

# Individual Communication to the United Nations Human Rights Committee

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Submitted by: Shani Cassidy on behalf of her deceased son Tyler Jordan Cassidy

Alleged victim: Tyler Jordan Cassidy

State party: The Commonwealth of Australia

Date of submission: 29 May 2013

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Claim: In the matter of Tyler Jordan Cassidy, Australia has violated its human rights obligations under Articles 6(1) and 2 of the *International Covenant on Civil and Political Rights*

Application: To the United Nations Human Rights Committee under Article 1 of the *Optional Protocol to the International Covenant on Civil and Political Rights*

Residence: Tyler was at all material times a resident of Australia

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## 1. Glossary of Defined Terms

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<b><i>Administrative Law Act</i></b>	<i>Administrative Law Act 1978 (Vic)</i>
<b><i>AHRC</i></b>	Australian Human Rights Commission
<b><i>Australia</i></b>	The Commonwealth of Australia
<b><i>Committee</i></b>	United Nations Human Rights Committee
<b><i>Confidential OPI Review</i></b>	Assessment undertaken by the OPI of the sufficiency of the primary investigation by Victoria Police into Tyler's death
<b><i>Confidential OPI Report</i></b>	Report entitled 'Review of Investigation by Victoria Police of Fatal Shooting of Tyler Jordan Cassidy', this report is subject to a confidentiality regime
<b><i>Coroner</i></b>	Victorian State Coroner Judge Jennifer Coate
<b><i>Coroners Act</i></b>	<i>Coroners Act 2008 (Vic)</i>
<b><i>ESD</i></b>	Victoria Police Ethical Standards Department
<b><i>ESTA</i></b>	Emergency Services Telecommunications Authority (Victoria)
<b><i>First Optional Protocol</i></b>	<i>Optional Protocol to the International Covenant on Civil and Political Rights</i>
<b><i>Homicide Squad</i></b>	Victoria Police Homicide Squad
<b><i>HRLC</i></b>	Human Rights Law Centre
<b><i>ICCPR</i></b>	<i>International Covenant on Civil and Political Rights</i>
<b><i>Inquest</i></b>	Inquest into the death of Tyler Jordan Cassidy
<b><i>Inquest Brief</i></b>	Inquest brief of evidence into the death of Tyler Jordan Cassidy prepared by Victoria Police
<b><i>Inquest Finding</i></b>	Finding into Death with Inquest: Tyler Jordan Cassidy [2011] Coroners Court of Victoria 5542/08 (Judge Jennifer Coate, 23 November 2011)
<b><i>Investigation</i></b>	The primary investigation into Tyler's death conducted by Victoria Police, together with the subsequent coronial inquest
<b><i>OPI</i></b>	Office of Police Integrity
<b><i>OPI Review of Investigations</i></b>	Report entitled 'Review of the investigative process following a death associated with police contact' (June 2011)
<b><i>OPI 2005 Report</i></b>	Report entitled, 'Review conducted by the OPI of six fatal shootings by police that occurred between January 2003 and May 2005'

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<b><i>OPI Review Issues Paper</i></b>	Report entitled 'Review of the investigation of deaths associated with police conduct: Issues Paper' (2010)s
<b><i>OPI 2009 Report</i></b>	Report entitled 'Review of the Use of Force by and against Victorian Police' (July 2009)
<b><i>Police Integrity Act</i></b>	<i>Police Integrity Act 2008</i> (Vic)
<b><i>VEOHRC</i></b>	Victorian Equal Opportunity and Human Rights Commission
<b><i>Victorian Charter</i></b>	<i>Charter of Human Rights and Responsibilities Act 2006</i> (Vic)

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## 2. Summary

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1. Tyler Jordan Cassidy (**Tyler**) was shot dead by members of Victoria Police on the evening of 11 December 2008 at All Nations Park, Northcote, in the State of Victoria, Australia. He was 15 years old when he died.
2. Ten shots were fired by three of the four police officers present at the time of Tyler's death. Five of those shots struck Tyler, who died within minutes at the scene.
3. Tyler was alone and armed with two large knives when police located him in All Nations Park. A total of 73 seconds elapsed from the time the Leading Senior Constable first saw and engaged with Tyler, to the time the police called for an ambulance having shot Tyler. During this short period, police sprayed Tyler with Oleoresin Capsicum foam spray and fired 10 shots. The police officers did not ask Tyler his name or age.
4. In Victoria, there is no independent investigative body mandated to investigate deaths associated with police contact.
5. Instead, the primary investigation into Tyler's death was conducted by Victoria Police investigators, and was followed by a coronial inquest (together, the **Investigation**).
6. Victoria Police prepared the inquest brief of evidence (**Inquest Brief**), which was then delivered to State Coroner Judge Jennifer Coate (the **Coroner**) for the inquest hearing.
7. The primary investigation was characterised by a number of deficiencies, including that:
  - (a) there were major delays in notifying the Victoria Police Major Crime Desk and the Homicide Squad that Tyler had died;
  - (b) there were delays in conducting drug and alcohol testing, and gunshot residue testing, of the police officers present at the time of Tyler's death;
  - (c) there were a number of indications that these police officers were not treated as suspects during the investigation;
  - (d) although ten shots were fired by police, no bullets were recovered;
  - (e) there were significant delays in identifying potential witnesses;
  - (f) Victoria Police released a media statement regarding Tyler's death prior to speaking with the author and Tyler's family; and
  - (g) various conversations between Victoria Police investigators and the author and her family were covertly recorded without the author's knowledge or permission.
8. The Coroner relied upon the Inquest Brief, prepared by Victoria Police following its primary investigation, at the inquest.
9. The author submits that the Investigation did not meet the procedural requirements of Article 6(1) of the ICCPR and, as a result, the State party has breached Article 6(1).
10. The author further submits that the State party has breached Article 2 because it has not ensured an effective remedy for the violation(s) of Tyler's right to life under Article 6(1).

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11. Tyler died as a direct result of the use of force by agents of the State party. In breach of Article 6(1), the State party has failed to provide an independent and effective investigation into Tyler's death. The author has suffered considerable and prolonged pain and distress as a result. She is committed to seeking to have Australia fulfil its human rights obligations, by implementing an independent investigative process that ensures deaths associated with police contact, such as Tyler's, are investigated in accordance with the procedural requirements of the right to life. Having an independent and effective investigation into deaths associated with police contact will serve to lessen the pain and distress suffered by deceased persons' families, and will maximise learnings from such unfortunate incidents to assist in averting such deaths in the future.

### 3. Facts of the Claim

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12. To enable a full understanding of the circumstances of Tyler's death, the context in which it occurred and the remedial options available to the author, the following is provided:
- (a) a chronology of events relevant to Tyler's death and its subsequent investigation;
  - (b) an overview of the use of force by Victoria Police;
  - (c) an overview of bodies and other authorities commonly involved in the investigation of police-contact related deaths; and
  - (d) an overview of the model of investigation of police-contact related deaths in Victoria, and the recent review of this model conducted by the Office of Police Integrity (*OPI*).

#### 3.1 Chronology of events

13. The table below outlines the events on the evening of Tyler's death, the steps subsequently taken to investigate Tyler's deaths, and details of the Coronial inquest.

DATE	EVENT
11 December 2008	<p>Tyler died from a gunshot wound to the chest in the following circumstances:<sup>1</sup></p> <ul style="list-style-type: none"><li>1. Tyler Jordan Cassidy was shot dead by police on the evening of 11 December 2008 at All Nations Park, Northcote. He was 15 years and 8 months old at the time of his death.</li><li>2. Ten shots were fired by three of the four police officers present in the park at the time of his death. Five of those shots struck Tyler, one of them fatally entering his body below his left clavicle and causing significant internal bleeding and the collapse of his right lung. He died within minutes at the scene.</li><li>3. About 11 minutes and 25 seconds before this shooting, Tyler had armed</li></ul>

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<sup>1</sup> Redacted Finding into Death with Inquest: Tyler Jordan Cassidy [2011] Coroners Court of Victoria 5542/08 (Judge Jennifer Coate, 23 November 2011) (*Inquest Finding*).

	<p>himself with two large knives he had very publicly stolen from a Kmart store inside the Northcote Plaza Shopping Centre which is adjacent to All Nations Park. He had then moved swiftly through the shopping centre, and adjoining shops and car park, pointing the knives at people and demanding that the police be called or people would die that night.</p> <p>4. Indeed about three minutes and two seconds before entering the Kmart store he had called 000 himself and said there was a "psychopath" with a shotgun that had gone crazy and that the police should "<i>shoot him fucken dead</i>".</p> <p>5. At least four people in and around Northcote Plaza that night had contacted 000 advising police of the presence of a male armed with knives threatening people.</p> <p>6. Four police arrived in two vans in response to these 000 calls. They were Leading Senior Constable Colin Dods (LSC Dods) and Senior Constable Richard Blundell (SIC Blundell) in one police van and Constable Antonia Ferrante (C Ferrante) and Constable Nicole De Propertis (C De Propertis) in the second van.</p> <p>7. LSC Dods and SIC Blundell quickly located Tyler who, upon seeing the police arrive, had run onto the roadway and placed himself in front of the van being driven by SIC Blundell. Upon seeing Tyler, SIC Blundell pulled up immediately and both he and LSC Dods got out of the van. LSC Dods had taken out his Oleoresin Capsicum (OC) foam spray and SIC Blundell immediately withdrew his firearm once he got out of the van.</p> <p>8. The first words spoken to Tyler were commands to him to show his hands, which he held behind his back.</p> <p>9. Tyler produced two knives, firmly gripping one in each hand. When asked to show his hands and drop the knives, Tyler said "you're going to have to kill me", "you're going to have to shoot me" and "I'll hurt you".</p> <p>10. Upon seeing the knives LSC Dods and SIC Blundell demanded he drop the knives. Tyler did not drop the knives. There is some mixed evidence about whether or not Tyler stepped forward towards LSC Dods and SIC Blundell upon them exiting their van. LSC Dods stepped forward and sprayed Tyler with OC foam. At this point, according to the evidence of LSC Dods he moved forward so that he was within the range of distance for the OC foam to be effective.</p> <p>11. After this foaming, Tyler ran across the adjoining skate park and into the grassed open area of All Nations Park. By this time the two police members in the second van, C Ferrante and C De Propertis, had joined LSC Dods and SIC Blundell on foot as they pursued Tyler into the park.</p> <p>12. Some metres into the grassed area of All Nations Park, past the skate park and across a track, Tyler stopped running and turned and faced all four police members who had chased him into the Park. LSC Dods described Tyler as pointing the knives at them in a "threatening manner". He was again foamed by LSC Dods, but apparently to no effect in that it did not result in Tyler laying down the knives or indicating his intention to stop.</p> <p>13. Refusing to obey the police calls to throw down the knives, Tyler started</p>
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	<p>advancing slowly on the police. The police stated they were commanding him to put down the knives and stop coming towards them or he would be shot. Throughout this exchange the police evidence was that Tyler responded by saying "I'm going to kill you" and "you're going to have to shoot me".</p> <p>14. All four police stated they backed away as Tyler continued to advance despite commands to him to stop and put down the knives.</p> <p>15. Tyler focused his advance on LSC Dods. LSC Dods continued to issue commands to Tyler to stop and disarm.</p> <p>16. LSC Dods fired a warning shot into the ground beside Tyler which did not halt Tyler's advance. After this warning shot was fired, LSC Dods became isolated from the other three members as Tyler continued to advance on LSC Dods. LSC Dods stated he felt forced to back up a set of concrete steps leading to a raised area of the adjoining skate park. LSC Dods then fired two shots at Tyler's legs as Tyler walked up the steps towards him. Apart from a "flinch" or "stumble", Tyler did not stop advancing on LSC Dods with the knives held firmly in each hand.</p> <p>17. As LSC Dods got to the top of the steps, he came up against a railing running around the steps' apex.</p> <p>18. As Tyler commenced his ascent of the steps towards LSC Dods, SIC Blundell fired twice and C. De Propertis fired once. As Tyler walked towards LSC Dods, SIC Blundell fired again. At this time, Tyler was standing in the vicinity of the top of a ramp in the skate park, down which he ultimately fell. LSC Dods stated that, fearing for his life and having exhausted all other non-lethal options, he fired three shots directly at Tyler's chest area as Tyler walked towards him, and as he (i.e. LSC Dods) was standing a step in from a ledge to the back of him and a ramp to the right. There were several shots fired in rapid succession at this time after which Tyler fell down the ramp and died minutes later.</p> <p>19. It was 73 seconds from the time LSC Dods first saw and engaged with Tyler on the roadway to the call for the ambulance in the wake of the shooting.</p> <p>Police officers at the scene called the Emergency Services Telecommunications Authority (<b>ESTA</b>) at 9:31pm.<sup>2</sup> At this time, Tyler was still alive.</p> <p>From that time, and throughout the evening of 11 December 2008 and the morning of 12 December 2008, further members of Victoria Police, including a Crime Investigations Unit, attended the scene of Tyler's death.</p> <p>Police officers were aware of the presence of the author, her partner Greg Taylor and her eldest son, Blake Cassidy, at the scene by about 10.00pm.<sup>3</sup></p> <p>The Major Crime Desk was notified that the shooting of Tyler was fatal at 10:32pm.<sup>4</sup></p>
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<sup>2</sup> Inquest Finding, above n1, [407].

<sup>3</sup> Ibid, [533].

	<p>At 10.38pm, the Major Crime Desk contacted the Homicide Squad of Victoria Police (<b>Homicide Squad</b>).<sup>5</sup></p> <p>At 10:40, Julian Goldrick, a Sergeant of Victoria Police attending the scene, contacted the Coroner's Court and obtained a case number (5542/08). The registrar of the Coroner's Court indicated that he would contact the duty coroner.<sup>6</sup></p> <p>Members of the Homicide Squad led by Detective Sergeant Allan John Birch, who arrived at 11:36pm,<sup>7</sup> attended the scene of Tyler's death and commenced the primary investigation into the circumstances in which it occurred.</p> <p>The Ethical Standards Department of Victoria Police (<b>ESD</b>) maintained oversight responsibility of the Homicide Squad's investigation into the circumstances of Tyler's death.<sup>8</sup> Acting Inspector Grant of the ESD was notified of the incident at 9:55pm on 11 December 2008.<sup>9</sup></p> <p>The Coroner attended a de-briefing conducted by Inspector Therese Walsh of Victoria Police sometime after 11:36pm<sup>10</sup> on the night of Tyler's death.<sup>11</sup> She had no further direct involvement in the investigation prior to the delivery of the Inquest Brief to the Coroner's Court in September 2009.</p>
23 April 2009	The Cassidy family wrote to the Coroner requesting that the conduct of the investigation into Tyler's death be removed from the Victoria Police and that the OPI take over conduct of the investigation.
24 April 2009	The Coroner wrote to the OPI seeking a response to the request by the Cassidy family that the OPI assume the conduct of the investigation into Tyler's death.
5 May 2009	The OPI responded to the Coroner's letter of 24 April 2009 stating that it would not investigate Tyler's death because the OPI lacked the resources and necessary charter to take over the investigation. The Director of the OPI subsequently requested Gerry Feltus and John Ashby of the OPI to assess the sufficiency of the police investigation into Tyler's death. <sup>12</sup>

<sup>4</sup> Inquest Brief, 3683.

<sup>5</sup> Ibid, 614, 3683.

<sup>6</sup> Ibid, 424.

<sup>7</sup> Ibid, 614.

<sup>8</sup> Ibid, 2383.

<sup>9</sup> Ibid, 2313.

<sup>10</sup> Ibid, 614.

<sup>11</sup> Ibid, 519.

<sup>12</sup> Inquest Exhibit 87, *OPI Review of investigation by Victoria Police of Fatal shooting of Tyler Jordan CASSIDY dated January 2010, authored by Gerald Feltus and John Ashby (Confidential OPI Report).*

13 May 2009	The Human Rights Law Centre ( <b>HRLC</b> ) wrote to the Coroner outlining the procedural requirements of the right to life including the need for an independent investigation in cases where a death occurs at the hands of State law enforcement authorities.
1 July 2009	The Coroner issued a letter stating that she would proceed to receive a brief of evidence from the Victoria Police conducting the investigation into the circumstances of Tyler's death, and that she was satisfied the current investigation in which Victoria Police were preparing a brief complied with the requirements of the right to life under the <i>Charter of Human Rights and Responsibilities Act 2006</i> (Vic) (the <b>Victorian Charter</b> ).
30 September 2009	The Inquest Brief was delivered to the Coroner's Court by Victoria Police.
November 2009	The Director of the OPI announced his intention to conduct a separate inquiry into the way in which police contact related deaths are investigated in Victoria. <sup>13</sup>
4 December 2009	The OPI received a letter from the Coroner requesting that the OPI consider addressing the following further issues in its assessment of the sufficiency of the Victoria Police investigation into Tyler's death: <ul style="list-style-type: none"> <li>• whether the Victoria Police members conducting the investigation complied with Victoria Police operating procedures, instructions, directives or policies and best practice; and</li> <li>• the sufficiency and appropriateness of relevant Victoria Police operating procedures, instructions and policies and protocols for police conducting investigations into coronial deaths where the death has been as a result of a police shooting.</li> </ul>
May 2009 - March 2010	The OPI conducted an assessment of the sufficiency of the police investigation of Tyler's death, but did not investigate Tyler's death. The OPI assessment incorporated consideration of the first further issue addressed in the letter received by the OPI from the Coroner on 4 December 2009 ( <b>Confidential OPI Review</b> ). The OPI produced as a result of this assessment a report, <i>Review of Investigation by Victoria Police of Fatal Shooting of Tyler Jordan Cassidy</i> ( <b>Confidential OPI Report</b> ). The contents of this report are subject to a confidentiality regime.
19 October 2010 – 11 March 2011	The hearing of the inquest into the death of Tyler Jordan Cassidy was conducted ( <b>Inquest</b> ). <sup>14</sup> Three of the four police officers present at the time of Tyler's death gave evidence at the Inquest.
June 2011	The OPI report entitled <i>Review of the investigative process following a death</i>

<sup>13</sup> OPI, *Review of the investigation of deaths associated with police conduct: Issues Paper*, 2010 (**OPI Review Issues Paper**). The Inquiry was conducted pursuant to s28(2) of the *Police Integrity Act 2008* (Vic).

<sup>14</sup> Hearing dates: 19-22, 25-29 October 2010, 1, 3-5, 8-12, 15-19 November 2010, 2, 3, 14-17, 20-14 December 2010, 10, 11 March 2011.

	<p><i>associated with police contact</i> was tabled in the Victorian Parliament by the OPI (<b><i>OPI Review of Investigations</i></b>).<sup>15</sup></p> <p>The OPI Review of Investigations concluded that 'the current legislative framework for the investigation and oversight of deaths associated with police contact is not optimal'. The OPI made a series of recommendations regarding improvements to the current model whereby Victoria Police is responsible for investigations, but noted that it was ultimately a matter for the Government of the State of Victoria to determine whether any policy and/or legislative changes are appropriate.<sup>16</sup></p> <p>A copy of this report is included at Annexure I.</p>
23 November 2011	<p>The Coroner handed down her findings from the Inquest (<b><i>Inquest Finding</i></b>), finding that Tyler had died from a gunshot wound to the chest fired by an officer of Victoria Police, in the circumstances described above.</p> <p>The Coroner made a number of relevant findings, which are discussed in more depth below. They include findings in respect of delay in the calling out of specialist forensic services, delay in notifying the Homicide Squad of Tyler's death, delay in drug and alcohol testing of the officers involved in the incident, the failure to make a general call for eye witnesses, and also poor or insensitive practices adopted by Victoria Police in engaging with Tyler's family.<sup>17</sup></p> <p>The Coroner also made eight recommendations, including, relevantly, recommendation 8:</p> <p style="text-align: center;"><b>Taking of police statements</b></p> <p style="text-align: center;">8. To allay perceptions regarding collusion and bias, without compromising the coherence of the account give [sic] by Victoria Police members following a police contact related death, I recommend that the Secretary to the Victorian Department of Justice provide an institutionally independent, legally trained person to observe the interview process with Victoria Police members involved in the incident.<sup>18</sup></p> <p>A copy of the findings and recommendations is included at Annexure B.</p>
17 February 2012	<p>Kieran Walshe, Deputy Commissioner, Victoria Police, provided a response on behalf of Victoria Police to the recommendations made by the Coroner.</p> <p>This response did not address any issues regarding the independence of the investigation of deaths related to police contact, and did not address recommendation 8.</p>

<sup>15</sup> Office of Police Integrity, *Review of the investigative process following a death associated with police contact* (June 2011) (***OPI Review of Investigations***).

<sup>16</sup> Ibid, 45.

<sup>17</sup> See eg Inquest Finding, above n1, [646]-[657].

<sup>18</sup> Ibid, Recommendations.

	A copy of the response is included at Annexure C.
11 April 2012	<p>Penny Armitage, Secretary, Victorian Department of Justice, provided a response on behalf of the Department of Justice to the Coroner's recommendations. This response relevantly stated:</p> <p style="padding-left: 40px;">In respect to recommendation 8 of those findings, I advise that the recommendation is under consideration and I expect to be able to provide a final response to that recommendation by 30 September 2012. This delay is necessary to allow further consultation between the Department of Justice, Victoria Police, the Victorian Bar Council and other relevant bodies, such as the Office of Police Integrity and to take into account training requirements for legally qualified persons who may be called upon to attend interviews of police officers involved in deaths following police contact; potential models for the administration of such an arrangement and funding implications from such a scheme (as it is unlikely that the scheme would operate on a <i>pro bono</i> basis).</p> <p>A copy of the response is included at Annexure D.</p>
28 September 2012	<p>Dr Claire Noone, Acting Secretary, Victorian Department of Justice, provided a final response on behalf of the Department of Justice to the Coroner's recommendations. This response, which also addressed recommendations made in an inquest into a separate death, relevantly stated:</p> <p style="padding-left: 40px;">I have given consideration to those recommendations and do not at this time propose to adopt the recommendations but will keep the issue identified under review for future consideration.</p> <p>The response stated that the Department of Justice considered that the recommendations:</p> <ol style="list-style-type: none"> <li>1. Are based on a perception that collusion or bias may occur in the interview process although both you and Coroner White do not identify any actual collusion or bias during the interviews of police members in either inquest;</li> <li>2. Have been rendered less necessary with the changes made to the Victoria Police oversight and conflict of interest rules in relation to such investigations; and</li> <li>3. Risk interfering in the operational independence of Victoria Police in conducting these investigations in a timely manner.</li> </ol> <p>A copy of the response is included at Annexure E.</p>
November 2012	<p>The OPI issued a '<i>Framework and guide for responding to critical incidents or deaths associated with Victoria Police contact</i>'. This framework sets out the protocols established between the OPI and Victoria Police which have been in operation since 2010 and incorporates lessons learnt from the OPI's experience since that date.</p>

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### 3.2 Police use of force in Victoria

13. By way of general background to the use of force by Victoria Police, between 1987 and 1994, there were 29 fatal shootings by Victoria Police.<sup>19</sup> In 1994, Victoria Police commenced five reviews to identify the reasons for the high number of shootings and also ways of reducing the number of people shot and killed by police.<sup>20</sup> In 1995, Victoria Police commenced a project to address the use of force by its members called Project Beacon. As a result of Project Beacon, police were taught to adopt a planned approach to the use of force, and informed that the success of an operation would primarily be assessed by reference to the extent to which the use of force was avoided or minimised.
14. Between 1995 and 2005, there were 16 fatal shootings by Victoria Police.<sup>21</sup>
15. In 2005, the OPI conducted a review of six fatal shootings by police that occurred between January 2003 and May 2005. The report of this review (**OPI 2005 Report**) concluded:

It appears that Victoria Police has lost some of its strategic focus on safety and avoiding the use of force which it developed during Project Beacon. For the most part, the policy, practices and procedures have remained unchanged but the requisite ongoing and continuous attention to use of force issues as part of the planning and decision-making of Victoria Police has fallen away. The result is a lack of effective risk management, a culture in which self-assessment, review and improvement are given insufficient attention, and a diminution of essential police training to accommodate other organisational priorities.<sup>22</sup>
16. The Report made 55 recommendations. Victoria Police accepted 49 of these in principle.<sup>23</sup>
17. Between February 2006 and December 2008, there were ten critical incidents involving firearm use by police, three of which resulted in a death (one of which was that of Tyler).<sup>24</sup>
18. In January 2009, an examination of police shooting critical incidents that had occurred since the review the subject of the OPI 2005 Report was undertaken by the Victoria Police Corporate Management Risk Division.<sup>25</sup> This review found a number of common themes emerging from each of the incidents, which reflected the findings of the OPI 2005 Report.
19. In November 2008, a further review by the OPI of the use of force by and against Victoria Police was commissioned.<sup>26</sup> This review was prompted by both the slow progress of Victoria Police in implementing the recommendations of the OPI 2005 Report, and also the

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<sup>19</sup> Office of Police Integrity Victoria, *Review of the Use of Force by and against Victorian Police* (July 2009) (**OPI 2009 Report**), 9. Available at: <http://www.ibac.vic.gov.au/docs/default-source/opi-parliamentary-reports/review-of-the-use-of-force-by-and-against-victorian-police---july-2009.pdf?sfvrsn=4>.

<sup>20</sup> Office of Police Integrity Victoria, *Review of fatal shootings by Victoria Police: Report of the Director, Police Integrity* (2005) (**OPI 2005 Report**), 1. Available at: <http://www.ibac.vic.gov.au/docs/default-source/opi-parliamentary-reports/review-of-fatal-shootings-by-victoria-police---nov-2005.pdf?sfvrsn=4>.

<sup>21</sup> Ibid, 2.

<sup>22</sup> Ibid, 55.

<sup>23</sup> OPI 2009 Report, above n19, 9.

<sup>24</sup> Ibid, 10.

<sup>25</sup> Victoria Police, *Corporate Management Review Division: Examination of Police Shooting Critical Incidents between July 2005 and December 2008* (February 2009).

<sup>26</sup> OPI 2009 Report, above n19, 9.

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announcement by Victoria Police in June 2008 that members would be trained with semi-automatic firearms.<sup>27</sup> The report of this Review (**OPI 2009 Report**) noted that since the OPI 2005 Report, at least eight Victoria Police reviews relevant to the use of force had been conducted, many of which had made similar recommendations.<sup>28</sup>

20. The 2009 OPI Report provided the following key findings:<sup>29</sup>
- (a) Since 2002, there had been a proliferation of reviews finding that Victoria Police is not effectively managing the risks associated with use of force. Most of the reviews made similar recommendations. However, Victoria Police seemed to lack the will or capacity to implement solutions to effectively address the identified problems.
  - (b) There was little evidence to suggest that the 'Operational Safety Tactics' training used by Victoria Police was informed by ongoing analysis, monitoring or research into the skills required by police to avoid or minimise the use of force.
  - (c) Although Victoria Police records substantial statistical data that is capable of contributing to the analysis of trends in the use of force, there was little evidence that it actively monitored or strategically examined the data to inform training and improve practices.
  - (d) There is a need to re-invigorate the monitoring framework and management structure to drive strategic vision that puts safety first and manages the risks associated with the use of force.
21. This history of an ongoing, significant, incidence of fatal shootings by Victoria Police, and numerous domestic reviews making recommendations that have not been effectively implemented by Victoria Police, demonstrates the urgent need for an independent and effective model of investigation to be implemented by Australia to uphold the procedural aspect of the right to life.

### **3.3 Relevant investigative and other bodies**

22. In Victoria, where a death associated with police contact occurs, it is common practice for the Victoria Police's Homicide Squad, the ESD, and the State Coroner's Office to be notified in the first instance and attend the scene.<sup>30</sup> The OPI had no specific role to play in the investigation of deaths associated with police contact, but had a general responsibility in relation to police misconduct and ethical and professional standards. As discussed further at 3.3.3, below, the oversight functions of the OPI have been recently transferred to the Independent Broad-based Anti-corruption Commission (**IBAC**). As with the OPI, IBAC has a general responsibility in relation to police misconduct, but no specific role to play in the investigation of deaths associated with police contact.
23. A description of each of these bodies is set out below.

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<sup>27</sup> Ibid.

<sup>28</sup> Ibid, 11.

<sup>29</sup> Ibid, 14.

<sup>30</sup> OPI Review Issues Paper, above n13, 24.

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### 3.3.1 Homicide Squad

24. The Homicide Squad conducts the primary investigation of deaths associated with police contact.
25. The Homicide Squad is a crime portfolio within Victoria Police.<sup>31</sup>
26. All deaths associated with police contact are investigated by the Homicide Squad or, where associated with a collision, the Major Collision Investigation Group.<sup>32</sup>
27. There was some debate at the Inquest as to whether the Homicide Squad's initial investigation and preparation of the Inquest Brief are subject to the direction of the coroner. Such a 'direction' is not prescribed by legislation, and the evidence of Detective Sergeant Birch - the lead investigator from Homicide Squad of the investigation into Tyler's death<sup>33</sup> - was that, while preparing an inquest brief, the Homicide Squad does not seek direction from the coroner, and that it was only subsequent to the production of an inquest brief that any further investigations would be conducted at the direction of the coroner.<sup>34</sup> The OPI Review into Investigations considered this issue and concluded:

The legal position appears to be that the police and the Coroner conduct their own investigations. The product of the police investigation is provided to the Coroner to assist the Coroner's investigation. This is done as a matter of cooperation between two agencies for the purposes of law enforcement and the administration of justice.<sup>35</sup>

28. It is noted that the *Coroners Act 2008 (Vic)* (**Coroners Act**) requires the coroner to liaise with other investigative bodies to avoid duplication of investigation.<sup>36</sup>

### 3.3.2 Ethical Standards Department

29. The ESD of Victoria Police oversees the investigation of deaths or serious injury incidents associated with police contact.<sup>37</sup>
30. The intended role of the ESD is to ensure there is 'no impediment to the investigation, and that the integrity of the investigation is maintained by active oversight'.<sup>38</sup>
31. 'Active oversight' includes:
  - (a) continuous monitoring of the investigation;
  - (b) making any relevant comment or directing further inquiries if it is considered necessary to satisfy any future internal or external examination of the adequacy

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<sup>31</sup> Victoria Police, 'About Victoria Police – Homicide Squad', [http://www.police.vic.gov.au/content.asp?Document\\_ID=309](http://www.police.vic.gov.au/content.asp?Document_ID=309).

<sup>32</sup> OPI Review of Investigations, above n15, 46.

<sup>33</sup> Inquest Finding, above n1, [491]. Members of Homicide Squad who assisted Birch on 11 December 2008 and following include Detective Senior Constable Warren Chapman, Detective Senior Constable Victor Anastasiadis, Detective Senior Constable David Barry, Detective Senior Constable Nigel L'Estrange and Detective Senior Constable David Leveridge.

<sup>34</sup> Inquest Transcript, T4182.9-T4185.20, T4218.21-T4219.11.

<sup>35</sup> OPI Review of Investigations, above n15, 24.

<sup>36</sup> *Coroners Act 2008 (Vic)*, s7.

<sup>37</sup> Ibid.

<sup>38</sup> Victoria Police Ethical Standards Department Oversight Guidelines, *Appendix A: Information for Investigating Members* (23 July 2010), cited in OPI Review Issues Paper, above n13, 26.

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and probity of the investigation. Any comment or direction for further enquiries must be done by the ESD Officer responsible for the active oversight through a Homicide Inspector or to the Independent Detective Sergeant;

- (c) ensuring the member investigating the incident advises the ESD Officer of developments during the investigation;
- (d) ensuring the investigation is conducted without bias for or against any police or civilians involved;
- (e) early proactive identification of both internal and external policy issues; and
- (f) ongoing case management and liaison with the relevant investigator.<sup>39</sup>

32. The OPI Review of Investigations found that:

Oversight of investigations by the Ethical Standards Department varied in quality, depending on the individual to whom the file had been allocated. There were no processes in place to ensure a proportionate response to a death associated with police contact.<sup>40</sup>

33. The nature and limitations of the oversight role performed by the ESD in respect of the Homicide Squad's investigation into Tyler's death is discussed further at paragraph 190, below (p42).

### **3.3.3 Office of Police Integrity / Independent Broad-based Anti-corruption Commission**

34. Until recently, the OPI had a general responsibility to detect, investigate and prevent police corruption and serious misconduct, and to ensure Victoria Police maintained the highest ethical and professional standards in accordance with the *Police Integrity Act 2008* (Vic) (***Police Integrity Act***).

35. The OPI was not required by the *Police Integrity Act* to undertake an investigation into a death associated with police contact.<sup>41</sup>

36. However, the OPI was empowered to conduct an 'own motion' investigation in respect of any matter relevant to the achievement of the Director of the OPI's objectives, which included objectives that arose in respect of police contact-related deaths.<sup>42</sup>

37. The OPI could conduct an investigation parallel to an investigation conducted by Victoria Police, or could conduct its own investigation into any aspect surrounding a death. However, the OPI had no authority to investigate a death associated with police contact to the exclusion, or instead, of Victoria Police.<sup>43</sup>

38. In the case of Tyler, the author requested that the OPI take over the conduct of the investigation into Tyler's death from Victoria Police, and the Coroner sought a response to this request from the OPI. The OPI responded that it would not investigate Tyler's death because it lacked the resources and necessary charter to take over the investigation. The

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<sup>39</sup> OPI Review Issues Paper, above n13, 26.

<sup>40</sup> OPI Review of Investigations, above n15, 45.

<sup>41</sup> Ibid, 24.

<sup>42</sup> Ibid. See also *Police Integrity Act 2008* (Vic), s44.

<sup>43</sup> Ibid.

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Director of the OPI subsequently requested Gerry Feltus and John Ashby of the OPI to assess the sufficiency of the police investigation into Tyler's death, which resulted in the Confidential OPI Review referred to above.

39. The Victorian Government has recently established IBAC, which has oversight of corruption and misconduct in the public sector, including misconduct by police officers.<sup>44</sup>
40. IBAC's principal objectives and functions include the identification, investigation and exposure of serious corrupt conduct and police misconduct. IBAC is relevantly empowered to investigate, following receipt of a complaint or notification, or on its own motion, police personnel misconduct. Following an investigation, IBAC is empowered to make non-binding recommendations, request (but not require) actions to be taken, and to make special reports.
41. With the establishment of IBAC, the OPI has been dissolved and, as at 11 February 2013, its oversight functions transferred to IBAC.

#### **3.3.4 Coroner's Court**

42. The State coroner has a statutory obligation to investigate deaths occurring in a range of circumstances.
43. The purposes of the coronial system include:
  - 'to provide for coroners to investigate deaths ... in specified circumstances';<sup>45</sup>
  - 'to contribute to the reduction of the number of preventable deaths ... through the findings of investigations and the making of recommendations by coroners';<sup>46</sup> and
  - 'the promotion of public health and safety and the administration of justice'.<sup>47</sup>
44. The *Coroners Act* does not prescribe the extent of the investigation required. However, the Coroner is required to liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths and fires.<sup>48</sup>
45. A coroner investigating a death must find, if possible:
  - (a) the identity of the deceased;
  - (b) the cause of death;

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<sup>44</sup> The *Independent Broad-based Anti-Corruption Commission Act 2011 (Vic)* came into effect on 1 July 2012 and established IBAC.

<sup>45</sup> *Coroners Act 2008 (Vic)*, s1(b).

<sup>46</sup> *Ibid*, s1(c).

<sup>47</sup> *Ibid*, Preamble.

<sup>48</sup> *Ibid*, s7.

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- (c) the circumstances in which the death occurred (unless the deceased was not a person placed in custody or care<sup>49</sup> and there is not public interest to be served in making a finding regarding those circumstances); and
- (d) any other prescribed particulars.<sup>50</sup>
46. A coroner may also comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.<sup>51</sup>
47. A coroner may report to the Attorney-General on a death which the coroner has investigated, and may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death, including recommendations relating to public health and safety or the administration of justice.<sup>52</sup>
48. However, the task of a coroner in conducting an inquest is confined to making certain findings and taking steps ancillary to the making of those findings. It does not involve either the determination or punishment of guilt, or the determination of a dispute *inter partes* or legal rights. It does not result in the making of enforceable orders.
49. As noted by former Attorney-General Robert Hulls when questioned by the Scrutiny of Acts and Regulations Committee of the Victorian Parliament, 'when exercising the majority of its powers, the Coroners Court will be acting in an administrative capacity'.<sup>53</sup>

### 3.4 Investigation of police contact-related deaths in Victoria

50. Notably, in its Concluding Observations following the fifth periodic review of Australia under the ICCPR in 2009, the United Nations Human Rights Committee (the **Committee**) expressed:
- ... concern at reports of excessive use of force by law enforcement officials against groups, such as indigenous people, racial minorities, persons with disabilities, as well as young people; and regrets that the investigations of allegations of police misconduct are carried out by the police itself.<sup>54</sup>
51. To date, no steps have been taken by Australia to alter the process of investigations of deaths associated with police contact being carried out by police.
52. As outlined above, in Victoria, the primary investigation of a death associated with police contact (excluding deaths involving a vehicle collision) is conducted by the Homicide Squad – a division of Victoria Police. This investigation is overseen by the ESD – a department of Victoria Police.

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<sup>49</sup> 'Person placed in custody or care' includes a person who a police officer is attempting to take into custody or who dies from injuries sustained while being taken into custody. See *Coroners Court Act 2008* (Vic), s3.

<sup>50</sup> *Coroners Court Act 2008* (Vic), s67(1) and (2).

<sup>51</sup> *Ibid*, s67(3).

<sup>52</sup> *Ibid*, s72.

<sup>53</sup> Scrutiny of Acts and Regulations Committee, *Alert Digest No 15 of 2008 – Ministerial Correspondence* (2008).

<sup>54</sup> Human Rights Committee, Concluding Observations on Australia, UN Doc CCPR/C/AUS/CO/5 (7 May 2009).

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53. The Homicide Squad prepares and delivers to the coroner an inquest brief of evidence on the basis of the primary investigation. The inquest brief forms the basis of the subsequent coronial inquiry.
54. In November 2009, following the author's request that the OPI assume the conduct of the Victoria Police investigation into Tyler's death (which was declined), the OPI announced a review of the model of investigating deaths associated with police contact in Victoria.
55. This review sought to identify the most appropriate framework for investigating deaths associated with police contact in Victoria.<sup>55</sup> Specifically, the purpose of the review was to establish:
- (a) the sufficiency and appropriateness of current Victoria Police policies, procedures and legislative framework for conducting investigations into deaths associated with police contact; and
  - (b) options to existing law and practice regulating the conduct of such investigations.<sup>56</sup>
56. The OPI Review of Investigations stated that the definition of 'deaths associated with police contact' should include, at a minimum, deaths associated with police use of force, police pursuits, police custody and a police operation.<sup>57</sup> If this definition is applied to police contact-related deaths, there are on average 16 such deaths in Victoria each year.<sup>58</sup>
57. The OPI Review of Investigations observed that:
- It is important that the investigation of a death associated with police contact is conducted in such a way as to give the public confidence that the circumstances surrounding the death will be subject to the highest levels of scrutiny. This is necessary to ensure that we may all learn from the death and take any necessary steps to prevent similar deaths recurring in the future.<sup>59</sup>
58. The OPI Review of Investigations identified the following principles as underpinning an optimal investigative framework in relation to deaths associated with police contact:
- (a) independence;
  - (b) effectiveness;
  - (c) promptness (timeliness);
  - (d) next of kin involvement; and
  - (e) sufficient public scrutiny (transparency).<sup>60</sup>

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<sup>55</sup> OPI Review Issues Paper, above n13, 7.

<sup>56</sup> Ibid, 9. See also Office of Police Integrity Victoria, *Investigating Deaths Associated with Police Contact*, <http://www.opi.vic.gov.au/index.php?i=135&m=224&t=1>.

<sup>57</sup> OPI Review of Investigations, above n15, 20.

<sup>58</sup> Ibid, 21.

<sup>59</sup> Ibid, 8.

<sup>60</sup> Ibid.

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59. The OPI Review of Investigations concluded that the current legislative framework for the investigation and oversight of deaths associated with police contact is not optimal.<sup>61</sup> It recommended:
1. That the Victorian Government acknowledges a death associated with police contact is a unique incident that requires a special response by the State.
  2. That relevant Victorian Government departments adopt the working definition of 'death associated with police contact' set out in this report to assist with the identification of deaths associated with police contact that require a special response by the State.
  3. That the Victorian Government consults with key stakeholders regarding an optimal legislative framework for the investigation and oversight of deaths associated with police contact in Victoria.
  4. That the State Coroner, the Department of Justice and Victoria Police have regard to the improvements to current processes suggested in this report.<sup>62</sup>
60. The OPI Review of Investigations ultimately considered that it was 'a matter for Government to devise and implement any change to the current framework'.<sup>63</sup>
61. The author is not aware of any steps taken by the Victorian Government to respond to the OPI Review of Investigations or to implement its recommendations.

## 4. Admissibility of Claim

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### 4.1 Overview

62. The author submits that this communication is admissible for determination by the Committee pursuant to the *Optional Protocol to the International Covenant on Civil and Political Rights* (the **First Optional Protocol**)<sup>64</sup> and in satisfaction of the *Rules of Procedure of the Human Rights Committee* (**Rules of Procedure**).<sup>65</sup>

### 4.2 Compliance with Article 1 of the First Optional Protocol

63. Article 1 of the First Optional Protocol provides:

A State Party to the Covenant that becomes a Party to the present Protocol recognizes the competence of the Committee to receive and consider communications from individuals subject to its jurisdiction who claim to be victims of a violation by that State Party of any of the rights set forth in the Covenant. No communication shall be received by the Committee if it concerns a State Party to the Covenant which is not a Party to the present Protocol.

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<sup>61</sup> Ibid, 25.

<sup>62</sup> Ibid, 16.

<sup>63</sup> Ibid, 9.

<sup>64</sup> Opened for signature 16 December 1966, 999 UNTS 302 (entered into force 23 March 1976).

<sup>65</sup> Human Rights Committee, *Rules of Procedure of the Human Rights Committee*, UN Doc CCPR/C3/Rev8 (22 September 2005).

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64. This communication concerns Australia. Australia ratified the *International Covenant on Civil and Political Rights* (the **ICCPR**)<sup>66</sup> on 13 August 1980 and acceded to the First Optional Protocol on 25 September 1991, and is therefore a State party to the ICCPR and a Party to the First Optional Protocol.
65. The violations of the ICCPR the subject of this communication concern Australia's conduct in respect of Tyler. Tyler was at all material times a resident of Australia and subject to the jurisdiction of both Australia and the State of Victoria. The events giving rise to the violations complained of occurred in 2008.
66. Tyler is an individual 'victim' for the purposes of Article 1 of the First Optional Protocol by reason of the direct involvement of Victoria Police officers in his death.
67. Pursuant to Rule 96(b) of the *Rules of Procedure*, where an individual victim is unable to submit the communication personally, the communication may be submitted on behalf of the victim. In this case, Tyler is deceased and therefore unable to submit the communication personally. Accordingly, this communication is submitted by the victim's mother, Shani Cassidy, on behalf of the victim.

#### **4.3 Compliance with Article 2 of the First Optional Protocol**

68. Article 2 of the First Optional Protocol provides:
- Subject to the provisions of article 1, individuals who claim that any of their rights enumerated in the Covenant have been violated and who have exhausted all available domestic remedies may submit a written communication to the Committee for consideration.
69. This communication concerns the violation of rights articulated in the ICCPR. The author submits that Australia has violated Articles 6(1) and 2 of the ICCPR as discussed at 5, below.
70. The exhaustion of domestic remedies is addressed at 4.5, below.

#### **4.4 Compliance with Article 3 of the First Optional Protocol**

71. Article 3 of the First Optional Protocol provides:
- The Committee shall consider inadmissible any communication under the present Protocol which is anonymous, or which it considers to be an abuse of the right of submission of such communications or to be incompatible with the provisions of the Covenant.
72. This communication is not made anonymously. It is submitted by Shani Cassidy on behalf of the victim, her son, Tyler.
73. There are no circumstances which would suggest that this communication is an abuse of the right of submission of communications in respect of violations of the ICCPR or is incompatible with the provisions of that instrument.

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<sup>66</sup> Opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

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#### 4.5 Compliance with Article 5 of the First Optional Protocol

74. Article 5(2) of the First Optional Protocol provides:

The Committee shall not consider any communication from an individual unless it has ascertained that:

- (b) The same matter is not being examined under another procedure of international investigation or settlement;
- (c) The individual has exhausted all available remedies. This shall not be the rule where the application of the remedies is unreasonably prolonged.

75. This matter is not being examined under another international investigation or settlement procedure.

76. This communication concerns Australia's failure to ensure an effective independent investigation into a death that resulted from a direct use of force by agents of the State, specifically, officers of Victoria Police, in violation of the right to life as articulated in Article 6(1) in conjunction with Article 2 of the ICCPR.

77. The author has exhausted all available remedies in respect of this violation of the right to life by Australia. The author further submits that, in the event that the Committee considers that all available domestic remedies have not been exhausted, any domestic remedies that are available are not effective and are therefore not required to be exhausted.<sup>67</sup>

##### 4.5.1 Exhaustion of domestic remedies: Overview

78. The Committee has held that remedies under the ICCPR are to be directed to effectively redressing a breach of human rights, and are not generally required to prevent a breach occurring:

The Covenant provides that a remedy shall be granted whenever a violation of one of the rights guaranteed by it has occurred; consequently, it does not generally provide preventative protection, but confines itself to requiring effective redress ex post facto.<sup>68</sup>

79. The author seeks remediation for the breach of her son's right to have his death investigated in accordance with the procedural requirements of Article 6(1). This does not require consideration of the factual findings made by the Coroner as to the circumstances of Tyler's death. Rather, remediation requires that the investigative process through which these factual findings were made be considered, to determine whether that process complied with Article 6(1) and, if it is found to be non-compliant, that the author be provided with appropriate redress.

##### 4.5.2 Exhaustion of judicial remedies

80. There are no further effective judicial remedies available to the author. The author submits that for the purpose of Article 5 of the Optional Protocol, judicial remedies should therefore be considered exhausted.

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<sup>67</sup> Human Rights Committee, *Views: Communication No 900/99*, 76<sup>th</sup> sess, UN Doc CCPR/C/76/D/900/1999 (13 November 2002) (**C v Australia**), [7.3].

<sup>68</sup> Human Rights Committee, *Views: Communication No 113/1981*, 24<sup>th</sup> sess, UN Doc CCPR/C/OP/1 (12 April 1985) (**CF et al v Canada**), [6.2].

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81. Judicial remedies that may be available to a person in the author's position comprise:
- (a) appealing the inquest findings and seeking a new inquest;
  - (b) seeking judicial review of the Coroner's decision on the scope of the Coronial investigation; and
  - (c) commencing a claim against the State, the Coroner, or Victoria Police for breach of the Victorian Charter.
82. For the reasons set out below, the author submits that each of these potential remedial options has been exhausted, is unavailable to her and/or will not provide an effective remedy.

#### **4.5.2.1 Appeal the Inquest Finding and seek a new inquest**

83. The author submits that it is not open to her to appeal the Inquest Finding and seek a new inquest.
84. An inquest finding can be appealed by:
- (a) making an application to the Coroner's Court seeking that the finding be set aside; and/or
  - (b) appealing the finding to the Supreme Court of Victoria.
85. A person may apply to the Coroner's Court for an order that some or all of the findings of a coroner after an investigation be set aside, and the investigation be re-opened.<sup>69</sup> However, such an order will only be granted where the Coroner's Court is satisfied that there are *new* facts or circumstances such that it would be appropriate to re-open the investigation.
86. The author submits this option is not available to her because there are no new facts or circumstances such that the Coroner's Court would be likely to consider it appropriate that the investigation be re-opened.
87. Even if there were new facts or circumstances (which there are not), setting aside the findings and re-opening the investigation will not provide redress for the breach of Article 6(1) complained of. A new coronial investigation will be tainted by the same flaws as the first. That is, it will rely on a primary investigation by Victoria Police and the preparation of an inquest brief of evidence by Victoria Police that does not, either alone or in conjunction with a coronial investigation, meet the procedural obligations of Article 6(1).
88. A person with a sufficient interest in the investigation may also appeal the findings of a coronial inquest to the Supreme Court of Victoria. However, a finding of a coroner can only be appealed to the Supreme Court of Victoria where it concerns a question of law.<sup>70</sup>
89. It is not open to the author to appeal the Inquest Finding because the violation complained of does not relate to a question of law regarding that Finding.

#### **4.5.2.2 Judicial review of Coroner's decision not to examine the model of investigation**

90. Judicial review of a decision of the Coroner may be sought:

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<sup>69</sup> *Coroners Court Act 2008* (Vic), s77.

<sup>70</sup> *Coroners Court Act 2008* (Vic), ss83 and 87.

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- (a) under the *Administrative Law Act 1978* (Vic) (the **Administrative Law Act**); or
- (b) under common law, seeking orders in the nature of certiorari, mandamus and/or prohibition.
91. As noted at 3.1, above (p7), the author wrote to the Coroner on 23 April 2009 requesting that the OPI assume the conduct of the primary investigation into Tyler's death to ensure the compatibility of the Investigation with the requirements of the Victorian Charter. The Coroner responded on 1 July 2009 stating that she had considered this matter and was satisfied that:
- ... in receiving the brief of evidence from Victoria Police and proceeding to an inquest, the Court is interpreting its powers and obligations under the new Coroners Act compatibly with the Charter of Human Rights and Responsibilities, including section 9 as read in accordance with the jurisprudence of comparable jurisdictions.
92. Further, in the early stages of the Inquest, the Coroner indicated that she would not examine the current model of how deaths associated with police contact are investigated in Victoria.<sup>71</sup> However, she confirmed that she would consider:
- ... the aspects of the facts in this particular investigation that raised issues about how the police behaved or investigated this death that touched upon competency, adequacy or impartiality in how evidence was collected, obtained or compromised as it was produced.<sup>72</sup>
93. In respect of this decision, the Coroner stated:
- In coming to the decision not to further the issue of the model of '*police investigating police*' in '*police contact related*' deaths, I relied upon section 7 of the *Coroners Act 2008* containing the responsibility of the Court to liaise with other investigative authorities where appropriate. I also relied upon the need to take into account the resources of this court. Putting to one side any jurisdictional argument, given the expertise and terms of reference of the OPI, it would be a duplication of a contemporaneous inquiry being conducted by another investigative agency on the exact issue. Not only would this be a duplication of the State's resources, it would be likely to significantly lengthen already protracted proceedings contrary to the intention of section 8 of the *Coroners Act 2008*.<sup>73</sup>
94. The author submits that it is not, and has not previously been, open to her to seek judicial review of the Coroner's decision not to examine the model of investigations into deaths such as Tyler's under the *Administrative Law Act*.
95. However, the author submits that, even if judicial review is or was available to her under the *Administrative Law Act* and/or the common law, judicial review is not capable of providing an effective remedy for the breach of Tyler's right to have his death investigated in a manner compatible with the procedural requirements of Article 6(1) because:
- (a) there is no other body in Victoria available to conduct the primary investigation; and

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<sup>71</sup> Inquest Finding, above n1, [572].

<sup>72</sup> Ibid.

<sup>73</sup> Ibid, [574]. The OPI Review of Investigations to which the Coroner referred is discussed at 3.4, above (pp19-21).

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- (b) the Coroner is only empowered to make recommendations, which the Committee has previously confirmed do not constitute effective remedy.<sup>74</sup>

#### 4.5.2.3 Claim for breach of the right to life

96. The author submits that it is not open to her to pursue a claim against the State, the Coroner or Victoria Police, for the breach of Tyler's right to have his death investigated in a manner compliant with the procedural obligations of the right to life in Article 6(1) of the ICCPR.
97. The Victorian Charter recognises and protects the right to life.<sup>75</sup> However, it is unclear whether the right to life protected by s 9 of the Victorian Charter includes procedural obligation to ensure that there is an impartial, effective and timely investigation into a death involving State responsibility. The Supreme Court of Victoria recently held that s 10 of the Victorian Charter, which protects the right to freedom from cruel, inhuman or degrading treatment, does not give rise to a right to an independent investigation of an alleged violation of the substantive right.<sup>76</sup> In its judgment, the Court noted that international jurisprudence recognises this right to an independent investigation, but considered that the Victorian Charter is to be construed according to its text in its own constitutional context.<sup>77</sup> If the reasoning in this decision is applied to s 9 of the Victorian Charter, the Court may also be reluctant to recognise a right to an independent investigation of alleged breaches of the right to life.
98. Even if the Victorian Charter is held to give rise to a right to an independent investigation of a death associated with police contact, s 39 of the Victorian Charter provides that the Charter does not give victims access to a stand-alone cause of action in respect of violations of the Charter.
99. Further, where a cause of action arises by way of 'piggy-backing' a human rights complaint to a non-Charter cause of action pursuant to s 39 of the Victorian Charter, the Supreme Court of Victoria is only able to make a declaration of inconsistent interpretation.<sup>78</sup> There is no mechanism requiring the amendment or repeal of legislative provisions declared inconsistent with rights protected by the Victorian Charter. The Supreme Court of Victoria is therefore not able to provide an effective remedy for the breach of Tyler's right to have his death investigated in accordance with the Victorian Charter.
100. There is no Federal human rights charter or other Federal or Victorian legislation that protects the right to life as articulated in the ICCPR. International instruments to which Australia is a party, such as the ICCPR, have no direct domestic application in Australia in the absence of implementing legislation.<sup>79</sup>

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<sup>74</sup> *C v Australia*, above n67, [7.3].

<sup>75</sup> *Victorian Charter of Human Rights and Responsibilities Act 2006 (Vic)*, s9.

<sup>76</sup> *Bare v Small* [2013] VSC 129 (Unreported, 25 March 2013). We understand that an appeal has been filed in this matter but is yet to be heard by the Victorian Court of Appeal.

<sup>77</sup> *Ibid*, [131].

<sup>78</sup> *Ibid*, s36.

<sup>79</sup> *Victoria v Commonwealth (Industrial Relations Act Case)* (1996) 187 CLR 416, 480-482.

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#### **4.5.3 Exhaustion of non-judicial remedies**

101. There are no further effective non-judicial remedies available to the author. The author submits that for the purpose of Article 5 of the Optional Protocol, non-judicial remedies should therefore also be considered exhausted.
102. Non-judicial remedies that may be available to a person in the author's position include:
  - (a) requesting that the OPI or IBAC investigate Tyler's death;
  - (b) petitioning the Victorian Government or the Australian Government;
  - (c) requesting a Royal Commission;
  - (d) making a complaint to an Ombudsman; and
  - (e) making a complaint to a human rights commission.
103. The author submits that each of these potential remedial options is unavailable to her and/or will not provide an effective remedy.

##### **4.5.3.1 Request the OPI or IBAC to investigate Tyler's death**

104. The author submits she has exhausted this option, and that it has not provided, and is incapable of providing, redress that is effective for the purposes of the First Optional Protocol.
105. Prior to the conclusion of Victoria Police's investigation into Tyler's death, the author requested that the OPI assume the conduct of that investigation. On 23 April 2009, the author wrote to the Coroner requesting that the OPI take over the conduct of the police investigation into Tyler's death. On 24 April 2009, the Coroner wrote to the OPI seeking a response to that request.
106. On 5 May 2009, the OPI responded to the Coroner's letter of 24 April 2009, stating that it would not investigate Tyler's death because it lacked the resources and necessary charter to assume the conduct of this investigation.
107. As discussed at 3.3.3, above (p17), the OPI was empowered to conduct an 'own motion' investigation into matters including those that arose in respect of a death associated with police conduct. It was further empowered to conduct an investigation parallel to an investigation by Victoria Police. However, it was not required to undertake an investigation into a death associated with police contact, and further was not empowered to investigate a death to the exclusion of Victoria Police.
108. Accordingly, the author submits there were no grounds on which she could have challenged or sought review of the OPI's decision to not assume the conduct of the investigation into Tyler's death.
109. The author submits that, had her request been granted and the investigation conducted in an effective manner, its effect would have been to prevent the breach of Tyler's right to have his death investigated in a manner compatible with the procedural requirements of Article 6(1).
110. However, as discussed at 4.5.1, above (p23), because Tyler's rights under Article 6(1) have now been breached, what is required is not an investigation that is compatible with Article 6(1), but rather an effective remedy for the breach of Tyler's rights.

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111. The assessment conducted by the OPI of the sufficiency of the investigation into Tyler's death, the Confidential OPI Review, did not address issues relating to the appropriateness of Victoria Police conducting such an investigation. Rather, as noted at 3.1, above (p7), the Confidential OPI Review was directed to identifying the sufficiency of the investigation, including whether the Victoria Police members conducting the investigation complied with relevant operating procedures and policies.
112. As discussed at 3.3, above (p15), the OPI separately conducted a review of the investigation in Victoria of deaths associated with police contact, which was prompted by the author's request that the OPI assume the conduct of the investigation into Tyler's death. The review concluded that the optimal investigative framework is one which is compatible with the procedural obligations of Article 6(1).<sup>80</sup> The OPI Review of Investigations further concluded that the current legislative framework for the investigation and oversight of deaths associated with police contact is underdeveloped and not optimal. It found that changes can and should be made to enhance the current process for the investigation of such deaths, and that such changes should be implemented as a priority by government.<sup>81</sup>
113. However, the OPI Review of Investigations has not, and can not, provide the author with an effective remedy because the OPI was empowered only to make recommendations.<sup>82</sup> The author is not aware that the Victorian Government has made any formal response to the OPI Review of Investigations.
114. Further, and as noted at paragraph 39, above, IBAC has recently been established. It is unclear whether the conduct of the officers present at Tyler's death would be regarded as 'police personnel misconduct' and could therefore be investigated by IBAC. However, the author submits that as IBAC only has the power to report, and make non-binding recommendations, and non-mandatory requests for action, at the conclusion of any investigation it does undertake, it is unable to provide a remedy that would be effective for the purposes of the First Optional Protocol.<sup>83</sup>

#### **4.5.3.2 Petition the Victorian Government or the Australian Government**

115. It is open to the author to petition the Victorian Government or the Australian Government to recognise that Tyler's rights have been breached, provide redress for this breach, and amend the investigative mechanism through which deaths associated with police contact are investigated.
116. However, a petition to the Victorian Government or the Australian Government does not have a reasonable prospect of success because there is no requirement that either Government provide any response or remedy.

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<sup>80</sup> The Report of the review further notes that participants in the review agreed that the principles developed by the European Court of Human Rights should underpin any framework for the investigation of police contact-related deaths. See OPI Review of Investigations, above n15, 28.

<sup>81</sup> OPI Review of Investigations, above n15, 25 and 44.

<sup>82</sup> *C v Australia*, above n67, [7.3].

<sup>83</sup> *Ibid.*

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117. In *C v Australia*, the Committee indicated that recommendatory remedies without binding effect cannot be described as 'effective' for the purposes of the First Optional Protocol. The Committee stated:
- ... any decision of these bodies even if they had decided the author's claims in his favour, would only have had recommendatory rather than binding effect, by which the Executive would, at its discretion, have been free to disregard. As such, these remedies cannot be described as ones which would, in terms of the Optional Protocol, be effective.<sup>84</sup>
118. The approach adopted by the Committee in *C v Australia* is applicable to this communication and consistent with the Committee's broader jurisprudence on the exhaustion of domestic remedies, which indicates that:
- remedies which involve unacceptably lengthy proceedings will not be considered effective or available and are not required to be exhausted;<sup>85</sup> and
  - authors are not required to make use of parliamentary petitions, supervisory complaints, applications to ombudspersons or other legal remedies that appear ineffective or without reasonable prospect of success.<sup>86</sup>
119. The author notes that in its decision in *Jonassen et al v Norway*,<sup>87</sup> the Committee found that the authors had not exhausted domestic remedies because they had not petitioned the government to exercise its discretion to expropriate the land the subject of the communication. However, the author submits that the Committee's decision in that case can be distinguished factually from the circumstances of this communication.
120. In that decision, the Committee observed that it is necessary for a complainant to exhaust all judicial and administrative remedies that offer 'a reasonable prospect of redress'.<sup>88</sup> The Committee considered that an application made to the government seeking the expropriation of the land, a remedy provided by law, had reasonable prospects of success.<sup>89</sup>
121. The author is not aware of any established legal or other formal mechanism through which she is able to petition the Victorian Government or the Australian Government to recognise the breach of Tyler's rights.
122. Accordingly, the author submits that a petition to the Victorian Government or the Australian Government cannot be considered to be an effective remedy or to have

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<sup>84</sup> Ibid.

<sup>85</sup> Human Rights Committee, *Views: Communication No 942/00*, 76<sup>th</sup> sess, UN Doc CCPR/C/76/D/881/1999 (25 October 2002) (*Jonassen & Ors v Norway*). See also First Optional Protocol, Article 5(2)(b).

<sup>86</sup> Human Rights Committee, *Views: Communication No 210/1986 and 225/1987*, 35<sup>th</sup> sess, UN Doc CCPR/C/35/D/210/1986 (6 April 1989) (*Pratt & Morgan v Jamaica*).

<sup>87</sup> *Jonassen & Ors v Norway*, above n85.

<sup>88</sup> Ibid, [8.6].

<sup>89</sup> The authors had filed claims for expropriation on 2 April 1998, and on 4 February 2000, the negotiating committee reached an agreement that it recommended to the parties. The State Party advised the Committee that the Government was confident that the Ministry of Agriculture would either enter into the recommended agreement or expropriate the land. The Committee further noted that this remedy could not be considered unduly prolonged as a reasonable explanation had been provided for the length of the process to date. Ibid, [8.9].

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reasonable prospects of success, and she is therefore not required to exhaust this option. The author notes that, as discussed further at paragraph 225, below, former Attorney-General Robert Hulls has indicated that the Victorian Government considers that the coronial system gives effect to the right to an effective investigation.

#### **4.5.3.3 Request a Royal Commission**

123. It is open to the author to request that the Australian Government establish a Royal Commission to conduct an inquiry into the investigation of Tyler's death. However, the author submits that she does not have reasonable prospects of success, and that a Royal Commission is unable to provide a remedy that is effective for the purposes of the First Optional Protocol.
124. A Royal Commission is a commission of inquiry established by the Governor-General, on the advice of the Federal Government, to inquire into and report upon a specified subject matter.<sup>90</sup> An individual has no power to compel the Governor-General of Australia to establish a Royal Commission.
125. Further, although Royal Commissions generally have broad powers, they do not exercise judicial power and are restricted to the Terms of Reference of the Commission.<sup>91</sup> The Report of a Royal Commission may include recommendations, but these do not have binding effect.
126. The author therefore submits that this remedy cannot be considered effective and is therefore not required to be exhausted (see paragraph 117, above).

#### **4.5.3.4 Complain to an Ombudsman**

127. The author submits that making a complaint to an Ombudsman is not an effective remedy for the purposes of the First Optional Protocol, and is therefore not required to be exhausted.
128. The author submits that it is not open to her to submit a complaint to the Commonwealth Ombudsman. The complaint the subject of this communication is not a complaint the Commonwealth Ombudsman is empowered to investigate. The Commonwealth Ombudsman is only empowered to investigate complaints regarding the administrative actions of Australian Government agencies and services, the Australian Federal Police, the Australian Defence Force, freedom of information, immigration, the postal industry, taxation and overseas students.<sup>92</sup>
129. The author submits that it is not open to her to submit a complaint to the Victorian Ombudsman. The Victorian Ombudsman cannot investigate complaints regarding courts or tribunals. The Victorian Ombudsman is empowered to consider complaints regarding Victorian Government departments, most statutory bodies, freedom of information and, in some circumstances, actions by staff of local councils.

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<sup>90</sup> *Royal Commissions Act 1902* (Cth), s1A.

<sup>91</sup> See eg *Lockwood v Commonwealth* (1954) 90 CLR 177, 181.

<sup>92</sup> See Commonwealth Ombudsman, *Complaints the Ombudsman can Investigate*, <http://www.ombudsman.gov.au/pages/making-a-complaint/complaints-the-ombudsman-can-investigate/>.

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130. Even if it is open to the author to make a complaint to either the Commonwealth Ombudsman or the Victorian Ombudsman, the author submits that these bodies are not able to provide an effective remedy. In *C v Australia*, the Committee considered certain administrative remedies, including the Commonwealth Ombudsman, and concluded that these remedies could not be described as 'effective' for the purposes of the First Optional Protocol.<sup>93</sup>

#### 4.5.3.5 Complain to a human rights commission

131. The author submits that it is not open to her to make a complaint to either the Australian Human Rights Commission (**AHRC**) or the Victorian Equal Opportunity and Human Rights Commission (**VEOHRC**). Even if she is able to make such a complaint, these bodies are not able to provide an effective remedy for the purposes of the First Optional Protocol and, accordingly, the author is not required to exhaust these options.
132. The author submits that it is not clearly open to her to submit a complaint to the AHRC. The AHRC is only empowered to consider complaints concerning an act of the Commonwealth or a Commonwealth agency.<sup>94</sup>
133. The author's complaint concerns the conduct of investigations into deaths associated with police contact in the State of Victoria, which is subject to the jurisdiction of the Victorian Government. Although the author submits in this communication that Australia has a duty to ensure that deaths associated with police contact are investigated in a manner compatible with its obligations under the ICCPR, it is not clear that its failure to ensure this could be characterised as an 'act of the Commonwealth' for the purposes of the *Australian Human Rights Commission Act 1986* (Cth).
134. The author further submits that it is not open to her to submit a complaint to the VEOHRC. The VEOHRC is empowered only to consider complaints relating to discrimination, sexual harassment and racial or religious vilification.<sup>95</sup> The author's complaint is not within the scope of complaints the Commission is empowered to consider.
135. Even if it is open to the author to make a complaint to either the AHRC or the VEOHRC, the author submits that these bodies are not able to provide an effective remedy. In *C v Australia*, the Committee considered certain administrative remedies, including the then Human Rights and Equal Opportunities Commission (now the AHRC), and concluded that these remedies could not be described as effective for the purposes of the First Optional Protocol.<sup>96</sup>

#### 4.6 Conclusion

136. The author has complied with the requirements of Articles 1, 2, 3 and 5 of the First Optional Protocol. In particular, the author submits that she has exhausted all judicial and non-

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<sup>93</sup> *C v Australia*, above n67, [7.3].

<sup>94</sup> *Australian Human Rights Commission Act 1986* (Cth), s3(1).

<sup>95</sup> See eg *Equal Opportunity Act 2010* (Vic), s122, and Victorian Human Rights and Equal Opportunities Commission, *Making a Complaint*, <http://www.humanrightscommission.vic.gov.au/index.php/making-a-complaint>.

<sup>96</sup> *C v Australia*, above n67, [7.3].

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judicial domestic remedies that are reasonably available to her and which could provide an effective remedy for the purposes of the First Optional Protocol. This matter is not currently being examined under any other procedure of international investigation or settlement. Accordingly, there is no bar to the Committee accepting this communication.

## 5. Submissions on Law and Merits of Claim

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137. The author submits that the current model in Victoria for the investigation of deaths associated with police contact is inconsistent with the State party's obligations under the ICCPR.
138. In particular, the State party has failed to ensure an effective and independent investigation into the death of Tyler as required by Article 6(1) of the ICCPR, and has not remedied this failure as required by Article 2 of the ICCPR.
139. The State party has therefore violated Articles 6(1) and 2 of the ICCPR.

### 5.1 Article 6(1) of the ICCPR

140. Article 6(1) provides:

Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

141. The Committee has stated that the right to life:

... is the supreme right from which no derogation is permitted even in time of public emergency which threatens the life of the nation (art. 4). However, the Committee has noted that quite often the information given concerning article 6 was limited to only one or other aspect of this right. It is a right which should not be interpreted narrowly.<sup>97</sup>

142. The Committee has further observed that 'the deprivation of life by the authorities of the State is a matter of utmost gravity'.<sup>98</sup>
143. The Committee's jurisprudence regarding the right to life is supplemented by jurisprudence of the European Court of Human Rights and the Inter-American Court of Human Rights.<sup>99</sup> The author submits that the jurisprudence of these bodies in respect of the right to life provides relevant guidance regarding the construction of the State Parties' obligations under Article 6(1) of the ICCPR to the extent that it is not inconsistent with the Committee's own jurisprudence.

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<sup>97</sup> ICCPR General Comment 6 (16<sup>th</sup> sess, 1982): Article 6: The Right to Life, A/37/40 (1982) 93, [1]. See also *García v Perú* (6 April 2006) Inter-American Court of Human Rights Series C No. 147 (*García v Perú*), [82].

<sup>98</sup> Human Rights Committee, *Views: Communication No 1447/2006*, 95<sup>th</sup> sess, UN Doc CCPR/C/95/D/1447/2006 (2 April 2009) (*Amirov v Russian Federation*), [11.5].

<sup>99</sup> Article 2 of the European Convention on Human Rights and Article 4 of the American Convention on Human Rights each articulate the right to life in terms substantially similar to those of the ICCPR.

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### 5.1.1 Substantive obligations

144. It is well established in international jurisprudence that the right to life imposes upon States' obligations that can be divided, for convenience, into 'substantive' obligations and 'procedural' obligations.<sup>100</sup>
145. The author submits that the substantive obligations imposed by the right to life under Article 6(1) of the ICCPR oblige Australia to ensure that:
- (a) the right to life is protected by law;
  - (b) no one is arbitrarily deprived of life; and
  - (c) appropriate legislative and administrative measures are taken to protect life and to guard against the arbitrary deprivation of life.<sup>101</sup>
146. These substantive obligations have been interpreted such that:
- (a) States must refrain from taking life 'intentionally'.<sup>102</sup>
  - (b) States must take appropriate steps to safeguard life.<sup>103</sup>
  - (c) States have a duty to establish a framework of laws, precautions, procedures and means of enforcement that will, to the greatest extent practicable, protect life.<sup>104</sup>
  - (d) States have a positive duty to adopt clear and detailed domestic law on the use of lethal force that should strictly regulate its use in accordance with the right to life.<sup>105</sup>
  - (e) Any use of force by State officials that results in a deprivation of life must have been 'absolutely necessary' and 'strictly proportionate' to the achievement of the permitted purpose.<sup>106</sup>
  - (f) In assessing whether the use of force is strictly proportionate, regard must be had to the nature of the aim pursued, the dangers of life and limb inherent in the

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<sup>100</sup> See eg Human Rights Committee, *Views: Communication No. 1756/2008*, 102<sup>nd</sup> sess, UN Doc CCPR/C/102/1756/2008 (24 August 2011) (**Zhumbaeva v Kyrgystan**), [8.10].

<sup>101</sup> ICCPR General Comment 6 (16<sup>th</sup> sess, 1982): Article 6: The Right to Life, A/37/40 (1982) 93, [1]; *R (Humberstone) v Legal Services Commission* [2010] EWHC 760, [44] (**R (Humberstone) v LSC**); *Savage v South Essex NHS Trust* [2009] 1 AC 681, [76]. See also *R (Gentle) v The Prime Minister* [2008] 1 AC 1356, [10]; *Hertfordshire Police v Van Colle* [2009] 1 AC 225.

<sup>102</sup> *McCann v United Kingdom* (1996) 21 EHRR 97 (**McCann v UK**); *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 (**R (Middleton) v WSC**); *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 65 (**R (Amin) v SHD**), 3 [19]; *Osman v United Kingdom* (1998) 29 EHRR 245 (**Osman v UK**), [115].

<sup>103</sup> *Ibid.*

<sup>104</sup> *McCann v UK*, above n102, [150], [156], [161]; *R (Middleton) v WSC*, above n102, [2]; *LCB v United Kingdom* (1998) 27 EHRR 212, [36]; *Osman v UK*, above n102; *Keenan v United Kingdom* (2001) 33 EHRR 913, [88]-[90]; *Edwards v United Kingdom* (2002) 35 EHRR 487 (**Edwards v UK**), [54]; *R (Amin) v SHD*, above n102 [30].

<sup>105</sup> *Leonidis v Greece* [2009] ECHR 5, (**Leonidis v Greece**) [56]; *Simsek v Turkey* [2005] ECHR 546 (**Simsek v Turkey**), [104]. See also *McCann v UK*, above n102, [151]-[156].

<sup>106</sup> *McCann v UK*, above n102, [148]-[149].

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situation, and the degree of risk that the force employed might result in loss of life.<sup>107</sup>

- (g) The use of force will be disproportionate if the authorities failed, whether deliberately or through lack of proper care, to take steps which would have avoided the deprivation of life without putting the lives of others at risk.<sup>108</sup>
- (h) The State has a responsibility to ensure that the way in which an operation is planned and executed does not require the use of unnecessary lethal force.<sup>109</sup>
- (i) Law enforcement agents must be trained to assess whether there is an absolute necessity to use firearms, not only on the basis of the relevant regulations, but also with due regard to the pre-eminence of respect for human life as a fundamental value.<sup>110</sup>

147. In the present circumstances, given that Tyler's death was the result of a fatal use of force by Victoria Police, there arises a potential breach of the substantive obligations (namely, whether the use of force was 'absolutely necessary' and 'strictly proportionate', whether Victoria Police failed to take steps which would have avoided the deprivation of life without putting the lives of others at risk, and whether Victoria Police planned and executed the operation in a way which did not require the use of unnecessary lethal force). Whether a breach of the substantive obligation in fact occurred can only be determined by way of an investigation of the use of force. This potential breach therefore engages the procedural obligations, which are discussed below.

148. The author is not requesting that the Committee determine whether a breach of the substantive obligations occurred. Rather, the author submits that the potential breach of the substantive obligations that resulted from the circumstances of Tyler's death enlivened the State party's duty to investigate Tyler's death in accordance with the procedural obligations. It is the State party's failure to fulfil this duty to investigate that is the subject of this communication.

### 5.1.2 Procedural obligations

149. An actual or potential breach of the substantive obligations engages the 'procedural' obligations.<sup>111</sup>

150. The positive obligations to provide a legal system to protect life under Article 6(1) requires State Parties to ensure an effective and official investigation where individuals have been killed as a result of the use of force by State agents.<sup>112</sup> The Committee has held that

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<sup>107</sup> Ibid, [193]-[194].

<sup>108</sup> Ibid, [193]-[194].

<sup>109</sup> *Leonidis v Greece*, above n105, [55]-[66].

<sup>110</sup> Ibid, [57].

<sup>111</sup> *Kaya v Turkey* (1998) 28 EHRR 1 (*Kaya v Turkey*), [87]; *Giuliani and Gaggio v Italy* [2011] ECHR 513, [269].

<sup>112</sup> Human Rights Committee, *Views: Communication No 942/00*, 98<sup>th</sup> sess, UN Doc CCPR/C/98/D/1619/2007 (11 May 2010) (*Pestaño v The Philippines*); *Zhumbaeva v Kyrgyzstan*, above n100, [8.10]; [7.6]; *Fedorchenko and Lozenko v Ukraine* [2012] ECHR 1721 (*Fedorchenko v Ukraine*), [41]; *McCann v UK* above n102, [161]; *R (Amin) v SHD* [2004], above n102, [20]; *Dodov v Bulgaria* (2008) 47 EHRR 41, [80]; *Vo v France* (2005) 40 EHRR 12 (*Vo v France*) [90]-[91];

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where the State is directly involvement in a death, it is required to ensure that there is an 'impartial, effective and timely investigation' into the death.<sup>113</sup> Consistently, the Inter-American Court of Human Rights has recognised that:

... the State has the obligation to initiate, ex officio and immediately, a genuine, impartial and effective investigation, which is not undertaken as a mere formality predestined to be ineffective.<sup>114</sup>

151. There is no specific form of investigation necessary to satisfy the State Party's obligation to investigate a death involving State responsibility.<sup>115</sup> However, the investigation must:
- (a) be hierarchically, institutionally and practically independent;<sup>116</sup>
  - (b) be adequate and effective;<sup>117</sup>
  - (c) be open to public scrutiny;<sup>118</sup>
  - (d) be prompt and carried out with reasonable expedition;<sup>119</sup> and
  - (e) involve the next-of-kin.<sup>120</sup>
152. The author submits that a State will be in violation of the procedural obligations of Article 6(1) where an investigation that meets these requirements is not conducted.

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*Calvelli and Ciglio v Italy* [2002] ECHR 3 (**Calvelli v Italy**), [49]; *Powell v United Kingdom* (2000) 30 EHRR CD 362; *García v Perú*, above n97, 85; *Pueblo Bello Massacre v Colombia* (31 January 2006) Inter-American Court of Human Rights Series C No. 140 (**Pueblo Bello Massacre v Colombia**), [142].

<sup>113</sup> See eg *Pestaño v The Philippines*, above n112, [9].

<sup>114</sup> *Pueblo Bello Massacre v Colombia*, above n112, [143]. See also *Mapiripán Massacre v Colombia* (15 September 2005) Inter-American Court of Human Rights Series C No. 134 (**Mapiripán Massacre v Colombia**), [219]; *García et al v Honduras* (21 September 2006) Inter-American Court of Human Rights Series C, No. 152, [119]; *Aranguren et al v Venezuela* (5 July 2006) Inter-American Court of Human Rights Series C, No. 150 (**Aranguren et al v Venezuela**), [79].

<sup>115</sup> *Jordan v United Kingdom* [2001] ECHR 327 (**Jordan v UK**), [105]; *R (Amin) v SHD*, above n102; *Pearson v UK* [2011] ECHR 3219.

<sup>116</sup> Human Rights Committee, *Views: Communication No 1225/2003*, 99<sup>th</sup> sess, UN Doc CCPR/C/99/D/1225/2003 (18 August 2010) (**Eshanov v Uzbekistan**), [9.6], [9.7]; *Pestaño v The Philippines*, above n112, [7.5]; *Fedorchenko v Ukraine*, [43]; *Jordan v UK*, above n115, [106]; *McKerr v United Kingdom* (2002) 34 EHRR 20 (**McKerr v UK**), [112]; *R (Amin) v SHD*, above n102, [20]; *Al-Skeini & Ors v United Kingdom* [2011] ECHR 1093 (**Al-Skeini v UK**); *Aranguren et al v Venezuela*, above n114, [81].

<sup>117</sup> *Pestaño v The Philippines*, above n112, [7.6]; Human Rights Committee, *Views: Communication No 1447/2006*, 95<sup>th</sup> sess, UN Doc CCPR/C/95/D/1447/2006 (2 April 2009) (**Amirov v Russian Federation**), [11.4]; *Fedorchenko v Ukraine*, [42]; *McKerr v UK*, above n116, [161]; *Simsek v Turkey*, above n105, [116]; *Tahsin Acar v Turkey* [2004] ECHR 149 (**Tahsin Acar v Turkey**), [223], [229]-[234]; *Jordan v UK*, above n115, [107]; *Al-Skeini v UK*, above n116; *Ximenes Lopes v Brazil*, (7 June 2003) Inter-American Court of Human Rights Series C No. 99 (**Ximenes Lopes v Brazil**), [148]; *Pueblo Bello Massacre v Colombia*, above n112, [146]; *Mapiripán Massacre v Colombia*, above n114, [234]; *Ituango Massacres v Colombia* (1 July 2006) Inter-American Court of Human Rights Series C No. 148 (**Ituango Massacres v Colombia**), [131].

<sup>118</sup> *McCann v UK*, above n102, [194]; *R (Amin) v SHD*, above n102, [20], [23]; *McKerr v UK*, above n116, [115]; *Al-Skeini v UK*, above n116; *Aranguren et al v Venezuela*, above n114, [82].

<sup>119</sup> *Pestaño v The Philippines*, above n112 [9]; *R (Amin) v SHD*, above n102 [22], [25]; *McKerr v UK*, above n116, [114]; *Leonidis v Greece*, above n105, [68]; *Ximenes Lopes v Brazil*, above n117,[148].

<sup>120</sup> *Jordan v UK* above n115, [106]; *R (Amin) v SHD*, above n102, [22]; *Fedorchenko v Ukraine*, [43]; *McKerr v UK*, above n116, [115]. See also *R (Humberstone) v LSC*, above n101; *Al-Skeini v UK*, above n116.

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153. Where both a primary and subsequent investigation are conducted, these procedural requirements have been found applicable to both.<sup>121</sup>

#### 5.1.2.1 Investigations must be 'independent'

154. The author submits that for an investigation to be 'effective', it is vital that it be independent.<sup>122</sup>

155. This is supported by previous views of the Committee. In its Concluding Observation following the fifth periodic review of Australia under the ICCPR, the Committee expressed regret that 'the investigations of allegations of police misconduct are carried out by the police itself'.<sup>123</sup>

156. The Committee stated in a separate concluding observation:

The State party should ensure the completion of investigations into such use of force, in conditions of total transparency and through a mechanism independent of the law enforcement authorities.<sup>124</sup>

157. The Committee has further indicated:

The State Party should actively pursue the idea of establishing an independent civilian body to investigate complaints filed against law enforcement officials.

...

The State Party should ... ensure that allegations of torture and similar ill-treatment, as well as deaths in custody, are promptly and thoroughly investigated by an independent body so that perpetrators are brought to justice.<sup>125</sup>

158. In its Views on communications alleging a breach of Article 6(1), the Committee has recognised an obligation to ensure a 'thorough, prompt and impartial investigation',<sup>126</sup> a 'separate independent investigation',<sup>127</sup> a 'speedy, independent investigation'<sup>128</sup> and 'an impartial investigation'.<sup>129</sup>

159. To avoid any perceived or actual risk of collusion, corruption or bias, bodies and individuals investigating potential breaches of the right to life must be truly independent from the individuals they are investigating.

160. The principle that an investigation into a death associated with the State should be conducted by persons hierarchically, institutionally and practically independent from those implicated in the events giving rise to the investigation is well established in international

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<sup>121</sup> See generally *Jordan v UK*, above n115.

<sup>122</sup> *Kelly and Ors v United Kingdom* [2001] ECHR 328 (***Kelly v UK***), [95]. See also *AM & Ors, R (on the application of) v Secretary of State for the Home Department & Ors* [2009] EWCA Civ 219.

<sup>123</sup> Human Rights Committee, Concluding Observations on Australia, UN Doc CCPR/C/AUS/CO/5 (7 May 2009).

<sup>124</sup> Human Rights Committee, Concluding Observations on Sweden, UN Doc CCPR/CO/74/SWE (24 April 2002), [10], [15].

<sup>125</sup> Human Rights Committee, Concluding Observations on Thailand, UN Doc CCPR/C/84/THA (8 July 2005), [15].

<sup>126</sup> *Eshanov v Uzbekistan*, above n116, [9.2].

<sup>127</sup> *Ibid*, [9.7].

<sup>128</sup> *Pestaño v The Philippines*, above n112, [7.5].

<sup>129</sup> *Amirov v Russian Federation*, above n98, [13].

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jurisprudence.<sup>130</sup> Investigations will not be considered hierarchically, institutionally and practically 'independent' in the following circumstances.

- (a) An investigation will not be hierarchically independent if the investigators are from the same chain of command as those being investigated.<sup>131</sup>
- (b) An investigation will not be institutionally independent from those implicated in the death if the investigators are from the same body as those being investigated.<sup>132</sup>
- (c) An investigation will not be practically independent if it does not involve a formally independent body and is not carried out with genuine independence:<sup>133</sup>
  - (i) it is not sufficient for an independent body to have oversight of an investigation where the investigation itself is carried out by police officers connected organisationally with those under investigation;<sup>134</sup> and
  - (ii) the investigators must not uncritically rely on the version of events they have received from members of the body being investigated.<sup>135</sup>

161. Relevantly, this means that investigations of the use of lethal force by police will lack sufficient independence if they are carried out by other members of the same police force, even where the investigators work in a different department or an independent body oversees the investigation.<sup>136</sup>
162. The author submits that cultural independence may also be necessary for an investigation to be effective.<sup>137</sup> A formally independent body may not be genuinely independent if it employs a significant number of former police officers who still identify culturally as police because there is a risk that, consciously or otherwise, police investigators will be sceptical of complainants and 'softer' on the police concerned.<sup>138</sup>
163. A key rationale for having an investigation that is independent is that it allays perceptions of wrongdoing, both by the deceased's family and the public generally. An independent framework for investigation ensures there is confidence that matters are properly investigated and that any wrongdoing is exposed, or equally, any conduct by officers is

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<sup>130</sup> *Jordan v UK*, above n115, [106]; *McKerr v UK*, above n116, [112]; *R (Amin) v SHD*, above n102, [20]; *Aranguren et al v Venezuela*, above n114, [81].

<sup>131</sup> *Ramsahai v Netherlands* [2007] ECHR 393 (***Ramsahai v Netherlands***), 335, 338, 340-341; *Jordan v UK*, [120]; *Al-Skeini v UK*, above n116.

<sup>132</sup> *Ibid.*

<sup>133</sup> *McKerr v UK*, above n116; *Simsek v Turkey*, above n105, [122]-[123]; *Tahsin Acar v Turkey*, above n117, [229]-[234]; *Eremiasova and Pechova v The Czech Republic* [2012] ECHR Application No. 23944/04 (***Eremiasova v Czech Republic***).

<sup>134</sup> *Jordan v UK*, above n115.

<sup>135</sup> *Ramsahai v Netherlands*, above n131, [335], [338], [340]-[341]; *Jordan v UK*, above n115, [120].

<sup>136</sup> *Ibid.*

<sup>137</sup> OPI Review, above n15, 35-37.

<sup>138</sup> Tamar Hopkins, 'An Effective System for Investigating Complaints Against Police', a study conducted for the Victoria Law Foundation of human rights compliance in police complaint models in the US, Canada, UK, Northern Ireland and Australia (August 2009) (***Hopkins***), 43-45, 48.

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effectively exonerated. For that reason, where there is no independent investigation, weaknesses or errors in the investigation may lead to actual or perceived bias.

164. This was explained in the report of the Royal Commission into Aboriginal Deaths in Custody:

The essential problem of the expertise of specialist, operational police investigators being employed in post-death investigations derives from the possibility of bias. In blunt terms, they may wish to protect other police from blame. They may wish to protect them from exacting scrutiny. More subtly, they may sympathetically project themselves into the position of the custodial officers and regard their explanations as having a credibility which they do not deserve.<sup>139</sup>

165. This rationale has been described by the Queensland Crime and Misconduct Commission in its report on the death of Mulrunji on Palm Island as the possibility for police officers to be 'handicapped in the performance of their professional duties by their over-identification with fellow officers who were under examination'.<sup>140</sup>

#### 5.1.2.2 Investigations must be 'adequate and effective'

166. The Committee has recognised that, when a person dies in circumstances that might involve a violation of the right to life, the State party has a duty 'to properly investigate' the death.<sup>141</sup>

167. International law requires an investigation into a death associated with the State to be 'effective', in that it must be capable of identifying the facts and leading to:

- (a) a determination of whether the force used was justified; and
- (b) the identification and punishment of those who may be responsible for the death.<sup>142</sup>

This 'is not an obligation of result, but of means'.<sup>143</sup>

168. In order to be 'adequate', the investigation should be aimed at:

- (a) the effective implementation of domestic laws which protect the right to life;
- (b) bringing the full facts to light;
- (c) ensuring accountability for deaths occurring under the responsibility of State agents;
- (d) exposing culpable and discreditable conduct and bringing it to public notice;
- (e) dispelling suspicion of deliberate wrong doing (if justified);

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<sup>139</sup> Commonwealth of Australia, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, 121 (***Royal Commission into Aboriginal Deaths in Custody***).

<sup>140</sup> Crime and Misconduct Commission, *CMC Review of the Queensland Police Service's Palm Island Review*, June 2010, xxvii.

<sup>141</sup> See eg *Pestaño v The Philippines*, above n112, [7.6]; *Eshanov v Uzbekistan*, above n116, [9.11]; *Amirov v Russian Federation*, above n98, [11.4]; *Zhumbaeva v Kyrgyzstan*, above n100, [8.10].

<sup>142</sup> *Amirov v Russian Federation*, above n98, [11.4]; *McKerr v UK*, above n116, [159], [161]; *Simsek v Turkey*, above n105, [116]; *Tahsin Acar v Turkey*, above n117, [223], [229]-[234]; *Fedorchenko v Ukraine*, [48]; *Jordan v UK*, above n115, [107]; *Al-Skeini v UK*, above n116; *Eremiasova v Czech Republic*, above n133.

<sup>143</sup> *Kelly and UK*, above n122, [96].

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- (f) rectifying dangerous practices and procedures; and
- (g) ensuring that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from their death may save the lives of others.<sup>144</sup>
169. The United Kingdom House of Lords has determined that, in respect of the requirement that the investigation be directed at determining how the deceased came by their death, 'how' must be interpreted in a broad sense in order to meet the requirements of Article 2 of the European Convention on Human Rights. This means seeking to determine not just 'by what means' but 'by what means and in what circumstances' the death occurred.<sup>145</sup> This interpretation is consistent with the requirements of a coronial inquest in Victoria, as discussed at 3.3.4, above (p18).
170. The primary investigators must take reasonable steps to secure evidence concerning the incident. The State may fail to meet its obligations to conduct an effective investigation where there is a deficiency in the primary investigation that undermines its ability to achieve its outcome.<sup>146</sup> For example, where police officers are not required to give evidence, or are instructed to conceal information, legitimate doubts will be raised as to the overall integrity of the investigative process.<sup>147</sup>
171. Adequacy and effectiveness require an investigation to be capable of promptly and expeditiously safeguarding the evidence to prevent loss or fabrication of evidence and collusion.<sup>148</sup> In practice, this means that the investigative body must be empowered and resourced to attend the scene of an incident as soon as practicable, gather evidence, interview witnesses, search premises and seize relevant materials and documents.
172. This does not mean that police cannot play any role in the investigation. The European Court of Human Rights has acknowledged that, as a practical matter, it may be necessary to involve police in securing the scene, collecting evidence, and identifying potential witnesses in the event of death or injury involving police.<sup>149</sup>

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<sup>144</sup> *R (Amin) v SHD*, above n102, [31]; *McKerr v UK*, above n116, [111]; *Edwards v UK*, above n104, [69]; *Jordan v UK*, above n115, [105]; *R (Middleton) v WSC*, above n102; *Leonidis v Greece*, above n105, [67]; *Eremiasova v Czech Republic*, above n133. See also *Ximenes Lopes v Brazil*, above n117, [148]; *García v Perú*, above n97, [84]; *Pueblo Bello Massacre v Colombia*, above n112, [143]. See also *Ituango Massacres v Colombia*, above n117, [298].

<sup>145</sup> *R (Middleton) v WSC*, above n102. The broader surrounding circumstances include such matters as the relevant legal or regulatory framework in place and the planning and control of the actions under examination. See also *McKerr v UK*, above n116, [109]; *Leonidis v Greece*, above n105, [59]; *McCann v UK*, above n116, [146]-[147].

<sup>146</sup> *Menson v United Kingdom* [2003] 37 EHRR CD 220 (***Menson v UK***). See also *R (Middleton) v WSC*, above n102, [10]; *McKerr v UK*, above n116, [113]; *Jordan v UK*, above n115, [107]; *Leonidis v Greece*, above n105, [68].

<sup>147</sup> *McKerr v UK*, above n116, [127]. See also *Amirov v Russian Federation*, above n98, [11.4].

<sup>148</sup> Submission to the Parliamentary Joint Committee on the Australian Commission for Law Enforcement Integrity's Inquiry into Law Enforcement Integrity Models, House of Representatives, Commonwealth of Australia, 2008, 18-19 (Tamar Hopkins). See also *Ramsahai v Netherlands*, above n131, where the European Court held at 330 that, although there was no evidence of collusion, the fact that two officers were not kept separate after an incident involving police use of force and were only questioned three days later resulted in a 'significant shortcoming in the adequacy of the investigation'.

<sup>149</sup> *Ramsahai v Netherlands*, above n102, [337]-[338], [340]-[341]; *Jordan v UK*, above n115, [118]-[119].

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173. However, while police are not forbidden from any necessary initial involvement in an investigation, the right to life requires that the investigation should be placed in the hands of the independent investigative body *at the earliest point* it is practicable to do so.<sup>150</sup>

#### 5.1.2.3 Investigations must be 'open to public scrutiny'

174. International law requires that investigations of deaths associated with police contact be sufficiently open and publicly accountable. There must be sufficient public scrutiny of investigations into deaths associated with police contact to 'secure accountability in practice as well as in theory, maintain public confidence in the authorities' adherence to the rule of law and prevent any appearance of collusion in or tolerance of unlawful acts'.<sup>151</sup> An investigation which is not open to public scrutiny and fails to provide a convincing explanation of events may engender mistrust of investigating authorities.<sup>152</sup>

175. The European Court of Human Rights has stated:

An investigation and its outcomes must have a certain level of transparency or scrutiny. For example, public scrutiny has been found to be lacking when reports and their findings were not published in either their full or extract forms.<sup>153</sup>

176. The author submits that the conduct of coronial inquests in open court will generally satisfy this obligation of public scrutiny. However, in order for this to be the case, it will be necessary for the Coroner to be responsible for the primary investigation or, alternatively, rely on an independent primary investigation.<sup>154</sup>

#### 5.1.2.4 Investigations must be 'prompt'

177. Under international law, an investigation into a death associated with the State must be prompt and carried out with reasonable expedition.<sup>155</sup>

178. The author submits that having a timely and efficient investigation assists in dispelling fears of attempts to cover up any misconduct, which in turn instils confidence in the integrity of investigations. This means an investigative body must be adequately resourced to carry out such prompt and full investigations. It might also require legislative time limits for the conduct of an investigation.<sup>156</sup>

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<sup>150</sup> *Ramsahai v Netherlands*, above n131, [339].

<sup>151</sup> *McCann v UK*, above n102, [194]; *R (Amin) v SHD*, above n102, [20], [23]; *McKerr v UK*, above n116, [115]; *Anguelova v Bulgaria* (2004) 38 EHRR 31 (*Anguelova v Bulgaria*), [40]; *Al-Skeini v UK*, above n116; *Aranguren et al v Venezuela*, above n114, [82].

<sup>152</sup> When such suspicious circumstances arise, the European Court of Human Rights has tended to find violations of the right to life. See for eg *Anguelova v Bulgaria*, above n151.

<sup>153</sup> *McKerr v UK*, 560, above n116.

<sup>154</sup> *McKerr v UK*, above n116, [127]. See also *Amirov v Russian Federation*, above n98, [11.4].

<sup>155</sup> *Pestaño v The Philippines*, above n112, [7.5]; *R (Amin) v SHD*, above n102, [22], [25]; *McKerr v UK*, above n116, [114]; *Leonidis v Greece*, above n105, [68]; *Ximenes Lopes v Brazil*, above n117, [148].

<sup>156</sup> Hopkins, above n138.

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### 5.1.2.5 Involvement of next-of-kin

179. The Committee has found that a deceased's next-of-kin should have access to all information relevant to the investigation, and should be entitled to present other evidence.<sup>157</sup>
180. The European Court of Human Rights has also placed emphasis on involving the next-of-kin in investigations.<sup>158</sup> The requirement that the next-of-kin be involved does not necessarily mean that the next-of-kin must be granted access to all documents and files of police, if there are operational reasons for refusing that access.<sup>159</sup>
181. The Inter-American Court of Human Rights has stated that next-of-kin should have extensive opportunities to participate and be heard, both in the clarification of facts and punishment of those responsible, and in seeking compensation. It has emphasised that this right to involvement does not displace the State's burden of initiating the investigation.<sup>160</sup>

### 5.1.3 Application of Article 6(1) to the death of Tyler

182. Where a death results from the direct use of force by police, the procedural obligations of Article 6(1) are enlivened.<sup>161</sup> The author submits that Tyler's death in the circumstances described at 3, above (p7), clearly engages these procedural obligations.
183. A death is associated with police contact where police officers are directly responsible for the death of a person, such as a police shooting, and also where the police knew, or ought to have known, that there was a real and immediate risk to the life of an identified individual, either by way of criminal acts by third parties or through self harm.<sup>162</sup>
184. Tyler died from a gunshot wound from one of ten shots fired by three of the four police officers present at the time of his death.<sup>163</sup> The author submits that this is a clear circumstance in which a death has resulted from the use of force by State officials and engages the State's obligations under Article 6(1). The State party was therefore required to ensure an effective and official investigation of Tyler's death.<sup>164</sup>
185. As described above, the procedural obligations of Article 6(1) require that an investigation:
- (a) be hierarchically, institutionally and practically independent;

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<sup>157</sup> *Eshanov v Uzbekistan*, above n116, [9.6].

<sup>158</sup> *Jordan v UK*, above n115, [105], [133]; see also *Nachova v Bulgaria* (2006) 42 EHRR 43; *Al-Skeini v UK*, above n116.

<sup>159</sup> *Ramsahai v Netherlands*, above n131, [348]-[349].

<sup>160</sup> *Pueblo Bello Massacre v Colombia*, above n112, [144]; *Mapiripán Massacre v Colombia*, above n114, [223].

<sup>161</sup> *Pestaño v The Philippines*, above n112, [7.6]; *McCann v UK* above n102, [161]; *R (Amin) v SHD*, above n102, [2004], [20]; *Dodov v Bulgaria* (2008) 47 EHRR 41, [80]; *Vo v France*, above n112, [90]-[91]; *Calvelli v Italy*, above n112, [49]; *Powell v United Kingdom* (2000) 30 EHRR CD 362; *García v Perú*, above n97, [85]; *Pueblo Bello Massacre v Colombia*, above n102, [142].

<sup>162</sup> *McCann v UK*, above n102, [3]; *R (Amin) v SHD*, above n102, [20], [23]; *R (Middeton) v WSC*, above n102, [20]; *Osman v UK*, above n102.

<sup>163</sup> Inquest Finding, above n1, 7.

<sup>164</sup> *McCann v UK*, above n102, [161]; *R (Amin) v SHD*, above n102, [20].

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- (b) be adequate and effective;
  - (c) be open to public scrutiny;
  - (d) be prompt and carried out with reasonable expedition; and
  - (e) involve next-of-kin.

186. The Investigation, comprising the primary investigation conducted by Victoria Police and subsequent coronial inquiry, did not meet these requirements. The author submits that a failure to comply with any one or more of these procedural obligations will result in a violation of Article 6(1).

#### **5.1.3.1 The investigation into Tyler's death**

187. As discussed above, a division of Victoria Police, the Homicide Squad, had responsibility for conducting the primary investigation into the circumstances of Tyler's death, including preparing the Inquest Brief for the Coroner.

188. Notably, Detective Sergeant Birch, the lead investigator into Tyler's death from the Homicide Squad,<sup>165</sup> gave evidence at the Inquest that, while preparing an Inquest Brief, the Homicide Squad does not seek direction from the Coroner. He said that it was only subsequent to the production of the Inquest Brief that any further investigations would be conducted at the direction of the Coroner.<sup>166</sup>

189. As discussed above, a department of Victoria Police, the ESD, maintained oversight responsibility of the Homicide Squad's investigation.

190. Detective Inspector Harry Aristidou was the on-call Superintendent for the ESD at the time of Tyler's death. The intended role of the ESD is to ensure there is 'no impediment to the investigation, and that the integrity of the investigation is maintained by active oversight'.<sup>167</sup> The oversight role performed by the ESD in respect of the Investigation was limited. Notably:

- (a) the ESD relied on information provided by Victoria Police, and did not make independent inquiries;<sup>168</sup>
- (b) timely and regular case management meetings were not held during the investigation.<sup>169</sup> The diary of Detective Sergeant Birch records only three meetings with the ESD between December 2008 and June 2009;<sup>170</sup>

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<sup>165</sup> Inquest Finding, above n1, [491]. Members of Homicide Squad who assisted Birch on 11 December 2008 and following include Detective Senior Constable Warren Chapman, Detective Senior Constable Victor Anastasiadis, Detective Senior Constable David Barry, Detective Senior Constable Nigel L'Estrange and Detective Senior Constable David Leveridge.

<sup>166</sup> Inquest Transcript, T4182.9-T4185.20, T4218.21-T4219.11.

<sup>167</sup> Victoria Police Ethical Standards Department Oversight Guidelines, *Appendix A: Information for Investigating Members* (23 July 2010), cited in OPI Review Issues Paper, above n13, 26.

<sup>168</sup> Inquest Transcript, T3114.26-T3116.12, T3121.5-31.

<sup>169</sup> *Ibid*, T4273.26-T4277.6.

<sup>170</sup> Inquest Brief, IB3490, IB3492 and IB3495.

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- (c) the ESD file contains little documentation relating to its oversight role after December 2008 other than a small number of administrative documents and correspondence;<sup>171</sup> and
- (d) two minor interventions by the ESD.<sup>172</sup>
191. As discussed above, the OPI declined the author's request that the OPI assume the conduct of the primary investigation. Instead, the OPI undertook a limited assessment of the sufficiency of the police investigation into the fatal shooting of Tyler in terms of compliance with operational procedures etc, and produced a confidential report.<sup>173</sup>
192. The Coroner, apart from attending the de-briefing conducted by Inspector Walsh on the night of Tyler's death, did not have any direct role or involvement in the primary investigation prior to the Inquest Brief being delivered to the Coroner's Court on 30 September 2009, more than nine months after Tyler's death.
193. The Coroner conducted a coronial inquest, based in large part on the Inquest Brief prepared by the Homicide Squad.

#### **5.1.3.2 The independence of the Investigation**

194. The author submits that the independence of the Investigation was tainted because the primary investigation was not conducted by a formally independent body and was not carried out with genuine independence.<sup>174</sup>
195. The structure of the model of investigation adopted in respect of Tyler's death – whereby Victoria Police investigate the actions of Victoria Police officers with limited oversight by a department of Victoria Police, the ESD, and the coroner (and in this case the OPI) – is one that cannot sufficiently dispel concerns about institutional or systemic bias.
196. The Investigation was not institutionally independent because the Homicide Squad had primary responsibility for the conduct of the investigation into Tyler's death.<sup>175</sup> The Homicide Squad is a crime portfolio within Victoria Police.<sup>176</sup> The primary investigation was therefore conducted by persons from the same body as the officers being investigated.
197. Nor was the Investigation practically independent. As described above, it is not sufficient for an independent body to have oversight of an investigation that is carried out by investigators organisationally connected with those under investigation.<sup>177</sup> For this reason, none of:

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<sup>171</sup> Inquest Transcript, T4273.26-T4277.6; Inquest Brief, IB3490, IB3492 and IB3495.

<sup>172</sup> Inquest Transcript, T4277.7-18 and T4277.26. Details of and information relating to these interventions are subject to a confidentiality regime.

<sup>173</sup> Confidential OPI Report; Inquest Exhibit 118, a letter from the Cassidy family to the Coroner dated 23 April 2009 and a letter from OPI to Coroner dated 5 May 2009.

<sup>174</sup> *McKerr v UK*, above n116; *Simsek v Turkey*, above n105, [122]-[123]; *Tahsin Acar v Turkey*, above n117, [229]-[234],

<sup>175</sup> *Ramsahai v Netherlands*, above n131, 335, 338, 340-341; *Jordan v UK*, above n115, 120.

<sup>176</sup> Victoria Police, 'About Victoria Police – Homicide Squad', available from the Victoria Police website which can be accessed at [http://www.police.vic.gov.au/content.asp?Document\\_ID=309](http://www.police.vic.gov.au/content.asp?Document_ID=309).

<sup>177</sup> *Jordan v UK*, above n115.

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- (a) the oversight by the ESD of the Homicide Squad's investigation into the death of Tyler;
  - (b) the Confidential OPI Report; or
  - (c) the Inquest,

were sufficient to ensure the independence of the Investigation.

198. The author submits that the lack of cultural independence is also likely to have impacted the effectiveness of the investigation because of the possibility that the investigators' objectivity and assessment may have been effected.<sup>178</sup> As a result of the organisational connection between the investigators and those under investigation, the primary investigation was not culturally independent.

199. The following aspects of the Investigation demonstrate the deficiencies of the model used to investigate Tyler's death, and its vulnerability to actual or perceived improper interference:

- (a) Contrary to best practice, and acknowledged by Victoria Police as a regrettable occurrence, one of the four police officers present at the time of Tyler's death, Constable Ferrante, was left unsupervised and did not, and was not requested to, leave the scene of Tyler's death immediately following the shooting. During the time she remained at the scene, Ferrante had contact with a number of witnesses.<sup>179</sup> The Coroner found:

Clearly, it was an error and not appropriate for the investigation, nor for the welfare of C. Ferrante, that she was left standing in the car park for half an hour in the wake of the shooting. It is not appropriate for the investigation because of the perception that it leaves a member involved in the incident with the opportunity to both hear accounts from witnesses of what they heard and saw before that member has been interviewed, but also has the potential for a member to interfere with potential crucial evidence to the investigation.<sup>180</sup>

- (b) Senior Sergeant Geoffrey Joshua contacted one of the police officers present at the time of Tyler's death and involved in the shooting, Leading Senior Constable Colin Dods, on his mobile while Dods was still at the scene of the shooting.<sup>181</sup> Senior Sergeant Joshua is hierarchically superior to Leading Senior Constable Dods.
- (c) There were delays in contacting the Major Crime Desk and the Homicide Squad. On the night of Tyler's death, the attending Crime Investigations Unit were responsible for contacting the Major Crime Desk but failed to do so. The Major Crime Desk did not become aware that the shooting was fatal until 10.32pm. They

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<sup>178</sup> Hopkins, above n138, 43-45, 48.

<sup>179</sup> Inquest Transcript, (Walsh) T2397.1, (Delle-Vergini) T2722.5-31, (Ferrante) T4098.29-T4100.15, T4099.24-T4102.8 and also T2723.1 and Inquest Brief 2221-5. See also Inquest Finding, above n1, [488].

<sup>180</sup> Inquest Finding, above n1, [488].

<sup>181</sup> Inquest Transcript, (Dods) T4284.10-14.

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proceeded to contact the Homicide Squad at 10.38pm, over one hour after the shooting.<sup>182</sup>

- (d) There were delays in conducting drug and alcohol testing of the officers involved in the shooting. The evidence shows that there was confusion regarding who was required to organise and demand drug and alcohol testing.<sup>183</sup> Following a number of conversations between Detective Senior Constable L'Estrange and various agencies,<sup>184</sup> at approximately 4.05 am on 12 December 2008, Jo Hearch from the Victoria Institute of Forensic Medicine arrived.<sup>185</sup> However, Hearch did not have the proper equipment for either a blood, urine or breath test.<sup>186</sup> The attendance of another nurse was arranged, and at 6.00 am Jan O'Connell attended.<sup>187</sup> The importance of drug and alcohol testing has added significance in the context of three of the four police officers having attended a police function where alcohol was consumed on the night of 10 December 2010.<sup>188</sup> The Coroner found:

The failure to have the members tested in a timely way is a serious one, and not of their making and indeed, as stated by the members, to their detriment. It is entirely unsatisfactory that this was not performed in a timely and professional way.<sup>189</sup>

- (e) There were delays in conducting gunshot residue testing of the officers involved in the shooting. Detective Sergeant Birch wrongly assumed that by contacting the Forensic Services Department, someone from the Gunshot Residue Section would attend to conduct gunshot residue testing of the officers involved in the shooting.<sup>190</sup> When Detective Sergeant Birch realised no one had attended to conduct the testing, Harald Wrobel from the Gunshot Residue Section of the Forensic Services Department was contacted.<sup>191</sup> This was some time after 1.00am on 12 December 2008. Due to a lack of gunshot residue particles detected, Wrobel was unable to ascertain a distance between the police officers and Tyler when they discharged their weapons.<sup>192</sup> The Coroner observed:

The public confidence necessary to be maintained in an investigation of this nature is enhanced by a perception of competency and transparency of the investigation.

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<sup>182</sup> Inquest Brief 614, and 3683. See also Inquest Finding, above n1, [515].

<sup>183</sup> Inquest Transcript, (L'Estrange) T2914.23-T2915.3 and T2915.16, (Birch) T4152.6-T4153.26 and also T4151.5-12 and Inquest Brief 1763.

<sup>184</sup> Inquest Transcript, (L'Estrange) T2915.16 and Inquest Exhibit 86, a statement by Detective Acting Sergeant Nigel Alan L'Estrange dated 28 July 2010 and including two bundles of notes.

<sup>185</sup> Inquest Brief 1763.

<sup>186</sup> Ibid, 1763 and Inquest Transcript, T4161.12-21.

<sup>187</sup> Inquest Brief 1763.

<sup>188</sup> Ibid, 378, 380 and 385.

<sup>189</sup> Inquest Finding, above n1, [502].

<sup>190</sup> Inquest Transcript, (Birch) T4147.20-T4149.27.

<sup>191</sup> Ibid, T4148.11.

<sup>192</sup> Ibid, T4247.16.

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Delays in the calling out of specialist forensics do nothing to enhance either the perception of competency or transparency.<sup>193</sup>

- (f) There were a number of indications that the police officers were not treated as suspects during the investigation. Detective Sergeant Birch stated that there was no evidence to doubt that the four police officers had discharged their firearms in defence of themselves or defence of another, and, therefore, it was inappropriate to suspect them of having committed any offence.<sup>194</sup> However, the evidence was that this conclusion was drawn largely from the statements of the police officers themselves.<sup>195</sup> Officers Blundell and Ferrante who were involved in the shooting stated that they did not consider the four police officers involved to be suspects.<sup>196</sup>
- (g) Most significantly, in contrast to the policy regarding interviews of significant witnesses of homicides, the interviews of the police officers involved in the shooting were not audio or video recorded. Each police officer was asked to agree to have their statement audio or video recorded, but each refused and stated they would prefer to give a written statement.<sup>197</sup> This was contrary to the preference of Detective Sergeant Birch,<sup>198</sup> who acknowledged that there is a stigma attached to video recording such statements because it implies that the police officer is a suspect.<sup>199</sup> The Coroner observed:

... whilst police remain the investigators in police related fatalities, the concern about the perception of a lack of transparency as to the nature of the investigation will not abate.<sup>200</sup>

As noted at 3.1, above, the Coroner made the following recommendation in relation to the taking of police statements:

8. To allay perceptions regarding collusion and bias, without compromising the coherence of the account give [sic] by Victoria Police members following a police contact related death, I recommend that the Secretary to the Victorian Department of Justice provide an institutionally independent, legally trained person to observe the interview process with Victoria Police members involved in the incident.<sup>201</sup>

The formal response provided by the Department of Justice to this recommendation (see 3.1, above) causes the author great concern. Effectively, the Victorian Government has indicated that, until evidence is provided of actual collusion or bias, members of Victoria Police will continue to conduct interviews of

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<sup>193</sup> Inquest Finding, above n1, [646].

<sup>194</sup> Inquest Transcript, (Birch) T4222.18.

<sup>195</sup> Ibid, T4222.16.

<sup>196</sup> Inquest Transcript, (Blundell) T3901.13, (Ferrante) T4103.6-16 and T4103.30-T4104.11.

<sup>197</sup> Inquest Transcript, (Birch) T4229.1-T4230.12.

<sup>198</sup> Ibid, T4170.6-T4171.10.

<sup>199</sup> Inquest Finding, above n1, [607].

<sup>200</sup> Ibid, [609] (footnote redacted).

<sup>201</sup> Inquest Finding, above n1, Recommendations.

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officers involved in a death associated with police contact with no independent oversight and no audio or video recording of the interview.

The author is particularly concerned by the Department of Justice's statement that appointing an independent observer risked 'interfering in the operational independence of Victoria Police'.

- (h) No general call for witnesses was made, and the time taken by the police to identify all relevant witnesses and to take their statements was criticised during the Inquest.<sup>202</sup> In particular, the Homicide Squad did not focus on identifying potential witnesses around Alphington station where Tyler had spent time the night of his death, and delayed canvassing the area until May 2010, more than 14 months after Tyler's death.<sup>203</sup>
- (i) Further, when one potential witness identified themselves to police, the police officer relayed the information to Leading Senior Constable Dods, who was involved in the shooting incident, rather than to the Homicide Squad which was investigating the shooting.
- (j) At 11.45pm on the night of Tyler's death, Victoria Police Assistant Commissioner Cartwright provided a briefing to assembled media. He subsequently authorised a media statement, which was released by Victoria Police a few hours after Tyler's death. This statement, and comments made during the media briefing, tended to justify the use of force by the four officers, and had the potential to lead an observer to believe that Victoria Police (and its investigators) had reached a concluded view that the use of force was justified.<sup>204</sup> The media statement was released by Victoria Police in breach of the policy regarding media interaction following a critical incident, as the Police failed to seek the Coroner's approval prior to releasing the statements.<sup>205</sup> The media statement released by Victoria Police early on 12 December 2008, and a newspaper article dated 13 December 2008 that includes comments made by Assistant Commissioner Cartwright, are included at Annexures F and G.
- (k) Homicide Squad interviews and meetings with the author and her family at their home were covertly recorded without their knowledge or permission.<sup>206</sup> The purpose of these conversations was intended to be to give information to the author and her family, not to obtain information.<sup>207</sup> When the author learnt of the

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<sup>202</sup> Inquest Brief, (L'Estrange) T2969.10 and T4223.27-T4227.10 and Confidential OPI Report, 4-5.

<sup>203</sup> Inquest Brief, 1810 and Inquest Transcript, (Birch) T41730.27-T4176.30 and T4260.18-T4261.19.

<sup>204</sup> Inquest Transcript, (Cartwright) T2454.21-T2455.21.

<sup>205</sup> Inquest Brief, 1807, Inquest Exhibit 72, a statement by Assistant Commissioner Timothy John Cartwright dated 5 July 2010 plus attachments, diary entries, notes and Media Protocols for incidents involving Police and the Coroner; and Inquest Transcript, (Cartwright) T2450.3-9.

<sup>206</sup> Inquest Finding, above n1, [613]-[633].

<sup>207</sup> Ibid, above n1, [618].

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covert recordings, she felt betrayed and lost trust in the police.<sup>208</sup> In secretly recording the conversations, the investigators had the purpose of protecting Victoria Police from anticipated criticism, including, it could be deduced, that the investigation had sought to exonerate Victoria Police members.<sup>209</sup> The Coroner stated:

The covert recording of the family in this way, and at this time, was not consistent with the perception of an impartial investigation. The attempts to explain it did not hold up to scrutiny as any proper part of an investigation on behalf of the Coroner.<sup>210</sup>

200. The following aspects of the ESD's oversight of the primary investigation<sup>211</sup> demonstrate that such oversight is insufficient to address the lack of independence in the Investigation:
- (a) The on-call Superintendent for ESD at the time of Tyler's shooting, Detective Inspector Aristidou, did not make independent inquiries regarding the circumstances of the shooting, but instead simply relied upon information given to him at the scene by Homicide Squad and other police members that correct procedures had been followed by the police officers.<sup>212</sup>
  - (b) Detective Inspector Aristidou relied upon information presented to him by Detective Inspector Clark of the Homicide Squad to prepare the account of the facts in the ESD briefing paper dated 12 December 2008, which was provided to the Assistant Commissioner.<sup>213</sup>
  - (c) Timely and regular case management meetings were not held by ESD during the primary investigation. The ESD file does not contain any minutes of 'case management meetings' or of any meetings at all.<sup>214</sup>
  - (d) The ESD file contains little documentation relating to the ESD's oversight role after December 2008 other than a small number of administrative documents and correspondence. Accordingly, the ESD file does not demonstrate any of the following:
    - (i) examination of the adequacy or integrity of the investigation;
    - (ii) evidence of continuous monitoring; or
    - (iii) discussion of whether the investigation was conducted without bias.

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<sup>208</sup> Inquest Exhibit 4, [95]-[98], a statement by Shani Cassidy dated 11 October 2010.

<sup>209</sup> Inquest Transcript, (Birch) T4189.13 and T4294.15.

<sup>210</sup> *Ibid*, [631].

<sup>211</sup> The key policies and procedures that govern the oversight role performed by ESD are contained in the ESD Investigation Oversight Framework in Appendix Q of the Discipline Investigation Manual and the Memorandum of Understanding between the Assistant Commissioner (ESD) and the Assistance Commissioner (Crime), signed on 18 July 2003.

<sup>212</sup> Inquest Transcript, T3114.26-T3116.12, T3121.5-31.

<sup>213</sup> Inquest Transcript, T3098.6-27.

<sup>214</sup> Inquest Transcript, T4273.26-T4277.8 and Inquest Brief 3490, 3492 and 3495.

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- (e) The Inquest Brief was not submitted to the ESD for review or comment prior to its provision by the Homicide Squad to the Coroner.<sup>215</sup>
- (f) There was no further evidence of updates being provided to the ESD by the Homicide Squad, other than two minor interventions by the ESD and three meetings mentioned by Detective Sergeant Birch in his oral evidence.<sup>216</sup>
201. The Confidential OPI Review did not purport to be, and indeed was not, a full oversight of the primary investigation. In any event, the Confidential OPI Review involved a number of significant limitations:
- (a) The scope of the Confidential OPI Review was limited to the sufficiency of the police investigation, and did not include review of the circumstances of the shooting or the conduct of police involved. Further, the Confidential OPI Report did not comment on whether the police officers involved acted in accordance with their training.<sup>217</sup>
- (b) There was no comment made regarding the drug and alcohol and gunshot residue testing of the four police officers involved. Indeed the authors of the report appeared to be unaware of the delay in testing prior to the Inquest.<sup>218</sup>
- (c) While the issue was discussed, the Confidential OPI Review did not directly consider the welfare of the Cassidy family in relation to the primary investigation.<sup>219</sup>
- (d) The Confidential OPI Review did not consider the issue of whether or not the police involved in the incident should have their interviews video or audio recorded.<sup>220</sup>
- (e) The authors of the Confidential OPI Report were unaware that the author and her family had been covertly recorded by members of the Homicide Squad prior to the Inquest.<sup>221</sup>
- (f) While the Confidential OPI Report noted the separation of the four police officers at the scene of the shooting when reviewing their statements, the OPI did not make further enquiries, or report on, how the separation was conducted. The authors of the report appeared to be unaware that a police officer involved in the shooting remained at the scene for half an hour after the shooting and had discussions with potential witnesses prior to the Inquest.<sup>222</sup>
202. The Coroner ostensibly provides a further level of oversight to the primary investigation conducted by the Homicide Squad. However, as described above, it is not sufficient for an independent body to have oversight of an investigation that is carried out by investigators

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<sup>215</sup> Inquest Exhibit 118, a letter from OPI to Coroner dated 5 May 2009.

<sup>216</sup> Inquest Transcript, T4277.7-18 and T4277.26; Inquest Exhibit 118, a letter from OPI to Coroner dated 5 May 2009.

<sup>217</sup> Confidential OPI Report, 5.

<sup>218</sup> Inquest Transcript, T294.013 and T2938.26.

<sup>219</sup> Ibid, T2948.15.

<sup>220</sup> Ibid, T2957.26.

<sup>221</sup> Ibid, T2949.12 and T2949.21.

<sup>222</sup> Ibid, T2961.12.

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organisationally connected with those under investigation. In any event, there are a number of deficiencies in the coronial oversight of the primary investigation which indicate that the effect of this oversight is not sufficient to ensure 'independence, transparency and integrity', and that the oversight does not afford the public further confidence in the investigation:

- (a) The Coroner did not practically control the Investigation prior to delivery of the Inquest Brief on 30 September 2009 and largely relied upon the Homicide Squad to conduct the primary investigation into Tyler's death.<sup>223</sup> Significantly, this occurred more than nine months after Tyler's death, with the effect that the Coroner's capacity to properly address any deficiencies identified in the primary investigation would have been impacted by the passage of time.
- (b) The Coroner relied upon the results of the primary investigation conducted by Victoria Police.
- (c) The Coroner was unaware of the covert recordings made by the Homicide Squad of conversations between its members and the author and her family until August 2010.<sup>224</sup>

203. As noted above, Detective Sergeant Birch gave evidence at the Inquest that, while preparing an Inquest Brief, the Homicide Squad does not seek direction from the Coroner. He said that it was only subsequent to the production of the Inquest Brief that any further investigations would be conducted at the direction of the Coroner.<sup>225</sup>

### **5.1.3.3 The adequacy and effectiveness of the Investigation**

204. As discussed at 5.1.2.2, above (p38), the requirement that an investigation be adequate and effective is an obligation of means, not result.<sup>226</sup>

205. Various authorities are part of the system by which the State of Victoria seeks to discharge the duty to investigate as an aspect of the right to life. To function effectively within that system, an independent investigative body requires both the legal power and practical capacity to gather primary evidence to be used in determining whether there has been a breach of the right to life.

206. The author submits that a coronial investigation lacks the means to be effective where a deficiency or inadequacy of the primary investigation undermines its outcome. The Royal Commission into Aboriginal Deaths in Custody Report emphasised the general inability of coroners in Australia to control the quality of preliminary police investigations which 'lay the foundation for the subsequent coronial inquest'.<sup>227</sup> The Final Report of the Royal Commission noted:

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<sup>223</sup> Inquest Transcript, T4185.3.

<sup>224</sup> Ibid, T4194.24.

<sup>225</sup> Ibid, T4182.9-T4185.20, T4218.21-T4219.11.

<sup>226</sup> *Kelly UK*, above n122, [96].

<sup>227</sup> Quoted in Boronia Halsted, November 1995, Australian Deaths in Custody, No. 10 Coroners Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study, <http://www.alc.gov>.

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The breadth and quality of the coronial inquest often 'reflected the inadequacies of perfunctory police investigations and did little more than formalise the conclusions of police investigators'.<sup>228</sup>

207. The author further submits that a coronial investigation lacks the means to be effective where the coroner is not empowered to direct the conduct of the primary investigation sufficiently to overcome any deficiency or inadequacy of that investigation. In 2005, Victoria Police stated in connection with the review of the *Coroners Act 1985* (Vic) that 'coroners do not have the power to issue directions directly to investigating police'. The response continued:

The investigating members have competing interests that they must consider, whereas the Coroner's focus may not take all competing interests into consideration. Therefore it is important for Victoria Police to remain as an independent body whilst assisting the Coroner with investigations.

... The ability for the Coroner to provide direction therefore would create the potential to hinder other competing interests for which police are accountable.<sup>229</sup>

208. The State will fail to meet its obligation to conduct an effective investigation where there is a deficiency in the primary investigation that undermines its ability to achieve its outcome.<sup>230</sup>

209. The author therefore submits that the Investigation was not adequate and effective because:

- (a) coroners in the State of Victoria generally lack the ability to control the quality of the primary investigation; and
- (b) there were deficiencies in the primary investigation that undermined the effectiveness of the coronial investigation and inquest into Tyler's death.

210. Further to the deficiencies discussed at 5.1.3.2, above (p43), the deficiencies of the primary investigation include the following:

- (a) Ten shots were fired by three police firearms, but no bullets were recovered. The Coroner found that this may have resulted at least in part because of the less than adequate briefings given to crime scene examiners, compounded by there being no contemporaneous reconstruction of events.<sup>231</sup>
- (b) No reconstruction of the incident, including the shooting, took place throughout the police investigation into Tyler's death.<sup>232</sup>
- (c) Tyler's computer was not examined until some days after its collection from the Cassidy home, resulting in the loss of the MSN chat history. This chat history may

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<sup>228</sup> *Royal Commission into Aboriginal Deaths in Custody*, above n139, Vol 1, 130.

<sup>229</sup> Coroners Act Review, Victoria Police's Response to the Discussion paper, received by the Law Reform Committee on 7 October 2005.

<sup>230</sup> *Menson v UK*, above n152, . See also *R (Middleton) v WSC*, above n102, [10]; *McKerr v UK*, above n116, [113]; *Jordan v UK*, above n115, [107]; *Leonidis v Greece*, above n105, [68].

<sup>231</sup> Inquest Finding, above n1, [588].

<sup>232</sup> *Ibid*, [593].

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have assisted in shedding light on the circumstances in which his death occurred, including anyone he contacted prior to leaving the house the night he died.<sup>233</sup>

(d) There was no general call for witnesses following Tyler's death.<sup>234</sup>

211. The author submits that where deficiencies such as these are associated with an investigation, legitimate doubts will be raised as to the overall integrity of the investigative process.<sup>235</sup>

#### **5.1.3.4 Openness of the Investigation**

212. The procedural obligations of the right to life as articulated by Article 6(1) require that investigations of deaths associated with police contact be open to public scrutiny to:

... secure accountability in practice as well as in theory, maintain public confidence in the authorities' adherence to the rule of law and prevent any appearance of collusion in or tolerance of unlawful acts.<sup>236</sup>

213. The conduct of coronial inquests in open court will generally satisfy this obligation of public scrutiny.

214. However, certain aspects of the Investigation bring into question whether the Investigation was sufficiently open as required by Article 6(1). For example, that the Homicide Squad failed to inform the Coroner of the covert recordings made of conversations members had with the author and her family.<sup>237</sup>

#### **5.1.3.5 Promptness of the Investigation**

215. An investigation into a death associated with police contact must be prompt and carried out with reasonable expedition.<sup>238</sup> Having a timely and efficient investigation assists in dispelling fears of attempts to cover up any misconduct and instils confidence in the integrity of the investigation.

216. The Investigation commenced the night of Tyler's death. However, the author submits that the following delays give rise to legitimate concerns about the promptness of the Investigation:

(a) The Homicide Squad was not notified of Tyler's death until over an hour after it occurred.<sup>239</sup>

(b) The police officers present at the shooting were not tested for drugs and alcohol until after 6am on 12 December 2008, which impaired the test results and which the Coroner found unsatisfactory.<sup>240</sup>

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<sup>233</sup> Ibid, [596]-[600].

<sup>234</sup> Ibid, [610].

<sup>235</sup> *McKerr v UK*, above n116, [127].

<sup>236</sup> Ibid.

<sup>237</sup> Inquest Exhibit 4, [95]-[98], a statement by Shani Cassidy dated 11 October 2010.

<sup>238</sup> *R (Middleton) v WSC*, above n102.

<sup>239</sup> Inquest Finding, above n1, [515].

<sup>240</sup> Inquest Finding, above n1, [502].

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- (c) Testing for gunshot residue was not undertaken until some time after 1am on 12 December 2008.<sup>241</sup>
  - (d) The Homicide Squad did not focus on identifying potential witnesses around Alphington station and delayed canvassing the area until May 2010.<sup>242</sup>
  - (e) The Inquest Brief was not provided to the Coroner until 30 September 2009.
  - (f) The Inquest commenced on 19 October 2010.
  - (g) The Inquest Finding was handed down on 23 November 2011.

#### **5.1.3.6 Involvement of the next-of-kin**

217. The procedural obligations of the right to life under Article 6(1) require that investigations into a death associated with police contact involve the next-of-kin to the extent appropriate.

218. The key rationale underlying this requirement is that the next-of-kin have a legitimate interest in an investigation capable of leading to a determination of whether the force used by the State was justified, and the identification and punishment of those responsible where appropriate. Further, an investigation has among its purposes to ensure, so far as possible, that:

... those who have lost their relative may at least have the satisfaction of knowing that lessons learned from [his or her] death may save the lives of others.<sup>243</sup>

219. The author submits that the nature of her and other members of her family's involvement in the investigation is inconsistent with the procedural obligations regarding the involvement of the next-of-kin under Article 6(1), namely:

- (a) As noted at paragraph 199(k), above, the Homicide Squad made covert recordings of conversations they had with the author and her family. This action engendered distrust in the Victoria Police's handling of the Investigation into Tyler's death.
- (b) As noted at paragraph 199(j), above, Assistant Commissioner Cartwright authorised a media release regarding Tyler's death at around 1am on 12 December 2008, just a few hours after Tyler's death, and prior to speaking with the author and her family. This caused considerable distress and unhappiness to the author and her family.<sup>244</sup>
- (c) Further, police officers represented to the author and her family that they would not release Tyler's name without consultation with them. Despite this, early in the morning of 12 December 2008, Tyler's name was put into the public domain, followed by a significant quantity of personal information about Tyler. It is noted that the Coroner found that there was no evidence as to how Tyler's name got into the public domain.<sup>245</sup>

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<sup>241</sup> Ibid, [509].

<sup>242</sup> Ibid, [610]; Inquest Brief, B1810; Inquest Transcript, (Birch), T4173.27-54176.30 and T4260.18-T4261.19.

<sup>243</sup> *R (Amin) v SHD*, above n102, [31].

<sup>244</sup> Inquest Finding, above n1, [551]-[552], [556].

<sup>245</sup> Ibid, [553]-[555].

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- (d) The victim's brother, Blake Cassidy, was restrained by police when he attempted to enter the scene of Tyler's death. When he sought to run past the police, he was put in handcuffs and left sitting under a tree for about half an hour.<sup>246</sup> Counsel assisting (with whom the Coroner agreed) stated that the treatment of Blake in all of the circumstances:

... is troubling for us as a community and worthy of redress by Victoria Police through its consideration of engaging suitable persons to deal with the welfare of families affected in this and like situations.<sup>247</sup>

- (e) Detective Acting Sergeant Sadler and Detective Senior Constable Cole of Victoria Police separated the author from her partner, Greg Taylor, and her son, Blake Cassidy, prior to delivering notification of Tyler's death.<sup>248</sup> The Coroner stated:

The evidence is that the delivery of the death notification to Mrs Cassidy lacked sympathy and understanding and fell short of the current police training and advice to members. The two members involved seemed unable to reflect on the possible shortcomings of their actions on the evening.<sup>249</sup>

- (f) On the night of Tyler's death, the author, her partner, Greg Taylor, and her eldest son, Blake Cassidy, were requested to attend at Preston police station to make statements. This is the station where two of the officers involved in the shooting were stationed, and the author and her family were questioned at that station shortly after Tyler's death in the early hours of the morning. However, the author submits that she and her family felt deeply aggrieved by having to attend in such circumstances, without legal or welfare support. The Coroner found that this 'lacked understanding and a willingness to be flexible about the family's needs at that time' and that 'this situation was handled inadequately by Victoria Police'.<sup>250</sup>

#### 5.1.4 Conclusion

220. Tyler's death resulted from a direct use of force by Victoria Police officers, and thus engaged the procedural obligations of Article 6(1) of the ICCPR. The State party was therefore required to ensure an effective and independent investigation into Tyler's death.

221. The State party has failed to ensure such an investigation:

- (a) **Independent:** The Investigation was not hierarchically, institutionally and practically independent because it was conducted by Victoria Police's Homicide Squad, with limited oversight by the ESD, a department of Victoria Police. The subsequent coronial inquiry relied on the results of the primary Victoria Police investigation and was not sufficient to ensure the independence of the overall Investigation.

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<sup>246</sup> Inquest Finding, above n1, [522]-[529].

<sup>247</sup> Ibid, [530]-[531].

<sup>248</sup> Ibid, [532]-[542].

<sup>249</sup> Ibid, [543].

<sup>250</sup> Ibid, [544]-[549].

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- (b) **Adequate and effective:** The Investigation was not adequate and effective because the Coroner relied on the results of a primary Victoria Police investigation she was not empowered to direct. The Coroner therefore lacked the means to ensure that the Investigation was capable of identifying the facts and leading to a determination of whether the use of force was justified, and the identification and punishment of those responsible.
  - (c) **Open to public scrutiny:** Certain aspects of the Investigation cast doubt on the openness of the Investigation, for example, the failure of the Homicide Squad to inform the Coroner that conversations between investigators and the author and her family had been covertly recorded.
  - (d) **Prompt:** Certain delays in the Investigation give rise to legitimate concerns about the promptness of the Investigation, for example, the delays in notifying the Homicide Squad of Tyler's death and delays in forensic testing.
  - (e) **Involve the next-of-kin:** The nature of the involvement of the author and her family in the Investigation is inconsistent with the obligation under Article 6(1) to involve the next-of-kin. For example, conversations between the family and investigating officers were covertly recorded, Victoria Police made public statements regarding Tyler's death prior to consulting the family, and the author and her family were requested to make statements to Victoria Police at the police station where two of the officers involved in Tyler's shooting were stationed without legal or welfare support.

## 5.2 Article 2 of the ICCPR

221.2 The State party has further failed to ensure an effective remedy under Article 2 of the ICCPR for the breach of Tyler's right to have his death investigated in accordance with the procedural obligations of Article 6(1).

222. Article 2 provides:

1. Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
2. Where not already provided for by existing legislative or other measures, each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant.
3. Each State Party to the present Covenant undertakes:
  - (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
  - (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative

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authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

- (c) To ensure that the competent authorities shall enforce such remedies when granted.

223. The Committee relevantly stated in *General Comment 31*:

Article 2, paragraph 3, requires that States Parties make reparation to individuals whose Covenant rights have been violated. Without reparation to individuals whose Covenant rights have been violated, the obligation to provide an effective remedy, which is central to the efficacy of article 2, paragraph 3, is not discharged. In addition to the explicit reparation required by articles 9, paragraph 5, and 14, paragraph 6, the Committee considers that the Covenant generally entails appropriate compensation. The Committee notes that, where appropriate, reparation can involve restitution, rehabilitation and measures of satisfaction, such as public apologies, public memorials, guarantees of non-repetition and changes in relevant laws and practices, as well as bringing to justice the perpetrators of human rights violations.<sup>251</sup>

224. The author submits that, if the Committee finds that Australia has breached Article 6(1) of the ICCPR in respect of the investigation of the death of Tyler, Australia has also breached its obligations under Article 2 of the ICCPR by:

- (a) violating one or more of the obligations under Article 6(1); and  
(b) failing to ensure an effective remedy for the violation(s) of Tyler's rights under the ICCPR, in particular his right to life as articulated in Article 6(1).

225. The Victorian Government has expressly recognised the existence of the obligation to ensure an effective investigation, and has stated that it will rely upon the coronial system in order to discharge this obligation. In the Statement of Compatibility for the Coroners Bill 2008, former Attorney-General Robert Hulls stated:

In other jurisdictions [the right to life] has been interpreted to include an obligation on government to ensure an effective investigation into certain deaths. As the most significant investigative mechanism into reportable and reviewable deaths, the coronial system gives effect to this right.<sup>252</sup>

226. The author submits that, although the Victorian Government recognises this procedural obligation, its reliance on a coronial investigation that in turn relies on a primary investigation conducted by Victoria Police is not sufficient to effect compliance with the procedural obligation to ensure an effective investigation.

227. The Inquest did not, and was not able to, provide the author with an effective remedy for the violation of Tyler's right to an independent and effective investigation under Article 6(1). As discussed at 3.3.4, above (p18), the Coroner has solely recommendatory powers. The Coroner may make recommendations to any Minister, public statutory authority or entity and, if to a public statutory authority or entity, that body must provide a written response

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<sup>251</sup> United Nations Human Rights Committee, *General Comment 31*, UN Doc CCPR/C/21/Rev.1/Add.13 (2004).

<sup>252</sup> Charter of Human Rights and Responsibilities Statement of Compatibility, Coroners Bill 2008, found at Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4030 (Robert Hulls, former Attorney-General).

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within three months.<sup>253</sup> However, the *Coroners Act* does not provide for any remedy in the event that a written response is inadequate or not provided.

228. The Coroner noted in the Inquest Finding that issues concerning the independence and quality of the primary investigation had been raised during the course of the Inquest. However, she made no express findings in relation to these issues.<sup>254</sup>
229. In the Inquest Finding, the Coroner made eight recommendations. One of these recommendations concerned a matter relevant to the violation of the right to life, the subject of this communication. This recommendation, directed to the Secretary to the Victorian Department of Justice, was that the Secretary provide an institutionally independent, legally trained person to observe the interview process with Victoria Police members involved in a police contact related death.
230. The Department of Justice's failure to implement this recommendation demonstrates the ineffectiveness of the coronial system as a means of:
- (a) bringing about compliance with the obligation to ensure an effective investigation; and
  - (b) providing access to an effective remedy for a breach of the obligation to ensure an effective investigation.
231. The author submits that neither the Inquest Finding nor the recommendations made by the Coroner provides her with an effective remedy for the non-compliance with the procedural obligations of Article 6(1) of the investigation into Tyler's death.
232. The author submits that as a result, she has not had, and does not have, access to an effective remedy for this violation. Further, Australia's violation of this obligation has not been remedied by sufficient changes in law, practice and procedure, by payment of compensation or by apology.
233. As a result, Australia has violated Article 2 of the ICCPR.

## 6. Remedies Sought

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### 6.1 Findings

234. Based on the submissions in Parts 3 and 5, above, the author respectfully requests the Committee to act under Article 5(4) of the Optional Protocol to make a finding that the State Party has violated Article 6(1) of the ICCPR.

### 6.2 Remedies

235. The author notes that, pursuant to Article 2 of the ICCPR, Australia is required to ensure the provision of effective remedies for human rights violations and the enforcement of those remedies.
236. The author respectfully submits that the following remedies would be effective:

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<sup>253</sup> *Coroners Court Act 2008* (Vic), s72.

<sup>254</sup> Inquest Finding, above n1, [106]-[581] and [658]-[675].

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- (a) Australia, including the Victorian Government, enact legislation and develop appropriate policies, processes, institutions and mechanisms to ensure the independent and effective investigation of all deaths associated with police contact in accordance with the requirements of Article 6(1).
- (b) Australia make a public apology and reparations to the author for its failure to ensure an effective and independent investigation of Tyler's death.

## 7. Annexures

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Annexed to this communication are the following:

- A: Impact Statement of Shani Cassidy
- B: Inquest Finding
- C: Victoria Police Response to Inquest Finding
- D. Department of Justice response to Inquest Finding
- E: Department of Justice final response to Inquest Finding
- F: Victoria Police Media Statement (12 December 2008)
- G: The Age, *Teen Shot Dead by Police* (13 December 2008)
- H: OPI Review Issues Paper
- I: OPI Review of Investigations