' call), Robert Huber attended Ballina Police Station to report that his partner had died.

15. Officer C (amongst other police) was in the station near the counter when Mr Huber made the report. Officer C recognised Mr Huber, having previously encountered him in connection with domestic violence charges.

16. Specifically, on 27 December 2022, police had attended a caravan park in Ballina in response to reports of Mr Huber assaulting Ms Lucena. Mr Huber was charged with Assault Occasioning Actual Bodily Harm and Common Assault, being charges that Officer C had some involvement with. Mr Huber was granted conditional bail, and served with an Apprehended Domestic Violence Order, which included the standard conditions (1)(a) to (c) [not to assault, threaten, harass or intimidate the protected person – Ms Lucenca], and also Condition 4, not to approach or be in the company of the protected person at least 12 hours after drinking alcohol or taking

illicit drugs.[642] Mr Huber had a history of domestic violence related charges against Ms Lucena in NSW.

17. At Ballina Police Station, Mr Huber told Officer C that he had tried to stop some cars on the way to the police station "Because I think my missus is dead". Officer C asked, "Where is she", and Mr Huber replied: "Near the Salvation Army building". Officer C then asked Mr Huber to show police to the scene.

18. Officer C travelled alone in his own vehicle (BLN14) to Holden Lane, whilst two other officers who were accompanying Mr Huber, travelled in a separate vehicle.

19. Once in Holden Lane, Mr Huber led the officers to a gated area on the side of the Salvation Army building. Police found Ms Lucena's body in amongst many items of clothing and strewn around; tragically, Ms Lucena was deceased.

20. Shortly after Ms Lucena's body was discovered by police, Mr Huber was placed under arrest for the murder of Ms Lucena.

Supreme Court Trial of Mr Huber

21. On 7 July 2025, Mr Huber was convicted of the manslaughter of Ms Lucena by unlawful and dangerous act in a judge alone trial before Justice Rothman.

22. On 11 September 2025, Mr Huber was sentenced to 12 years' imprisonment, with a non-parole period of 9 years.

23. During the trial, there was a significant focus on the expert evidence of two forensic pathologists as to the medical cause of the death; there was also evidence as to the putative time of death.

24. In his decision of *R v Huber* [2025] NSWSC 714, Justice Rothman ultimately made the following finding as the time of death (at [430]):

> While I do not consider that the precise time of death is particularly important in these proceedings, I do not consider the description of Mr Leadbetter of hearing what he thought might have been the deceased at 9.30pm reliable. <u>It is likely that the deceased died at or about 7.20pm</u>. She may well have been deceased when Ms Hudson-Moon saw her. But it may be that she died just after 9:30pm.

[642] Tab 4, p 3.