OPERATION ALMAS

COMMISSIONER OF POLICE'S SUBMISSIONS

A. INTRODUCTION

1. The following submissions respond to Counsel Assisting's submissions dated 29 December 2025 (**CA**).

2. The Commissioner recognises that the families and friends of Ms Lucena will be forever affected by her death, and offers his sincere and respectful condolences.

B. SOME KEY FACTS

3. At the outset, it is worth recapping some key events in 2025:

   a) On 7 July 2025, in sentencing the perpetrator for Ms Lucena's homicide, Justice Rothman concluded the following about key events on the night of 3 January 2023:

      i) At 7:03pm, a person called 000 to report that there was a man "*bashing the hell out of his woman at the back of the Salvation Army in Ballina*": [115].

      ii) At or about 7:20pm, Ms Lucena likely died: [430]. While Justice Rothman also said that it "*may be*" that she died just after 9:30pm ([430]), this possibility appeared to be based on the evidence of one witness ([158]-[159]) whom Justice Rothman described being "*unreliable as to times, dates and details*": [169].

      iii) At 7:55pm, police arrived at the Salvation Army. In making this finding, Justice Rothman noted that one of the attending officers "*provided reasons that the Police were delayed in answering the call at 7:03pm about the bashing of the female*", but did not outline those reasons in the judgment: [134].

   b) On 27 July 2025, the ABC published the article "*Loved ones, watchdog raise concerns about NSW Police response to Lindy Lucena's fatal bashing*". The opening sentence of the article states that a witness called triple-0 to report that a man was bashing the hell out of the woman at the location where her body was later found. In addition, the tenor of the article was to the effect that had responded appropriately, Ms Lucena would or could still be alive.

c) On 31 July 2025, Ms Higginson wrote to LECC, making a formal complaint about the conduct of the NSW Police Force in responding to the assault and subsequent death of Ms Lucena. The complaint misstates the facts, or otherwise propounds infirmly based assertions. For example:

i) Ms Higginson asserted that "[*t]o delay a response to a domestic violence call by almost an hour when the location of the incident was 2 minutes drive from the police station is the antithesis of timely*". As the evidence has shown, this is not a fair characterisation of what happened. On no view were officers sitting around in a police station, two minutes away, "*delaying*" their response.

ii) Ms Higginson asserted that "*Justice Stephen Rothman reported that the likely time of Ms Lucena's death occurred between 7:20pm and 9:30pm*". That is not what Justice Rothman found. But despite that, Ms Higginson makes the serious claim that "*it is not unreasonable to see causation between the alleged serious police negligence and the subsequent death of Ms Lucena*". For reasons that will be given later, this claim is not credible.

d) On 15 August 2025, LECC wrote to Ms Higginson and informed her that it had decided to investigate whether the conduct of the police officers involved in the response to the assault and subsequent death of Ms Lucena amounted to serious misconduct or serious maladministration under Part 6 of the *Law Enforcement Conduct Commission Act 2016* (NSW).

e) On 16 August 2025, Ms Higginson published a media release that, among other things, alleged that police had failed in their duty in serious circumstances, and implied that police had "*a role*" in the death of Ms Lucena, and had either "*failed her*" or made her a "*victim*".

f) On 3 December 2025, while explaining the scope of Operation Almas on the first day of the inquiry, the Commissioner referred to "*questions about the police response [raised]…by the media and by Ms Higginson MLC in a letter written to the Commission in July 2025*": T3.21-24.

g) On 29 December 2025, Counsel Assisting fairly submitted that the evidence did not establish any actual or potential police misconduct: CA [299]-[300]. She also observed that the evidence established "*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": CA [300]. She also noted that "*it cannot be said that had [a certain kind of search] been undertaken, Ms Lucena's life would have been saved*", which "*cannot be known and may ultimately be thought unlikely*": CA [196].

4. The preceding has a number of important implications for the Commission's report.

5. *First*, the Commission should vindicate the conduct of police in the kind of terms used by Counsel Assisting. That course would ordinarily be appropriate where the evidence does not permit of any other conclusion. It is even more appropriate when the conduct of members of the NSW Police Force has been the subject of unfair public attack. There is no public interest in the community being misled about the conduct of police, nor is it right that members of the NSW Police Force who did their best under trying circumstances face the additional hardship of being publicly maligned for their conduct.

6. *Secondly*, in drafting its report, the Commission should be more careful in phrasing certain matters than would ordinarily be appropriate, in order to avoid giving the impression that it has a role in investigating the question of whether the NSW Police Force, had it acted differently, would or could have saved the life of Ms Lucena. The Commission and lawyers involved in this matter understand the remit of Operation Almas. However, it is clear from various public statements that some see Operation Almas as a mechanism for deciding questions of causation of Ms Lucena's death. To avoid contributing to this misperception, it would be appropriate for the Commission to avoid analysing the adequacy of the search for Ms Lucena when officers arrive at the scene, and to avoid language like "*a missed opportunity*" to describe the result of the search that was done: CA [195]. However clear that kind of language is to the Commission and the lawyers involved in this matter, it will inevitably be misunderstood by media outlets and the public as implying a missed opportunity to save Ms Lucena's life.

C. SHOULD THE COMMISSION CONSIDER THE ADEQUACY OF SEARCH FOR MS LUCENA?

7. A focus in Counsel Assisting's submissions is whether the search performed by Officer C and D at Holden Lane was adequate. However, there is no utility in the Commission considering this question.

8. Generally speaking, the only reason for the Commission to consider the appropriateness of conduct of the NSW Police Force is to assist in ensuring that the conduct of the NSW Police

Force is as appropriate as possible going in the future. In this case, however, there is no proposed recommendation based on the adequacy of the search. The closest Counsel Assisting's submissions come to raising a possible future-focussed issue is to the effect that police were operating on a "*heuristic bias*" that "*one call makes it less likely that the event is serious or ongoing*": CA [199]. This can be answered in two ways:

a) The use of heuristics – whether they are called heuristics or called heuristic biases – is essential to police activity. That includes in assessing the seriousness of incidents raised by 000 calls. As was clear from the evidence, it cannot be assumed that callers give an accurate or complete account of the information that would be helpful in assessing the urgency of the call and responding appropriately. So, as was the premise of many of Counsel Assisting's questions, the NSW Police Force has to analyse that information critically and apply rules of thumb – which are heuristics – to limited information. One example is that incidents of violence can move from their original location, even though the location of an alleged incident of violence is described in a static way by the caller. The question is therefore not whether the use of heuristics *per se* is appropriate – they are not only appropriate, but necessary – but whether any particular heuristic is unhelpful because its expected accuracy deviates too far from its actual accuracy.

b) The heuristic in issue is that one call makes it less likely that the event is serious or ongoing: CA [199]. The evidence does not establish that this heuristic is unhelpful. It accords with both common sense and the evidence of experienced police officers that at least when the event in question is an act of violence in public, there is a correlation between the number of calls about events and the seriousness of an event. That is because as the seriousness of violence in public increases, it is more likely that (i) that act of violence will be perceived by members of the public; and (ii) that any member of the public who observes an act of violence will be moved to report it to 000. However, it is important to be clear that this heuristic is one about correlation, not about fact; saying that more calls predict more seriousness is not the same thing as saying that the mere fact that because an incident only attracts one call, it is not serious. In this case, the heuristic did not correctly predict the outcome – not through the fault of anyone, but because of the inherent character of heuristics. The fact that the expected outcome did not match the actual outcome is not a reason to discard the heuristic. To the contrary, the evidence of the experienced police officers before the

Commission heard suggests that it is a helpful rule of thumb to throw into the large mix of considerations that are raised by often obscure 000 calls.

9. The only other potential utility of considering the adequacy of the search lies in determining whether a more far-ranging search would have saved Ms Lucena's life. That is not territory into which the Commission should wade. However, should it decide to the contrary, a more wide-ranging search would not have prevented Ms Lucena's death. On the best available information, Ms Lucena died at or about 7.20pm, some thirty-five minutes before police started searching. Assuming a more far-ranging search would have revealed her body (which itself is doubtful, given the fading light, the gates and the surrounding detritus), her survival in this hypothetical plainly depends on transportation to hospital (which would have taken a significant amount of time to both arrange and implement) and medical treatment at the hospital (which, even were Ms Lucena alive at this point, cannot be said with any confidence to be enough to have saved her life). Put simply, on the available evidence, a theory that maintains causation between the adequacy of the search and Ms Lucena's death is not credible.

10. The Commission need not, and therefore should not, consider the adequacy of the search performed by the officers at Holden Lane. If it does, it should conclude that the search was adequate, given the information they had, and the unworkability that arises if the Commission concludes that the officers should have searched down the side of the Salvation Army (which would mean that many other locations would have to have been searched as well and which, in the aggregate, would impose an unworkable burden on police officers).

D. PROPOSED RECOMMENDATION 1

11. Proposed Recommendation 1 is as follows:

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.

12. For the following reasons, the Commissioner is content for part of the recommendation to be made as described below.

D.1. "Shared offsider" dispatch assist model (1(a))

13. This part of the proposed recommendation should not be made. Radio Operations Group (ROG) is already keenly aware of the comparative advantages and disadvantages of the "shared offsider" method and the merging of channels. This issue was considered in detail as recently as 31 January 2024. Experienced officers have decided, after serious consideration, to remain with the status quo. That being so, to accept this aspect of the recommendation would only entail the expenditure of unnecessary resources that are needed in other places.

D.2. CAD System (1(b))

14. NSWPF is in advanced negotiations with a preferred tenderer for the next generation CAD System. While the current CAD System is fit for purpose, the Commissioner accepts a proposed recommendation that involves giving consideration to how improvements could be made in relation to the broadcasting of long-term Priority 3 jobs and PD/PAC responsibilities in taking/resolving Priority 3 jobs after they have been in list greater than a determined period of time (e.g. 12-24 hours).

D.3. Resourcing at the Newcastle Radio Operations Centre (1(c))

15. This part of the recommendation should not be made, because ROG is already keenly aware of resourcing constraints. ROG instructs as follows:

> Staffing levels at Newcastle Radio Operations has been a focus for ROG for several years. The initial training for Communications Officers is 15 weeks, and as such this presents challenges with filling vacant positions. Officers that have successfully passed the Communications Officer course for 2023-2025: 2023: 13, 2024: 14, 2025: 6. There is currently a further class with 7 officers projected to (successfully) complete the training course in February 2026, with recruitment commenced for up to 10 suitable officers to begin in May 2026. There are currently 7 vacancies which will be filled at the completion of the May 2026 class.
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> Across all centres, staffing numbers and operational needs is also a strong focus for ROG, with resourcing considered holistically across the five centres, and not as silo operations. Recently, the Radio Operations Group introduced the Real Time Manager (RTM) position, based at Sydney Radio Operations. The RTM is responsible for real-time monitoring of air traffic and workloads across all radio channels, with a focus on merged channels as well as operational needs dynamically. Ongoing risk assessments are conducted based on air traffic and CAD incidents. These assessments involve evaluating workloads across ROG in real-time and making informed decisions to meet the command's operational needs. This includes assessing air traffic, CAD incidents on a channel, operator experience levels, and other relevant factors. The RTM

organises and responds as necessary, including unmerging channels when workloads increase or when merged channels are deemed inappropriate. The RTM can also reallocate channels between radio centres to optimise resource use. This real-time monitoring allows for the splitting of individual channels during major incidents and events. Supervisors in each centre are also expected to monitor workloads, especially on busy channels, and devise solutions when channel merging is not suitable. RTM's utilise dashboards which are real time live information that assist in the risk assessment and decision-making process. The development of this function is ongoing and there has been a focus to enhance this role to better distribute workload across the five radio centres.

D.4. ROG SOPs

16. This part of the recommendation should not be made, because ROG, after serious consideration, maintains that the ROG SOP they are achievable and appropriate. In relation to repeat broadcasting of Priority 2 incidents every 60 seconds, ROG instructs:

> The Priority 1 and 2 SOP requiring the broadcast of outstanding incidents every 60 seconds is appropriate. These incidents must meet criteria relating to serious crime or threats to life. Failing to broadcast them, particularly when they have not yet been acknowledged by police—creates a risk to community safety. Other broadcast SOPs have been reviewed over the past two years, including reducing the frequency of lower priority job broadcasts. Police are also now able to use personally issued devices and MDTs in day to day policing, where traditionally this information was communicated over police radio and managed by the dispatcher. This free's up radio air traffic assisting in the dispatcher to prioritise priority incidents.

E. PROPOSED RECOMMENDATION 2-5

17. Proposed Recommendations 2 and 3 are as follows:

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.

18. Proposed Recommendation 4 is as follows:

> **Recommendation 4**
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> 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.

19. Proposed Recommendation 5, raised by the Commission, is that the NSW Police Force implement a procedure to provide a copy of all Critical Incident Declaration/Non-Declaration by Region Commander forms (P1179) to the Commission in a timely manner.

20. The evidence does not support any of these proposed recommendations, and they should not be made:

a) This incident is the wrong vehicle for making them: Consistent with Counsel Assisting's submission that the decision not to declare a critical incident was "*certainly open*" (CA [292]), the decision not to declare a critical incident in this case was correct. The only legal mechanism for declaring a critical incident in this case was via s 111(b) of the LECC Act, which fastens to the formation of the conclusion that there are "*other grounds for considering it is in the public interest to do so*". This precondition has never been enlivened, nor is it suggested that it was. To the extent it may be considered that public statements heightened the need for transparency, it is important not to attribute the views of one media outlet or public figure (whoever they are) to the public at large. Nor should the views of one media outlet or public figure necessarily be given significant weight for the purpose of s 111(b), especially where those views have an infirm basis in the facts.

b) The cost of implementing the recommendations outweighs any benefit:

   i) It is rare that the decision to declare a critical incident will hinge solely on s 111(1)(b), as it did in this case, and it is already within the existing skillset of senior officers to read legislation

   ii) A Situational Report (SITREP) is already completed for all serious incidents – and that report flows through to the senior executive, who can provide oversight and can intervene if necessary.

iii) In light of the above, it is hard to see the value proposition in investing limited resources in extra training, guideline revision, database modification or voluntary information sharing with the Commission in response to a situation as idiosyncratic as this one.

c) Not appropriate to deviate from the balance that Parliament struck: By s 111, Parliament gave the Commissioner of Police the power to declare an incident to be a critical incident, and did not give LECC a role in overseeing the exercise of that power. By s 114, LECC obtains a significant amount of power from the declaration of a critical incident that it otherwise would not have. Given Parliament's design of s 111, 114 and the remainder of Part 8, it would not be appropriate for the Commissioner of Police to go beyond this design to develop their own kind of oversight function for LECC to exercise. Such an arrangement would give rise to LECC having the appearance of a conflict of interest, which is apt to undermine its standing.

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