IN THE CORONERS COURT OF VICTORIA

AT MELBOURNE

INQUEST INTO THE DEATH OF TYLER CASSIDY

COURT REF: 5542/08

HUMAN RIGHTS LAW RESOURCE CENTRE PRELIMINARY SUBMISSIONS ON METHODS OF INVESTIGATION OF DEATHS ASSOCIATED WITH POLICE CONTACT

1. By letter dated 15 September 2010 the solicitors assisting the Coroner asked the Human Rights Law Resource Centre ('HRLRC') to 'state what alternative model for [an investigation of a fatal police shooting] is available and what recommendations [HRLRC] submits that her Honour should make in this inquest about the model of investigation for such matters.'

2. HRLRC refers to its submissions on the scope of this inquest dated 11 June 2010, in particular, the detailed overview of the international jurisprudence on the right to life including the obligation to investigate deaths at the hands of State authorities, contained in Annexure 1 to those submissions.

3. On 18 June 2010 HRLRC made a submission to the Office of Police Integrity (**OPI**) in respect of its inquiry into the adequacy and appropriateness of Victoria Police policies and procedures for investigating deaths associated with police contact.[1]

Summary

4. In this inquest, the Coroner should make the following 11 recommendations about the model of investigation of deaths associated with police contact.

Recommendation 1

The Victorian Government should establish a body independent of Victoria Police to investigate deaths associated with police contact[2] (the **Independent Body**). The Independent Body should be hierarchically, institutionally and practically independent from Victoria Police.

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1 This submission draws from the recommendations and discussion in HRLRC's submission to the OPI, which is available on HRLRC's website: www.hrlrc.org.au.

2 The scope of 'deaths associated with police conduct' is discussed in HRLRC's submission to the OPI at section 6 (page 14 and following) and should include among other things deaths as a result of police shootings.

Recommendation 2

The Independent Body should conduct the primary investigation into deaths associated with police contact on behalf of, and at the direction of, the Coroner and prepare the brief to be used in coronial proceedings.

Recommendation 3:

The Independent Body must be properly established and adequately empowered and resourced to effectively conduct investigations.

Investigations of deaths associated with police contact must be placed in the hands of the Independent Body at the earliest practicable point.

Recommendation 4:

The Independent Body must be adequately 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.

Recommendation 5:

Investigations of deaths associated with police contact should be conducted promptly and, if necessary, time limits should be set to minimise delay in investigations.

Recommendation 6:

Investigations into deaths associated with police contact must be conducted in a manner that is open to public scrutiny, such as through a full examination of the investigation in the coronial process.

Recommendation 7:

Investigations into deaths associated with police contact should involve next-of-kin to the extent necessary to safeguard their legitimate interests.

Recommendation 8:

The Victorian Government should either establish a new body or provide an existing body, such as the OPI, with appropriate resources and powers to operate as the Independent Body responsible for investigating deaths associated with police contact. The Independent Body must have all the features to ensure that investigations are independent, effective, adequate, prompt, subject to public scrutiny and involve the family of the deceased.

Recommendation 9:

The Independent Body should, whenever possible, engage qualified and competent civilians to act as investigators.

Recommendation 10:

Police officers involved in deaths associated with police contact should be treated no differently to members of the public involved in criminal investigations, subject to one exception. Police involved in a death associated with police contact may, in the absence of any other police in attendance, be required to attend to some policing of the scene, for example, to secure the evidence. This should only occur: where no other police are present, for the purpose of preserving evidence, and for the limited period of time necessary for other police officers or the Independent Body to arrive.

Recommendation 11:

Police statements must be video recorded and, where reasonably practicable, police suspects and witnesses should be questioned within 24 hours of notification of the complaint/incident. Precautionary measures should be taken immediately after a death associated with police contact, such as separating police officers involved in the deaths as soon as the incident occurs and conducting separate interviews.

Independence of Investigations

5. To avoid any perceived or real 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.

6. The rationale for this position is described by the Queensland Crime and Misconduct Commission in its report on the death of Mulrunji on Palm Island, where it identified the possibility of police officers being 'handicapped in the performance of their professional duties by their over-identification with fellow officers who were under examination'.[3] Similarly, the Royal Commission into Aboriginal Deaths in Custody stated:

> 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

[3] Crime and Misconduct Commission, *CMC Review of the Queensland Police Service's Palm Island Review*, June 2010, xxvii.

position of the custodial officers and regard their explanations as having a credibility which they do not deserve.[4]

7. True independence is only achieved when an investigation is hierarchically, institutionally and practically independent of the organisation being investigated, that is:

   (a) the investigators are not from the same chain of command as those being investigated;

   (b) the investigators are not from the same organisation as those being investigated; and

   (c) the investigators do not uncritically rely on the version of events they have received from members of the body being investigated.[5]

8. This means, for example, that investigations of the excessive use of force by police will lack sufficient independence if they are carried out by other members of the same police force, even if the investigators work in a different department or an independent body oversees the investigation.[6]

9. Further, 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.[7]

10. Neither internal nor external oversight can cure the deficiencies of an investigation of a death associated with police contact that is conducted by a department of the police or an associated body of the police. The investigative body itself must be independent.

11. This proposition has been continually supported by European courts, which have established that it is not sufficient for an independent body to have oversight of an

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4 E Johnston, *National report: Royal Commission into Aboriginal Deaths in Custody*, vol 1, Australian Government Publishing Service, Canberra, 1991, 121.

5 *Ramsahai v Netherlands* [2007] ECHR 393 (15 May 2007), 335, 338, 340–341; *Jordan v United Kingdom* [2001] ECHR 327 (4 May 2001) 120.

6 *Ramsahai v Netherlands* [2007] ECHR 393 (15 May 2007), 335, 338, 340–341; *Jordan v United Kingdom* [2001] ECHR 327 (4 May 2001) 120.

7 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), 43-45, 48.

investigation, where the investigation itself is carried out by police officers connected organisationally with those under investigation:[8]

> Supervision [of the police investigation] by another authority, however independent, has been found not to be a sufficient safeguard for the independence of the investigation.[9]

12. For this reason, the current oversight by the Ethical Standards Division (**ESD**) of the Homicide Squad's investigations into deaths associated with police contact does not make the current system of investigating such deaths human rights compliant. Nor does the conduct of a coronial investigation and inquest, where that investigation and inquest is reliant upon the Homicide Squad's investigations (see paragraphs 15 to 18 below).

Recommendation 1

The Victorian Government should establish a body independent of Victoria Police to investigate deaths associated with police contact[10] (the **Independent Body**). The Independent Body should be hierarchically, institutionally and practically independent from Victoria Police.

Adequacy and Effectiveness

13. The duty to investigate is an aspect of the right to life. Different authorities (including the Coroners Court) are part of the system by which the State of Victoria discharges that duty. To function effectively within that system, the Independent Body needs both the legal power and the practical capacity to gather primary evidence to be used in determining whether there has been a breach of the right to life.

14. UK and European case law establishes that, in order adequately to discharge the state's responsibilities in respect of the right to life, an investigation into a death at the hands of state agents should be aimed at:

    (a) bringing the full facts to light;

    (b) exposing culpable and discreditable conduct and bringing it to public notice;

    (c) dispelling suspicion of deliberate wrong doing (if justified);

    (d) rectifying dangerous practices and procedures; and

    (e) 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.[11]

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8 *Jordan v United Kingdom* (2001) 37 EHHR 52, [120]; *McKerr v United Kingdom* (2002) 34 EHRR 20, [128]; *Kelly v United Kingdom* application no. 30054/96, 4 August 2001, [114].

9 *Ramsahai v The Netherlands* [2007] ECHR 393, [337]; *Bati v Turkey* [2004] ECHR, [135].

10 The scope of 'deaths associated with police conduct' is discussed in HRLRC's submission to the OPI at section 6 (page 14 and following) and should include, among other things, deaths as a result of police shootings.

15. To be effective, the investigation must be capable of achieving these outcomes. It must be capable of leading to a determination of whether the force used was justified and the identification and punishment of those responsible.[12] This 'is not an obligation of result, but of means'.

Interaction with the Coroners Court

16. A coronial inquest is a method of investigation capable of achieving these outcomes. But the effectiveness of a coronial inquest is undermined where there is a deficiency in the primary investigation.[13]

17. In Australia, the Final Report of Royal Commission into Aboriginal Deaths in Custody noted:

> 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.[14]

18. The Royal Commission Report emphasised the general inability of Coroners to control the quality of preliminary police investigations which 'lay the foundation for the subsequent coronial inquest'.[15]

19. In this regard, HRLRC notes that, in its response to the Victoria Law Reform Committee's Discussion Paper on the effectiveness of the *Coroners Act 1985* (Vic), Victoria Police suggested that "Coroners do not have the power to issue directions directly to investigating police". Victoria Police's 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

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11 *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [31]; *McKerr v United Kingdom* (2002) 34 EHRR 20, [111]; *Edwards v United Kingdom* (2002) 35 EHRR 487, [69]; *Jordan v United Kingdom* (2001) 37 EHRR 52, [105]; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182; *Leonidis v Greece,* application no. 43326/05, 8 January 2009, [67].

12 (2001) 37 EHRR 52.

13 *Menson v United Kingdom* [2003] 37 ERR CD 220. See also *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 [10]; *McKerr v United Kingdom* (2002) 34 EHRR 20 [113]; *Jordan v United Kingdom* (2001) 37 EHRR 52, [107]; *Leonidis v Greece* [2009] ECHR 5, [68].

14 Royal Commission into Aboriginal Deaths in Custody 1991, National Report, Australian Government Publishing Service, Canberra, Vol. 1, 130, available at: http://www.austlii.edu.au/au/other/IndigLRes/rciadic/.

15 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, available at http://www.aic.gov.

> important for Victoria Police to remain as an independent body whilst assisting the Coroner with investigations.
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> ... The ability for the Coroner to provide direction therefore would create the potential to hinder other competing interests for which police are accountable.[16]

20. If the Victorian Government were to create an Independent Body, or to properly empower and resource an existing body such as the OPI to be the Independent Body to conduct primary investigations into deaths associated with police contact, then the Independent Body should conduct the primary investigations into deaths associated with police contact on behalf of, and at the direction of, the Coroner (in place of the Homicide Squad) and should prepare the brief to be used in coronial proceedings.

Recommendation 2

The Independent Body should conduct the primary investigation into deaths associated with police contact on behalf of, and at the direction of, the Coroner and prepare the brief to be used in coronial proceedings.

An Independent Body with sufficient powers and capacity to conduct primary investigations

21. An Independent Body conducting a primary investigation should be capable of promptly collecting and preserving relevant evidence, so as to limit its loss and to limit the possibility (and the perception of a possibility) of fabrication of evidence and collusion.[17] 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.

22. This does not mean that police must play no role in the investigation. The European Court of Human Rights has acknowledged that, as a practical matter, it may be

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16 Coroners Act Review, Victoria Police's Response to the Discussion paper, received by the Law Reform Committee on 7 October 2005.

17 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 (Tamar Hopkins), 18-19; see *Ramsahai and Others v The Netherlands* [2007] ECHR 393 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'.

necessary to involve police in securing the scene, collecting evidence, and identifying potential witnesses in the event of death or injury involving police.[18]

23. However, while police are not forbidden from any necessary involvement in the preservation of evidence at the scene of a death associated with police contact, the right to life requires that control of the investigation into such a death should be placed in the hands of the Independent Body at the earliest point it is practicable to do so.[19] The Independent Body should be in a position to assume control of an investigation within an hour of a relevant incident occurring.

Recommendation 3:

The Independent Body must be properly established and adequately empowered and resourced to effectively conduct investigations.

Investigations of deaths associated with police contact must be placed in the hands of the Independent Body at the earliest practicable point.

Recommendation 4:

The Independent Body must be adequately 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.

Promptness

24. 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.[20] This, of course, 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.[21]

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18 *Ramsahai v Netherlands* [2007] ECHR 393 (15 May 2007), 337-338, 340–341; *Jordan v United Kingdom* [2001] ECHR 327 (4 May 2001), 118-119. An example of how this has been implemented in practice is set out below in paragraphs 47 and following.

19 *Ramsahai v Netherlands* [2007] ECHR 393 (15 May 2007), 339.

20 Tamar Hopkins, above n 7. It also serves to shorten the period of uncertainty for those whose conduct is under investigation.

21 Tamar Hopkins, above n 7.

Recommendation 5:

Investigations of deaths associated with police contact should be conducted promptly and, if necessary, time limits should be set to minimise delay in investigations.

Public Scrutiny of Investigations via the coronial process

25. The duty to investigate requires investigations of deaths associated with police contact to 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'.[22] An investigation which is not open to public scrutiny and fails to give a convincing explanation of events may engender mistrust of investigating authorities.[23]

26. The conduct of coronial inquests in open court will generally satisfy this obligation of public scrutiny. However, it will be necessary for the Coroner to be empowered, where necessary in the interests of justice, to conduct a full examination of the primary investigation during the coronial process. Where police officers are not required to give evidence, or are instructed to conceal information, it will raise legitimate doubts as to the overall integrity of the investigative process.[24]

Recommendation 6:

Investigations into deaths associated with police contact must be conducted in a manner that is open to public scrutiny, such as through a full examination of the investigation in the coronial process.

Involvement of the next-of-kin

27. The European Court has placed increasing emphasis on involving the next-of-kin in investigations.[25]

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22 *Anguelova v Bulgaria* (2004) 38 EHRR 31, [140].

23 Note: when such suspicious circumstances arise, the European Court has tended to find violations of the right to life, a notable example being *Anguelova v Bulgaria,* no.38631/97, 13 September 2002.

24 *McKerr v United Kingdom* (2002) 34 EHRR 20, [127].

25 *Jordan v United Kingdom* (2001) 37 EHRR 52, [105], [133]; see also *Nachova v Bulgaria* (2006) 42 EHRR 43.

28. The next-of-kin have a legitimate interest in an investigation capable of leading to a determination of whether the force used was justified and the identification and punishment of those responsible. Further, as noted above (paragraph 14(e)), the 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'.[26]

29. A coronial inquest is an appropriate forum for the involvement of the next-of-kin. In addition, in many circumstances the co-operation of the next of kin will also be of significance to the primary investigation. A primary investigative body that is independent (and is perceived to be so) will more readily secure the co-operation and confidence of the next-of-kin.

30. It is noted that 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.[27]

Recommendation 7:

Investigations into deaths associated with police contact should involve next-of-kin to the extent necessary to safeguard their legitimate interests.

Who should conduct primary investigations into deaths associated with police contact in Victoria?

31. HRLRC considers that currently there is no body or institution in Victoria that is appropriately independent, empowered and resourced to discharge the state's obligation to investigate deaths associated with police contact. The Victorian Government should either establish a new body or provide an existing independent body with appropriate resources and powers. The OPI and the proposed Victorian Integrity and Anti-Corruption Commission (**VIACC**) are considered briefly in the following paragraphs.

32. HRLRC considers that the OPI is sufficiently independent to investigate deaths associated with police contact. However, the OPI has shown in the context of this Inquest that it is unable to conduct adequate and effective investigations as it is neither expressly empowered to investigate deaths in custody nor resourced to undertake that role.

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26 *R (Amin) v Secretary of State for the Home Department* [2003] 4 All ER 1264, [2003] UKHL 51, [31] (Bingham LJ).

27 *Ramsahai v Netherlands* [2007] ECHR 393, [348]-[349].

33. The OPI is empowered to investigate allegations of 'serious misconduct' and 'corruption'. Arguably 'serious misconduct' could include deaths associated with police contact. However, in practice, investigations into deaths associated with police contact are conducted by the Coroner, with the primary, on-the-ground investigation undertaken by the Homicide Squad with oversight by ESD. The OPI does not currently play a role in investigating deaths in custody, and it is not resourced to do so.[28]

34. HRLRC considers that, to become an appropriate Independent Body, the OPI would require a fundamental change to the investigative mandate it currently has and to its funding and operations. As outlined above, the Independent Body would be required, among other things, to become the primary investigator of deaths in custody and to attend the scenes of incidents to collect and preserve evidence.

35. On 2 June 2010, Premier John Brumby announced the creation of VIACC.[29] Legislation to establish VIACC is not expected to pass until late 2011.[30] The Director, Police Integrity, will be one of the three independent officers comprising VIACC. It is intended that VIACC will oversee the workings of, among other things, the OPI and will have the power to search homes and force witnesses to answer questions in closed hearings.[31] New powers to be given to the OPI to investigate unsworn officers working for Victoria Police were also announced. [32]

36. On the basis of current information, it does not seem that VIACC will have the necessary powers and resources to conduct human rights-compliant investigations of deaths in custody. Further, there is no indication that human rights-compliant investigation of deaths associated with police contact is the intended role of VIACC.

37. However, as with the OPI, if VIACC were adequately empowered and resourced, in accordance with the principles set out above, then it may be an appropriate body to discharge the State's responsibility to ensure independent investigations of deaths in custody.

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28 As explained in paragraphs 10 – 12 above, oversight of a police investigation by an independent body has been found to be insufficiently independent to satisfy the requirements of the right to life.

29 *Government adopts the Proust Integrity Model* (2 June 2010) The Premier of Victoria, available at http://www.premier.vic.gov.au/component/content/article/10643.html.

30 Stephen McMahon with APP, 'Anti-corruption commission to be established in Victoria targeting judges, police and MPs', *Herald Sun,* 4 June 2010, available at http://www.heraldsun.com.au/news/proust-review-into-states-anti-corruption-bodies-due-today/story-e6frf7jo-1225874510277.

31 Ibid.

32 Ibid.

Recommendation 8:

The Victorian Government should either establish a new body or provide an existing body, such as the OPI, with appropriate resources and powers to operate as the Independent Body responsible for investigating deaths associated with police contact. The Independent Body must have all the features to ensure that investigations are independent, effective, adequate, prompt, subject to public scrutiny and involve the family of the deceased.

The importance of civilian investigators

38. HRLRC maintains that any Independent Body involved in the investigation of deaths associated with police contact should engage appropriately trained and experienced civilians as investigators. It is acknowledged that former police officers will be a necessary part of the staff of an Independent Body, particularly at the outset. However there are many civilians with the appropriate forensic skills and expertise to train as investigators. The reasons for encouraging the engagement of civilian investigators are two-fold:

- First, they will more readily be accepted to be independent from the police. This assists in building confidence in the Independent Body in the eyes of the public at large. It also removes barriers to witnesses candidly supplying information through their reluctance to disclose information to police.
- Second, it may be expected that some former police officers will identify institutionally with the officers the subject of their investigation in the manner described in the extract from the report of the Queensland Crime and Misconduct Commission cited at paragraph 6 above.

Recommendation 9:

The Independent Body should, whenever possible, engage qualified and competent civilians to act as investigators.

Management of police officers involved in the incident

39. A critical question to be answered in respect of deaths associated with police contact will generally be: what was known by the police and were the acts or omissions of police members reasonable, proportionate, and lawful in the circumstances? Perhaps the most significant source of the information required to answer those questions will be the police members themselves. Particular care is needed to protect the integrity of the evidence that police members have to give.

40. For the purposes of investigations into deaths associated with their conduct, police members should be treated no differently to members of the public involved in criminal investigations. If police are suspects in an investigation, they should be treated as such. If they are witnesses to an incident, then they should be treated as witnesses.

41. To treat police members more favourably could impact upon the effectiveness of investigations into deaths associated with police contact. Further, any preferential treatment of police witnesses or suspects would undermine public trust in the system of justice and increase perceptions of corruption and collusion.

42. It will occasionally be necessary for police involved in a death to secure the evidence at the scene. This should only occur where no other police are present, only for the purpose of preserving evidence, and only for the limited period of time necessary for other police officers or the Independent Body to arrive. They should not discuss their observations with other potential witnesses, whether fellow police members or members of the public. They should be relieved of this task and separated as soon as other officers arrive at the scene. As mentioned above, the Independent Body should be able to attend the scene of deaths in custody and take carriage of the investigation within the first hour of the incident.

43. Police interviews must be video recorded and, where reasonably practicable, police suspects and witnesses should be questioned within 24 hours of notification of the complaint/incident (subject to the right to refuse to answer questions on "self-incrimination" grounds[33]). Precautionary measures should be taken, such as separating police officers involved in deaths in custody as soon as the incident occurs and conducting separate interviews.

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33 As noted in paragraph 26 above, legitimate doubts will be raised about the integrity of the investigative process where the police officers involved in the circumstances of a death are not required to give evidence. Where a witness objects to giving evidence on grounds that the evidence may incriminate him or her, the Coroner may, if satisfied that there are reasonable grounds for the objection, issue a certificate under section 57 of the *Coroners Act 2008* (Vic) the effect of which is that the evidence cannot be used against the witness in a proceeding in any other court.

Recommendation 10:

Police officers involved in deaths associated with police contact should be treated no differently to members of the public involved in criminal investigations, subject to one exception. Police involved in a death associated with police contact may, in the absence of any other police in attendance, be required to attend to some policing of the scene, for example, to secure the evidence. This should only occur where: no other police are present, for the purpose of preserving evidence, and for the limited period of time necessary for other police officers or the Independent Body to arrive.

Recommendation 11:

Police statements must be video recorded and, where reasonably practicable, police suspects and witnesses should be questioned within 24 hours of notification of the complaint/incident. Precautionary measures should be taken immediately after a death associated with police contact, such as separating police officers involved in the deaths as soon as the incident occurs and conducting separate interviews.

Current Victoria Police Policy and Process

44. Deaths associated with police contact are currently investigated by the Homicide Squad, with oversight from ESD. In its "Review of investigation by Victoria Police of fatal shooting of Tyler Jordan Cassidy", the OPI noted that [redacted]

45. In any event, this structure for investigating deaths associated with police contact is not sufficiently independent of the police to discharge the state's investigative obligation under the right to life.

46. Neither internal nor external oversight can cure the deficiencies of an investigation of a death associated with police contact that is conducted by a department of the police or an associated body of the police. As noted at paragraphs 10 to 12 above, this proposition has been continually supported by European courts, which have established that it is not sufficient for an independent body to have oversight of an investigation, where the

34 [redacted]

investigation itself is carried out by police officers connected organisationally with those under investigation:[35]

Other models for investigating police related deaths

*Police Ombudsman of Northern Ireland (**PONI**)*

47. A prime example of an impartial and effective investigative body is the Police Ombudsman of Northern Ireland (**PONI**). The PONI arrive at a scene within an hour of any death or serious injury involving police and distinguish themselves from police officers by wearing orange jackets.

48. PONI investigators interview all police and civilian witnesses and, if there is an incident in which a civilian may be charged and police are investigating, the rule is the more serious allegation has primacy, which usually means the PONI investigation has primacy. Any information collected is then provided to the other team afterwards.[36]

49. PONI uses independent scientists and medical experts, attends most post mortems that are conducted by the state pathologist and is in charge of collecting evidence for the Coroner.[37] Further, PONI dedicates an overwhelming majority of its staff to public human rights complaints and runs a 24 hour response service.[38]

*Special Investigations Unit (**SIU**) (Ontario, Canada)*

50. The Special Investigations Unit (**SIU**) of the Canadian province of Ontario is an example of an investigative body that is appropriately independent from police and has the capacity and resources to conduct its own investigations.

51. The SIU was the first civilian agency in the world given the mandate to conduct investigations into the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by police officers. It was established in 1990

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35 *Jordan v United Kingdom* (2001) 37 EHHR 52, [120]; *McKerr v United Kingdom* (2002) 34 EHRR 20, [128]; *Kelly v United Kingdom* application no. 30054/96, 4 August 2001, [114].

36 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 (Tamar Hopkins), 21.

37 Ibid.

38 cf. OPI which only dedicates about 5% (that is, 7 out of 130) of its staff to public complaints: Tamar Hopkins, above n 7, 101.

by legislation.[39] It is headed by a director who is empowered to lay criminal charges against officers.[40]

52. Measures aimed at promoting institutional independence of the SIU from the police forces of Ontario are built into its establishing legislation. The director of the SIU may not be a police officer or a former police officer.[41] Serving police officers cannot be appointed as investigators,[42] and an investigator who is a former police officer cannot participate in an investigation relating to a police force of which he or she was once a member.[43] The legislation imposes on police officers a duty of co-operation with the SIU in the conduct of investigations.[44]

53. The SIU's budget has grown significantly to fund the proper discharge of its investigative function. At its inception the SIU had to rely on police services to collect and submit physical evidence. This meant a loss of control over the gathering of crucial physical evidence in its investigations. In 1992 the SIU gained its own in-house forensic investigation capacity. Today, the SIU has two full time forensic identification supervisors who oversee nine as-needed forensic identification investigators.

*Independent Police Complaints Commission (**IPCC**) (England and Wales)*

54. The Independent Police Complaints Commission (**IPCC**) of England and Wales was established by the *Police Reform Act 2002* (UK) and became operational in 2004. It handles complaints about police conduct and it also considers 'appeals' from the handling of complaints directly by the Professional Standards Department of the police. Its mandate is not confined to investigation of the use of force by police.

55. The IPCC does not provide a suitable model for an independent body for the investigation of deaths associated with police contact in Victoria. It appears to be compromised, among other things, by a failure to ensure organisational independence and the independence of its investigative staff, and by its broad and ill-defined role and objectives.

56. On 23 March 2010 the Home Affairs Committee of the House Commons (**the Committee**) published a report into the IPCC which concluded that the IPCC 'requires

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39 *Police Services Act* RSO 1990 (Ontario), Part VII.

40 Ibid, s 113(7).

41 Ibid, s 113(2),(3).

42 Ibid, s 113(3).

43 Ibid, s 113(6).

44 Ibid 113(9).

reform of some kind'.[45] It concluded that the IPCC was over-worked, particularly in its appeal function.[46] Although the IPCC had an independent investigative capacity, the IPCC conceded that investigative delays were often connected to its reliance on outside expert and forensic evidence.[47]

57. The Committee found evidence of unsatisfactorily long time periods to resolve complaints and insufficient disclosure of information to parties with an interest in the investigation process.[48]

58. The IPCC was criticised for a lack of independence as an organisation and for the manner of its use of former police officers as investigators. It was suggested that the IPCC should be removed from the remit of the Home Office (which also incorporated the police) and into the Ministry of Justice.[49] The Committee expressed shock that a situation had been allowed to develop where former police officers could end up investigating possible ex-colleagues in their former force.[50]

59. The criticisms of the IPCC demonstrate the importance of a clear mandate and of structural and staff independence in building confidence in the investigative process. The IPCC has clearly not built a public perception of independence. The Committee noted evidence it had received reflecting perceived institutional bias by the IPCC against complainants.[51] The evidence from complainants and their representatives suggested that the IPCC was not perceived as exhibiting objectivity and impartiality to users.[52] The Committee recorded 'repeated evidence that the IPCC is too close to the police and has not yet established an independent, corporate identity separate from the police complaints service'.[53]

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45 Home Affairs Committee, House of Commons *The Work of the Independent Police Complaints Commission* [2010] HC 366 (23 March 2010) available at http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhaff/366/366.pdf .

46 Ibid [45].

47 Ibid [17].

48 Ibid [20].

49 Ibid [42].

50 Ibid [31].

51 Ibid [22].

52 Ibid [33].

53 Ibid [42].

Australian investigation models

60. No Australian jurisdiction currently has a human rights-compliant system for investigating deaths in custody. Following three coronial inquests into the death of Mulrunji in police custody on Palm Island, and serious misgivings about the investigation by the Queensland Police Service of that case, on 18 May 2010, the Crime and Misconduct Commission (**CMC**) took over the role of investigating deaths in police custody from the Queensland Police Service. [54]

61. The CMC is yet to finalise its processes for investigations of deaths in custody. Whilst the CMC is institutionally independent of the Queensland Police Service, on the basis of public statements to date, the CMC is probably not practically independent from the Queensland Police. There are Queensland Police officers seconded to the CMC and further, the Queensland Police will continue to assist the CMC with investigations into deaths in police custody, which will encourage the perception of bias. [55]

62. While the recent broadening of CMC's powers is a useful example of steps which can be taken to overcome perceptions of police bias, it still falls short of the standard of independence required in Victoria. In order to comply with its obligations under the Victorian Charter, the Victorian Government needs to adopt a model for investigating deaths in custody which is independent in the sense discussed in this submission.

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54 This decision was made following findings from the coronial inquest into the death in custody of Mulrunji Doomadgee on Palm Island: Cameron Atfield, 'CMC to investigate custody deaths', *brisbanetimes.com.au,* 18 May 2010, available at http://www.brisbanetimes.com.au/queensland/cmc-to-investigate-custody-deaths-20100518-vaxq.html.

55 Cameron Atfield, at n 54 above; *Frequently asked questions – Is the CMC another police force?,* Crime and Misconduct Commission, available at http://www.cmc.qld.gov.au/asp/index.asp?pgid=10698&cid=5266&id=121..