UN communication lodged by Shani Cassidy

Background

Tyler Cassidy was 15 years old when he was shot by members of Victoria Police in December 2008.

The primary investigation into his death was undertaken by Victoria Police. This is because Victoria does not have a model for the independent investigation of deaths associated with police contact. Although an inquest was ultimately held (almost two years later), the State Coroner relied upon the brief of evidence prepared by Victoria Police.

The State Coroner handed down her findings in the inquest on 23 November 2011. She found that the Victoria Police officers involved in Tyler's death had acted within the limitations of the training and skills provided to them by Victoria Police (at [463]).

The Coroner identified a number of aspects of the Victoria Police investigation which she acknowledged undermined the public perception of competency and transparency of the investigation. She declined, however, to investigate and comment on the way in which "police contact related" deaths are investigated in Victoria.

The existing model of "police investigating police" in Victoria has long been criticised. This model breaches the right to life which, since 2006, has been enshrined in Victorian law following the enactment of the *Charter of Human Rights and Responsibilities Act 2006* (Vic). The Victorian Government has taken no steps to correct this breach by introducing a model for the independent investigation of police contact related deaths.

On 3 September 2013, Shani Cassidy submitted a communication to the United Nations Human Rights Committee (***Human Rights Committee***) on behalf of her son, Tyler. The communication seeks a finding that Australia breached its human rights obligation by failing to ensure that there was an independent and effective investigation into Tyler's death.

Recent developments

In December 2014, the Human Rights Committee transmitted to Mrs Cassidy a copy of the Australian Government's submission in response to her communication. Australia submits that Mrs Cassidy's communication is not admissible for determination by the Human Rights Committee because Ms Cassidy has not exhausted the remedies available to her in Australia (as required by Article 5 of the First Optional Protocol). Australia also submits that even if Mrs Cassidy's communication is admissible, her allegation that Australia violated its obligations under Article 6(1) of the ICCPR by failing to ensure an effective and independent investigation into Tyler's death is without merit. The Australia Government rejects Mrs Cassidy's submission that "independence" requires that all aspects of an investigation be conducted by an entirely separate body and submits that the investigation into Tyler's death was sufficiently independent to satisfy the requirements of the right to life under Article 6(1). In its submission the Australian Government acknowledges the "regrettable practices"

that occurred during the investigation into Tyler's death, and refers to a number of changes which are said to have been made to investigative processes since Tyler's death.

On 10 March 2015 Mrs Cassidy submitted a reply submission to the Human Rights Committee. In her reply, Mrs Cassidy sets out why her communication is admissible. Mrs Cassidy reiterates that investigations of the use of lethal force by police will lack sufficient independence if they are carried out by members of the same police force, even where the investigators work in a different department or if an independent body has oversight of the investigation. Mrs Cassidy maintains that Australia violated Article 6(1) by failing to ensure a hierarchically, institutionally and practically independent investigation into Tyler's death. Her reply submission notes that changes made to investigative processes since Tyler's death are not relevant to the question of whether Australia breached its obligations in connection with the investigation into Tyler's deaths. Further none of these changes remedy the fundamental defects in the investigative model that gave rise to the breach of Article 6(1).

The Human Rights Law Centre has assisted Mrs Cassidy in making the communication and preparing her reply to the Australian Government's submission to the Human Right Committee.

Mrs Cassidy hopes that, as a result of this communication, Federal and State governments will establish independent models for investigating deaths associated with police contact, so that victims' families and the public generally can have confidence that such deaths are being effectively and impartially investigated.

What is the legal basis for the communication?

The communication alleges that Australia has violated the *International Covenant on Civil and Political Rights* (***ICCPR***) by failing to ensure an independent and effective investigation was conducted into Tyler's death. An independent and effective investigation of deaths associated with police contact is required by the right to life, enshrined in Article 6(1) of the ICCPR.

The right to life obliges Australia to provide a legal system which protects life. As part of this obligation, the State is required to ensure an impartial, effective and timely investigation where State agents have been directly involved in a death.[1] International law and jurisprudence requires that the investigation:

- be hierarchically, institutionally and practically independent;
- be adequate and effective;
- be open to public scrutiny;
- be prompt and carried out with reasonable expedition; and
- involve the next-of-kin.

Mrs Cassidy and the Human Rights Law Centre believe that Australia has violated these obligations in relation to the investigation into Tyler's death. Most significantly, the investigation was not conducted by an independent body, but was conducted by the same institution of which the police officers who shot Tyler were members.

Why has the communication been made to the Human Rights Committee?

Mrs Cassidy has submitted this communication to the Human Rights Committee because there are no effective remedies available to her under Australian law.

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[1] Human Rights Committee, *Views: Communication No 942/00*, 98th session, UN Doc CCPR/C/98/D/1619/2007 (11 May 2010).

The Human Rights Committee is a body of independent experts mandated to monitor the implementation of the ICCPR: http://www2.ohchr.org/english/bodies/hrc/. It has the power to examine complaints made by individuals about a violation of the ICCPR.

Australia ratified the ICCPR in 1980 and submitted to the jurisdiction of the Human Rights Committee when it became a party to the First Optional Protocol in 1991.

What can the Human Rights Committee do?

The Human Rights Committee is able to make a finding that Australia has violated the ICCPR. If it makes such a finding, it can also recommend that Australia take specific remedial action. Recommended remedies may include, for example, that legislation be enacted to ensure an independent and effective investigation is conducted into all deaths associated with police contact, and that a public apology be made to Mrs Cassidy.

The Human Rights Committee is not able to compel the Australian Government to act on its findings or recommendations. However, a finding by the Human Rights Committee that Australia has violated the ICCPR would be a strong condemnation of Australia's compliance with its international legal obligations and also its commitment to protecting and promoting human rights.

Key facts about Tyler's death and the investigation of his fatal shooting

Fifteen year old Tyler was shot dead by members of Victoria Police on 11 December 2008. 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.

Tyler was alone and armed with two large knives when police located him at the All Nations Park in Northcote, Victoria. 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. The officers did not ask Tyler his name or age during their engagement with him.

In Victoria, there is no independent investigative body mandated to investigate deaths associated with police contact. Mrs Cassidy requested that the Office of Police Integrity (***OPI***)[2] assume the conduct of the investigation, but the OPI (now defunct) declined to do so. Instead, the primary investigation into Tyler's death was conducted by Victoria Police investigators.

Following the primary investigation, Victoria Police prepared a brief of evidence on which the then State Coroner relied at the inquest.

At the inquest into Tyler's death, both the Cassidy family and the Human Rights Law Centre identified a number of deficiencies in the primary investigation:

- The police officers involved in the shooting were not treated as suspects at any stage during the investigation. In contrast to the policy regarding interviews of significant witnesses of homicides, the interviews of the police officers were not audio or video recorded. Each officer refused to have their statement audio or video recorded, and instead provided a written statement. They were not compelled to submit to an audio or video recording.

  In relation to this issue, the Coroner observed (at [614]):

  > "…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."

[2] As of 11 February 2013, the former OPI oversight functions were transferred to the Independent Broad-based Anti-corruption Commission.

The lead investigator into Tyler's death from the Homicide Squad stated to the Coroner that there was no evidence to doubt that the four 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. However, his conclusion was drawn largely from the statements of the police officers themselves rather than after any independent investigation of the events that took place.

- There were delays in contacting the Major Crime Desk and the Homicide Squad.
- Drug and alcohol testing of the officers did not occur until more than 8 hours after the shooting. Notably on this issue, the Coroner observed (at [651]):

> "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. Delays in the calling out of specialist forensics services do nothing to enhance either the perception of competency or transparency."

- There were issues with the timeliness with which and the manner in which witnesses were identified. In regard to the call for witnesses, the Coroner commented (at [658]):

> "Whilst I did not conclude in this investigation that it was compromised by a failure to make a general call for eye witnesses, as a matter of principle, in a situation such as this, members of the public with information should be requested to provide it to a designated member or contact number. It is done regularly for police investigations generally and to do any less for an investigation of this nature appears unbalanced."

- One of the officers involved was left unsupervised at the scene and had contact with a number of witnesses. On this issue, the Coroner observed (at [493]):

> "Clearly, it was a mistake and not appropriate for the investigation, nor for the welfare of [the police officer], that she was left standing in the car park for half an hour in the wake of the shooting. It was 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 of witnesses of what they head 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."

- In breach of the Victoria Police Media Protocols for Incidents Involving Police and the Coroner, Victoria Police failed to seek the Coroner's approval prior to releasing a media statement on the evening of the shooting. The media statements released by Victoria Police 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, before an investigation had even taken place.
- The investigators from the Homicide Squad covertly recorded interviews and meetings they had with the Cassidy family, without the family's knowledge or permission. On this issue, the Coroner commented (at [636]):

> "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."

The Coroner declined to make any general comments or recommendations in relation to the model of "police investigating police" which exists in Victoria. She did, however, make the following recommendations:

Recommendation 7

> To ensure the immediate and ongoing welfare of the family of the deceased in a police contact related death and to guide the timing and need for the family to proceed to make an immediate statement, I recommend that Victoria Police arrange for a suitable welfare person to attend and assist the family at the scene and be available to them thereafter.
>
> **Recommendation 8**
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> To allay perceptions regarding collusion and bias, without compromising the coherence of the account given 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.

In its response to the Coroner's recommendation, the Victorian Department of Justice stated it did not proposed to adopt Recommendation 8, but would keep the issue under review for future consideration.[3]

The need for an alternative model of investigation of police contact related deaths

The history of an ongoing, significant incidence of fatal shootings by Victoria Police in particular, and numerous reviews that have made recommendations which have not been effectively implemented by Victoria Police, demonstrates the urgent need for an independent and effective model of investigation to be implemented to uphold the right to life.

A 2009 OPI review into the use of force by and against Victoria Police in 2009 found "there had been a proliferation of reviews finding that Victoria Police is not effectively managing the risks associated with the use of force" and that "Victoria Police seemed to lack the will or capacity to implement solutions to effectively address the identified problems".[4]

A further review by the OPI in 2011 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".[5]

The OPI identified five principles as underpinning an optimal investigative framework - independence, effectiveness, promptness, next of kin involvement and sufficient public scrutiny and concluded that the current legislative framework in Victoria is "not optimal".[6]

There are, on average, 16 deaths in Victoria each year associated with police use of force, police pursuits, police custody and police operations.[7] Mrs Cassidy and the Human Rights Law Centre

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[3] Letter from Dr Claire Noone, Acting Secretary, Victorian Department of Justice to Her Honour Judge Jennifer Coate, Victorian Coroner (28 September 2012).

[4] Office of Police Integrity Victoria, Review of the Use of Force by and against Victoria Police, July 2009, 14. 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.

[5] Office of Police Integrity, Review of the investigative process following a death associated with police contact, June 2011, 8. Available at http://www.ibac.vic.gov.au/docs/default-source/opi-parliamentary-reports/review-of-the-investigative-process-following-a-death-associated-with-police-contact---tabled-june-2011.pdf?sfvrsn=4.

[6] Ibid.

[7] Ibid, 21.

believe this figure clearly justifies the establishment and resourcing of an independent investigative body.

As numerous domestic reviews have failed to stem the high incidence of fatal police shootings in Victoria, Mrs Cassidy and the Human Rights Law Centre have turned to the Human Rights Committee, in the hope that the international community will be able to encourage Australian governments to introduce systemic change.

Examples of independent models of investigation of police conduct related deaths

Independent models of investigating police conduct related deaths have been established in a number of jurisdictions:

- Northern Ireland established the Police Ombudsman of Northern Ireland (***PONI***) in 2000, which has investigated all deaths in which police were or appeared to be involved or implicated. PONI investigators are independent from the Police Service of Northern Ireland.
- England and Wales established the Independent Police Complaints Commission, which, since 2004, has investigated deaths in police custody or in which police were implicated.
- Ontario, Canada, has established the Special Investigations Unit, which is an independent law enforcement agency that investigates serious injury and deaths involving police officers.
- New Zealand has established the Independent Police Conduct Authority which, since 2007, has investigated deaths and serious bodily injuries which police officers caused, or appeared to have caused.

Further, following the death of Mulrunji on Palm Island in 2004, the Queensland Coroner has been given primary responsibility for the investigation of deaths in custody in Queensland.[8] The Queensland model does not fully meet the requirements of an independent and effective investigation as required by Article 6(1) of the ICCPR. However, it provides an example of an incremental step that can be taken to improve the investigation of police contact related deaths.

[8] Independent Expert Panel, 'Simple Effective Transparent Strong: an independent review of the Queensland police complaints, disciple and misconduct system, 2011. Available at: www.premiers.qld.gov.au/publications/categories/reviews/qps-complaints.aspx