Communication No. 2296/2013

Submitted by Ms Shani Cassidy in her own name and on behalf of Mr Tyler Jordan Cassidy

under the First Optional Protocol to the

International Covenant on Civil and Political Rights

Australian Government Submission

on Admissibility and Merits

to the United Nations Human Rights Committee

Office of International Law

Attorney-General's Department

Canberra

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INTRODUCTION

1. By letter dated 29 October 2013, the Secretariat of the United Nations, Office of the High Commissioner for Human Rights, conveyed to the Australian Permanent Mission to the United Nations Office in Geneva the text of Communication No. 2296/2013 concerning Australia. The communication was submitted to the Human Rights Committee under the First Optional Protocol to the International Covenant on Civil and Political Rights by Ms Shani Cassidy (the author) on both her behalf and on behalf of her deceased son, Mr Tyler Jordan Cassidy (Mr Cassidy), through her representative, Ms Anna Brown, Director of Advocacy & Strategic Litigation at the Human Rights Law Centre.

2. In accordance with rule 97, paragraph 2 of the Committee's Rules of Procedure, the Committee requested that Australia submit to it information and observations in respect of both the admissibility and merits of the author's allegations, which are the subject of the communication, by no later than 31 October 2014.

3. Australia acknowledges the tragic circumstances of Mr Cassidy's death, and expresses its sympathy to Mr Cassidy's mother, Ms Cassidy, and to Mr Cassidy's family and friends.

4. Having given careful consideration to each of the author's allegations in the communication, Australia respectfully submits that they are inadmissible, and should be dismissed by the Committee without consideration of their merit. Should the Committee take the view that any of the allegations are admissible, Australia further submits that each of the claims should be dismissed for lack of merit.

5. The Australian Government notes that these submissions have been prepared in consultation with the Government of the State of Victoria.

SUMMARY OF ALLEGATIONS AND AUSTRALIAN GOVERNMENT RESPONSE

A. Allegations

6. The author alleges that Australia has breached articles 2, 6(1) and 14 of the International Covenant on Civil and Political Rights.[1] The alleged violations of these articles of the Covenant arose from the fatal shooting of Mr Cassidy by Victorian Police officers in 2008. The author alleges that Australia 'failed to ensure an effective and independent investigation' into the death of her son, Mr Cassidy, as required by articles 6(1) and 14 of the Covenant, and consequently is in breach of article 2, by not providing an effective remedy.[2]

Article 6(1)

7. The author argues that Australia, by failing to ensure an effective and independent investigation, failed to fulfil its obligations under article 6 of the Covenant to protect Mr Cassidy's right to life.

8. The author has not asked the Committee to determine whether or not a breach of the 'substantive obligations' imposed by article 6(1) of the Covenant occurred.[3] That is, whether or not Mr Cassidy was arbitrarily deprived of his life. Rather, the author submits that the alleged breach under article 6(1) that resulted from the circumstances of Mr Cassidy's death was a failure to provide a sufficiently independent investigation into the circumstances of Mr Cassidy's death.[4]

Article 14

9. The author argues that the right to a fair and public hearing into Mr Cassidy's death was not effectively guaranteed because the investigation into the death 'meant that the subsequent Inquest was itself not sufficiently independent and impartial'.[5]

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[1] Submission by Ms Shani Cassidy, represented by Ms Anna Brown, Human Rights Law Centre, *Cassidy v Australia* (Communication No 2296/2013), 3 September 2013, paragraphs 9–12, 138–139 (Author's submissions).
[2] Author's submissions, paragraph 138.
[3] Author's submissions, paragraph 148.
[4] Author's submissions, paragraph 148.
[5] Author's submissions, paragraph 229.

Article 2

10. The author further alleges that Australia has not remedied this alleged failure to adequately investigate Mr Cassidy's death, as required by article 2, and has therefore breached the author's right to access to justice under article 2(3) of the Covenant.[6]

Remedies sought

11. The remedies sought by the author are, that:

    I. 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).

    II. Australia make a public apology and reparations to the author for its failure to ensure an effective and independent investigation of Mr Cassidy's death.[7]

B. Australian Government Response

12. Australia respectfully submits that the allegations made by the author are inadmissible and are without merit.

13. Australia argues that the author's allegations are inadmissible because, firstly, the author has failed to exhaust domestic remedies and, secondly, the author has failed to substantiate her claims.

14. Australia further submits that the allegations that it has violated articles 2, 6(1) and 14 of the Covenant are without merit, as the coronial investigation into the death of Mr Cassidy was independent and effective and constituted an effective remedy.

[6] Author's submissions, paragraph 138.
[7] Author's submissions, paragraph 246.

OUTLINE OF FACTS

15. This section sets out the relevant facts surrounding Mr Cassidy's death and the investigation into Mr Cassidy's death.

A. Circumstances of the shooting

16. Mr Cassidy was fatally shot by police officers of Victoria Police on the evening of 11 December 2008 at All Nations Park, Northcote, in the State of Victoria, Australia. Mr Cassidy was 15 years old when he died.

17. The circumstances surrounding Mr Cassidy's death were considered by the Coroner during the coronial investigation into Mr Cassidy's death. These circumstances are outlined in detail in the Coroner's findings, published on 23 November 2011. Australia accepts the facts as outlined in the Coroner's findings. As described in the Coroner's findings, immediately before Mr Cassidy was fatally shot, he was advancing on a police officer, with knives pointed at, and making threats to kill, that police officer. The police officers present had attempted non-lethal responses to Mr Cassidy's actions, including deploying oleoresin capsicum spray. The Coroner found that police fired at Mr Cassidy at a time when a police officer was 'in immediate and perilous danger of serious injury or death'.[8]

B. Investigation of Mr Cassidy's death

18. The then-State Coroner, Judge Jennifer Coate, conducted the coronial investigation into Mr Cassidy's death.[9] The State Coroner presides over the Coroners Court of Victoria. The Coroner conducted the investigation pursuant to the *Coroners Act 2008* (Vic).[10]

19. The Coroners Court of Victoria is a specialist inquisitorial court comprising independent judicial officers responsible for investigating deaths and making recommendations for the prevention of deaths. In Victoria, all police shooting deaths are investigated by way of a coronial investigation, which includes a mandatory public inquest.[11] The Coroner must find

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[8] Judge Jennifer Coate, Coroners Court of Victoria, *Redacted Finding into Death with Inquest: Tyler Jordan Cassidy*, Court Reference: 5542/08 (23 November 2011), paragraph 461 (Inquest Findings).

[9] As a judicial officer, the State Coroner was afforded the legislative and common law protection of judicial office, including tenure, powers and immunities, and legislatively protected remuneration.

[10] The investigation commenced under the *Coroners Act 1985* (Vic), and transitioned to the *Coroners Act 2008* (Vic), which commenced operation on 1 November 2009.

[11] The only relevant exception to the requirement to conduct an inquest is where a person has been charged with a criminal offence in respect of that death: *Coroners Court Act 2008* (Vic), section 53(2)(b).

if possible, the identity of the deceased, the cause of death and the circumstances in which a death occurred. How a Coroner exercises control over the coronial investigation (including the conduct of the inquest) in any particular case is a matter for the Coroner's discretion as a judicial officer.

20. The Coroner was in charge of and led the coronial investigation into Mr Cassidy's death from the night of the incident, when the Coroner was first notified of the death, to the delivery of the Coroner's inquest findings.

Assistance to the Coroner

21. The Coroner was assisted in her investigation by an independent Counsel Assisting (a barrister) from the Victorian Bar and solicitors from a legal firm. The Victorian Institute of Forensic Medicine and the Victoria Police Homicide Squad produced and gathered evidence for, and on behalf of, the Coroner.

22. The Victorian Institute of Forensic Medicine comprises professional medical and scientific specialists. These specialists conducted forensic medical examinations for, and on behalf of, the Coroner. At the discretion of the Coroner, information and reports prepared by the Victorian Institute of Forensic Medicine formed part of the inquest brief.

23. The Victoria Police Homicide Squad comprises specialist death investigators. A detective from the Victoria Police Homicide Squad was nominated as the Coroner's investigator to gather evidence for, and at the direction of, the Coroner. The Coroner's investigator had full access to the investigative resources of Victoria Police. The Coroner's investigator may also exercise any special powers granted by the Coroner under the Coroners Act. The Coroner's investigator can be directed, at the Coroner's discretion, to pursue particular lines of inquiry, timing and approaches. At the discretion of the Coroner, information, reports and witness statements prepared by the Coroner's investigator formed part of the inquest brief.

Oversight and integrity

24. The Victoria Police Ethical Standards Department[12] and the Office of Police Integrity[13] provided oversight and integrity functions relating to the conduct of the Coroner's investigator. These bodies have no jurisdiction to oversee the exercise of the Coroner's judicial discretion or decision-making, or the conduct of staff at the Victorian Institute of Forensic Medicine. These additional functions are an acknowledgement of the potential for real or perceived conflicts of interest to arise where specialist police investigators gather evidence in relation to a police contact death.

25. The Ethical Standards Department prepared an oversight file, detailing compliance with practices, policies and the impartiality of police action. This file was provided to the Coroner. The Coroner determined that the file should form part of the inquest brief.

26. The Office of Police Integrity was an independent integrity body that, at the time of the investigation into Mr Cassidy's death, oversaw the conduct of police in Victoria. The Office of Police Integrity oversaw the conduct of the Coroner's investigator and the functions of the Ethical Standards Department. The Office of Police Integrity conducted a review into the actions of the Coroner's investigator and the oversight role of the Ethical Standards Department in relation to Mr Cassidy's death. The report, *Review of Investigation by Victoria Police of Fatal Shooting of Mr Tyler Jordan Cassidy* (2010) was provided to the Coroner. The Coroner determined that the report would form an exhibit at Mr Cassidy's Inquest.

27. The Office of Police Integrity also conducted a broader review of the way in which deaths associated with police contact were being investigated at that time in Victoria. The report, *Review of the investigative process following a death associated with police conduct* was tabled in Parliament in June 2011. This report was tabled after Mr Cassidy's Inquest.

The inquest

28. The Coroner conducted the inquest into the death of Mr Cassidy over 41 days of public hearings held between 19 October 2010 and 11 March 2011. Mr Cassidy's family

[12] The Ethical Standards Department is now the Professional Standards Command.

[13] The functions of the Office of Police Integrity are now the responsibility of the Independent Broad-based Anti-corruption Commission. The Office of Police Integrity was replaced by the Independent Broad-based Anti-corruption Commission on 10 February 2013.

exercised their right to be involved in the coronial investigation as interested parties. The family was represented by legal counsel at the inquest (and at preliminary hearings) and was provided the inquest brief. Family members also exercised their right to make submissions about all aspects of the inquest, including the scope of the inquest and potential witnesses, as well as cross-examination of those witnesses and submissions as to the findings the Coroner ought to make on the evidence available.

29. The Coroner considered a broad range of evidence at the inquest. The final inquest brief was in excess of 3760 pages. It included approximately 115 witness statements and 121 exhibits, and included statements from the police officers involved in the shooting. The inquest produced a further 4499 pages of evidence (recorded on transcript) based on the examination (and cross-examination) of witnesses, the submissions from interested parties, as well as the production of further documents which became part of the evidentiary material. Police officers involved in the shooting gave oral testimony at the inquest and were subjected to questioning and cross-examination by the Coroner, Mr Cassidy's family and other interested parties.

30. The scope of the inquest was broad and included the circumstances of Mr Cassidy's death, whether the use of force was justified and whether anything could be done to avoid such a situation in the future. The Coroner also critically examined the process of gathering evidence for a coronial investigation. This line of enquiry addressed competency, adequacy, and impartiality in how evidence was collected, obtained or potentially compromised as it was produced, as well as practices that support the coronial process itself.

31. The Coroner handed down her findings on 23 November 2011. The Coroner's findings are published on the Coroners Court website (http://www.coronerscourt.vic.gov.au/).

32. The Coroner's findings address the circumstances of Mr Cassidy's death and make broad comments and recommendations in respect of lessons learnt and changes that ought to be made in response to Mr Cassidy's death.

SUBMISSIONS ON ADMISSIBILITY AND MERITS

A. Admissibility

33. Australia respectfully submits that the author's allegations are inadmissible because, firstly, the author has failed to exhaust domestic remedies and, secondly, has failed to substantiate her claims.

34. Australia refers to the Committee's recent decision in *Hickey v Australia* in which it held that the communication was inadmissible under article 2 of the Optional Protocol to the Covenant.[14] The facts and claims alleged by the author of that communication, Ms Hickey, are analogous to this communication. They concern the independence of investigations of deaths involving police. Australia submits that the Committee should follow its views in *Hickey v Australia* in the present communication.[15] In *Hickey v Australia*, the Committee considered that the author had failed to sufficiently substantiate her claims and, on that basis, found her allegations inadmissible.[16] In particular, the Committee also appeared to attach importance to the author's failure to lodge an appeal against any aspect of the investigation or of the findings of the Coroner.[17]

a. Failure to exhaust domestic remedies

35. Australia submits that the author's claims under articles 2, 6(1) and 14 of the Covenant are inadmissible on the ground that she has not exhausted all domestic remedies as required by rule 96(f) of the Committee's Rules of Procedure and article 5(2)(b) of the Optional Protocol. Australia submits that the author has not properly made out her submission that all judicial and non-judicial domestic remedies that are reasonably available to her and could provide an effective remedy have been exhausted. The author has failed to exhaust remedies available through the following domestic bodies and processes:

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[14] Human Rights Committee, *Hickey v Australia* (Communication No 1995/2010), 5 September 2014 (Advanced unedited version) (*Hickey v Australia*).
[15] The Hickey communication was submitted on 14 February 2010 by Ms Elizabeth Hickey, on behalf of her deceased son, Mr Thomas Hickey. On 14 February 2004, Mr Hickey was riding his bicycle at high speed, and shortly after being observed by officers of the Police Force of New South Wales, he fell and was impaled on the poles of a metal fence. He died the following day. The author claimed that her son was a victim of a violation of his rights under articles 6 and 26, alone and in conjunction with article 2, of the Covenant.
[16] *Hickey v Australia* (1995/2010) paragraph 8.4.
[17] *Hickey v Australia* (1995/2010) paragraph 8.4.

- appealing the inquest findings, seeking a new inquest and seeking judicial review, and
- commencing a claim against the State of Victoria, the Coroner or Victoria Police.

36. Australia agrees that the administrative remedies raised by the author at paragraphs 101–135 of her submissions would not constitute effective remedies due to their 'recommendatory rather than binding effect', and does not press them.[18]

Failure to appeal against the inquest findings of the Coroner and seek judicial review

37. Australia argues that it is open to the author to appeal against the Coroner's findings in the inquest into Mr Cassidy's death and to seek a new inquest.

38. The Coroners Act provides for appeals from the Coroners Court of Victoria to the Supreme Court of Victoria on questions of law.[19] Part 7 of the Coroners Act contains appeal provisions in relation to the findings of a Coroner.[20] These relate to the mandatory matters that a Coroner must find; that is, the identity of the deceased, the cause of death and the circumstances in which the death occurred.[21] The Supreme Court may make any order that it thinks appropriate, including individual relief or remedy in the nature of certiorari, mandamus, prohibition or quo warranto.[22] The Supreme Court may also remit the matter for re-hearing with or without any direction in law.[23] An appeal must be made within six months of the determination of the Coroner, however, the Supreme Court may grant leave to appeal out of time.[24]

39. The author submits that it is not open to her to appeal the inquest finding and seek a new inquest because there are no new facts or circumstances to justify the Coroners Court reopening the investigation[25] and because the alleged violation does not relate to a question of law.[26] The author further submits that, even if there were new facts or circumstances, reopening the investigation would not redress the alleged breaches because it would be

[18] Human Rights Committee, *C v Australia* (Communication No 900/1999), 13 November 2002, paragraph 7.3.
[19] *Coroners Act 2008* (Vic), section 87(1).
[20] *Coroners Act 2008* (Vic), section 83.
[21] *Coroners Act 2008* (Vic), section 67(1).
[22] Supreme Court Rules (General Civil Procedures) Rules 2005, rule 56.01.
[23] *Coroners Act 2008* (Vic), section 87(4).
[24] *Coroners Act 2008* (Vic), sections 83(3), 86.
[25] *Coroners Act 2008* (Vic), section 77. This must also be determined to be appropriate.
[26] Author's submissions, paragraphs 83, 86, 89.

'tainted' by reliance on Victoria Police's brief of evidence, which the author argues does not meet the procedural obligations of article 6(1) of the Covenant.[27]

40. Without commenting on the merits of an appeal, Australia argues that the author could appeal against the Coroner's findings in the inquest into Mr Cassidy's death and seek a new inquest on the grounds that:

- the findings were not open on the evidence
- there was a failure to accord natural justice, or
- there was an 'insufficient inquiry'.

These three grounds are discussed in detail below. The Committee has previously expressed the view that it is incumbent on the author to pursue available remedies, including court proceedings, and that 'mere doubts about the effectiveness of domestic remedies do not absolve an author of the requirement to exhaust them'.[28]

Findings which are not open on the evidence

41. The Supreme Court of Victoria, a Court of record established by the *Constitution Act 1975* (Vic), and the Court of Appeal of Victoria, provide avenues of appeal over the judicial exercise of coronial powers. An appeal to the Supreme Court is an appeal on a question of law.[29] It is agreed with the author that she could not appeal an error of fact as it is not the function of the Supreme Court to conduct a merits review of a Coroner's decision. However, there is a ground for challenging factual findings where the Coroner's primary findings of fact were not open on the evidence before the Coroner.[30] If the author could establish that there was no evidence to justify certain findings made by the Coroner in relation to the adequacy of the primary investigation, such an appeal may have a reasonable prospect of success. A fact-finding error, in certain circumstances, can also be grounds for judicial review. It is open to the author to appeal on a question of law that the Coroner's

[27] Author's submissions, paragraph 87.
[28] Human Rights Committee, *Badu v Canada* (Communication No 603/1994), 18 July 1997, paragraph 6.2.
[29] *Coroners Act 2008* (Vic), section 87(1).
[30] *Thales Australia Ltd v Coroner's Court of Victoria* [2011] VSC 133, paragraphs 58–59.

findings were tainted by an incorrect finding of a jurisdictional fact.[31] The author has not done so.

A failure to accord natural justice

42. An important basis for an application to quash an inquiry and the findings of a Coroner is enlivened where there has been a failure to accord natural justice.[32] A relevant principle of natural justice requires the Coroner to conduct the inquest so that there would not be 'a reasonable apprehension that [the Coroner] might not bring an impartial and unprejudiced mind to the resolution of the question involved in it'.[33]

43. In the Australian case of *R v Matterson; ex parte Moles*, the Supreme Court of Tasmania considered an application for judicial review on the basis that the Coroner was not impartial and unprejudiced in relation to the evidence of a police officer in a case involving a fatal shooting by police.[34] The decision in *Matterson* is relevant in highlighting the availability of this ground of review. Accordingly, the author may have a basis for seeking review of the coronial findings in circumstances where the inquiry is said to be insufficiently independent and impartial. However, the author has not pursued such a remedy.

Insufficiency of inquiry

44. It may be held that there has been an 'insufficient inquiry' if a Coroner fails to deal with fundamental issues concerning the statutory obligations relating to findings.[35] Coronial investigations, if not properly carried out, can be challenged. If a Coroner's findings only address peripheral matters, or fail to deal with key issues concerning the circumstances in a way that meant a proper or sufficient inquiry did not take place, it is open for a party to appeal the inquest findings.[36]

45. Australian courts exercising supervisory jurisdiction over coronial inquiries have held that the absence of a sufficiently full inquiry may render the result of a coronial inquiry nugatory so that no miscarriage of justice results by leaving the findings intact.[37] For instance, the

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[31] *Minister for Immigration and Citizenship v SZMDS* [2010] HCA 16.
[32] *Annetts v McCann* [1990] HCA 57.
[33] *Livesey v New South Wales Bar Association* (1982–1983) 151 CLR 288, 294.
[34] *R v Matterson; Ex parte Moles* (1994) 4 Tas R 87.
[35] *R v Matterson; Ex parte Moles* (1994) 4 Tas R 87, paragraph 96; *In ex parte Routledge* (1943) 60 WN (NSW) 18.
[36] *In ex parte the Attorney-General* (1915) 15 NSWSR 355, 357.
[37] *In ex parte the Attorney-General* (1915) 15 NSWSR 355, 357.

Supreme Court of Tasmania has held that if evidence of a matter is controversial and central to the inquisition, but not referred to by the Coroner, the Court should exercise its supervisory jurisdiction and intervene.[38]

46. Accordingly, as the author appears to be of the view that the Coroner failed to deal with the competency, adequacy and impartiality of the police investigation into Mr Cassidy's death, then it may be available to her to pursue a claim on the grounds that there has been an insufficient inquiry. However, the author has chosen not to do so.

Remedies

47. Australia does not accept the author's submission that any new inquest would not offer 'a reasonable prospect of success' because it would still be reliant on the allegedly tainted inquest brief.[39] The Coroner has extensive powers of investigation when a new hearing is held, which are not limited to relying on any existing evidence including that gathered by Victoria Police. The Coroner can conduct further inquiries and exercise powers to gather evidence, compel documents and summon witnesses to answer questions.[40] Furthermore, the Coroners Act enables the Court to refer matters to prosecutorial bodies to consider whether criminal proceedings should be instituted.[41]

48. In response to the author's submission that the remedies available via these mechanisms are not capable of providing an effective remedy, Australia submits that the Supreme Court affords a range of remedies. The Supreme Court is able to quash the previous inquest findings and order for a new inquest to be conducted, both under the Coroners Act, and through common law remedies such as certiorari and mandamus.[42] A legally binding judicial determination that the original inquest was flawed would be a significant remedy.

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[38] *R v Matterson; Ex parte Moles* (1994) 4 Tas R 87.
[39] Human Rights Committee, *Pereira v Panama*, (Communication No 437/1990), 21 October 1994, paragraph 5.2.
[40] See 'Powers of Coroner' in Part 4, Division 4 and Part 5, Division 2 of the *Coroners Act 2008* (Vic).
[41] *Coroners Act 2008* (Vic), section 72(2).
[42] See *Coroners Act 2008* (Vic), section 87(2); Supreme Court Rules (General Civil Procedures) Rules 2005, rule 56.01; *Annetts v McCann* (1990) 170 CLR 596; *R v Matterson; ex parte Moles* (1994) 4 Tas R 87; *Ex parte Routledge* (1943) 60 WN (NSW) 184; *Ex parte A-G* (1915) 15 SR (NSW) 355; *Lange v Registrar-General* [1950] VLR 307; *R v Smith; ex parte S Mead* [1975] Tas NC 8.

Failure to pursue a civil claim or criminal prosecution

49. Australia accepts the author's submission that it is not open to her to pursue a claim against the State of Victoria on the basis of the *Charter of Human Rights and Responsibilities Act 2006* (Vic). Victoria does not allow for a stand-alone claim for damages for a breach of the 'right to life' under the *Charter of Human Rights and Responsibilities Act 2006* (Vic). However, it is open to the author to seek damages for wrongful death or negligence at common law, which she has not done.[43] A civil action could enable the author to obtain significant redress for any alleged wrongdoing associated with Mr Cassidy's death. For example, English courts have found civil damages to be an appropriate remedy for a substantive violation of the right to life in cases involving death through police negligence.[44]

50. The Victorian criminal justice system also provides a mechanism to prosecute murder and manslaughter (in relation to the death of Mr Cassidy), or offences in relation to any alleged improprieties of the investigation. Criminal prosecutions can be initiated by private citizens.[45] The author has not initiated such a prosecution.

Administrative remedies

51. The Committee has previously stated that an author must make use of not only all judicial but also all administrative avenues that offer him or her a reasonable prospect of redress.[46] Australia submits that one administrative remedy available to the author that would provide her with a reasonable prospect of success is to make a complaint to the Independent Broad-based Anti-corruption Commission. Australia understands that the author has not requested the Independent Broad-based Anti-corruption Commission to examine the investigation.

52. The author claims in her submissions at paragraph 114 that the Victorian Independent Broad-based Anti-corruption Commission only has the power to report and

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[43] See Human Rights Committee, *Gilberto François Croes v. The Netherlands*, (Communication No 164/1984), 7 November 1988, paragraph 10.

[44] See *Pearson v United Kingdom* [2011] ECHR 2319.

[45] The Director of Public Prosecution can intervene in a private prosecution at the committal proceeding stage, or at trial, with a view to continuing it themselves or, by offering no evidence, terminating it, see s 22(1)(b)(ii) of the *Public Prosecutions Act 1994* (Vic). More generally, see Richard G Fox, *Victorian criminal procedure: state and federal law*, 13th Edition, (2010), paragraph 2.3.1.

[46] Human Rights Committee, *Jonassen et al v Norway* (Communication No 942/2000), 25 October 2002, paragraph 8.6.

make non-binding recommendations and non-mandatory requests for action. To the contrary, the Independent Broad-based Anti-corruption Commission has broad jurisdiction to investigate police conduct. It has the capacity to conduct its 'own motion' investigation into various aspects of deaths associated with police contact or following a complaint. The Independent Broad-based Anti-corruption Commission may undertake a range of separate investigative action, including an independent investigation into all aspects of a police contact death.[47] The Independent Broad-based Anti-corruption Commission's referral powers enable it to refer matters to prosecutorial bodies to consider whether or not to institute criminal proceedings,[48] and can also initiate criminal proceedings as a prosecutorial body in its own right in relation to any matter arising out of an investigation.[49] It is true that a request to investigate will not automatically be granted. However, this domestic avenue would only have been exhausted if the author had made a request to the Independent Broad-based Anti-corruption Commission.

b. Failure to substantiate claims

53. Rule 96(b) of the Rules of Procedure requires the Committee, in reaching a decision on the admissibility of a communication, to ascertain:

> That the individual claims, in a manner *sufficiently substantiated*, to be a victim of a violation by that State party of any of the rights set forth in the Covenant.[50]

54. Australia notes that for the purposes of Article 2 of the Optional Protocol, a 'claim' is not merely an allegation, but 'an allegation supported by substantiating material'.[51] The Committee's previous views further suggest that an author must submit sufficient evidence in substantiation of his or her allegations as would establish a *prima facie* case.[52]

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[47] *Independent Broad-based Anti-corruption Commission Act 2011* (Vic), section 64(1)(c); Independent Broad-based Anti-corruption Commission, *Special report following* the Independent Broad-based Anti-corruption Commission's *first year of being fully operational* (2014), 13.

[48] *Independent Broad-based Anti-corruption Commission Act 2011* (Vic), section 74(1).

[49] *Independent Broad-based Anti-corruption Commission Act 2011* (Vic), section 190.

[50] Human Rights Committee, *Rules of Procedure of the Human Rights Committee*, CCPR/C/3/Rev.10 (11 January 2012), rule 96(b) (emphasis added).

[51] *Report of the Human Rights Committee* (Vol I) – 94th Session, 95th Session, 96th Session (2009), UN Doc A/64/40, paragraph 118.

[52] Statements by the Committee indicate that the author must 'submit *sufficient evidence* substantiating the allegation for purposes of admissibility': A/64/40 [118]; A/63/40 [108]; A/62/40 [119]; A/61/40 [115]. While these statements do not refer to evidence constituting a *prima facie* case, Australia assumes that, in effect, this is what is required.

55. For the reasons set out below in relation to the merits, Australia submits that the author has failed to provide sufficient evidence to substantiate her claims in relation to:

- Article 6(1) – The author has not been able to substantiate her claim that the investigation into Mr Cassidy's death was not independent or effective so as to breach article 6(1) of the Covenant.
- Article 14 – Australia submits that the right to a fair and public hearing by a competent, independent and impartial tribunal under article 14 of the Covenant does not apply to a coronial investigation.
- Article 2 – The author has not been able to provide evidence for her claim that Australia has breached the author's right to an effective remedy under article 2(3) of the Covenant by not remedying the alleged failure to investigate Mr Cassidy's death.

B. Merits

Article 6(1) – The right to life

56. Article 6(1) of the Covenant relevantly 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.

Allegations

57. The author claims that Australia has violated article 6(1) by failing 'to ensure an effective and independent investigation into the death of Mr Cassidy as required by Article 6(1)' of the Covenant.[53] The author submits that the right to life imposes obligations upon States that can be divided into 'substantive' and 'procedural' obligations.[54] According to the author, the substantive obligations imposed by the right to life under article 6(1) of the Covenant oblige Australia to ensure that:

- the right to life is protected by law
- no one is arbitrarily deprived of life, and
- appropriate legislative and administrative measures are taken to protect life and to guard against the arbitrary deprivation of life.[55]

58. The author states that she is not requesting the Committee to determine whether Australia breached the substantive obligations of article 6(1).[56] Rather, the author submits that a potential breach of article 6(1) arising from the death of Mr Cassidy engaged the procedural obligations of article 6(1).[57] That is, the author argues that Australia's duty to investigate Mr Cassidy's death in accordance with the procedural obligations imposed by article 6(1) was enlivened, and that Australia violated its obligation by failing to fulfil this duty.[58] For the record, Australia disputes that there was any 'potential breach' of article 6(1) involved in the death of Mr Cassidy.

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[53] Author's submissions, paragraphs 138–139.
[54] Author's submissions, paragraph 144.
[55] Author's submissions, paragraph 145.
[56] Author's submissions, paragraph 148.
[57] Author's submissions, paragraph 149.
[58] Author's submissions, paragraph 148.

59. The author submits that the procedural obligation to ensure an effective and official investigation where individuals have been killed as a result of the use of force by State agents derives from the positive obligations to provide a legal system of protecting life under article 6(1) of the Covenant.[59] Although acknowledging that '[t]here is no specific form of investigation necessary to satisfy the State Party's obligation to investigate a death involving State responsibility', the author submits that 'the investigation must:

- 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.'[60]

60. The author further submits that these procedural requirements apply to both primary and subsequent investigations.[61]

Australian Government Response

61. For the reasons discussed above, Australia's primary submission is that the communication is inadmissible. However, if the Committee finds that the author's claims under article 6(1) are admissible, Australia respectfully submits that these claims in relation to article 6(1) are without merit.

62. As a preliminary matter, Australia rejects the author's assertion at paragraph 143 of her submissions that the views of the Human Rights Committee can be supplemented by the decisions of the European Court of Human Rights (ECHR) and the Inter-American Court of Human Rights (IACHR).[62] Australia is not bound by the decisions of these two regionally-based treaty regimes to which Australia is not a party and which relate to different treaties to that under consideration here. As a matter of international law, the nature of the obligations in one treaty cannot be determined by reference to a similar obligation in another. Furthermore, the ECHR's jurisprudence offers limited support to the

[59] Author's submissions, paragraph 150.
[60] Author's submissions, paragraph 151.
[61] Author's submissions, paragraph 152.
[62] Author's submissions, paragraph 143.

author's propositions, as the Court takes a case-by-case approach to assessing the adequacy of investigations.

a. The scope and content of article 6(1) of the Covenant

The content of the duty under article 6(1)

63. The obligation of a State not to deprive a person of his or her life is not absolute. Only *arbitrary* deprivation of life represents a violation of article 6(1) of Covenant. Arbitrariness is not to be equated with 'against the law'; it is to be interpreted more broadly, and encompasses elements of 'inappropriateness, injustice and lack of predictability'.[63] Whether or not a deprivation of life is arbitrary must be interpreted in the specific circumstances of each individual case. Compliance with article 6(1) involves a number of elements, including positive measures to prevent breach of the obligation, such as protecting the right to life by law, as well as investigating deprivations of life to ensure that it was not arbitrary under article 6(1) of the Covenant. A duty to investigate should not be considered in isolation of these other elements. Accordingly, Australia respectfully submits that the substantive and procedural elements of article 6(1) cannot be considered in isolation from one another.

64. The deprivation of life by authorities of the State, including the police, is not arbitrary *per se*.[64] The best protection against arbitrary deprivation of life by State authorities is both protective measures relating to the use of force and adequate systems to investigate deaths. States Parties are obliged to protect the right to life *by law* but the national legislature has broad discretion as to how best to fulfil this duty.[65] As stated by the Committee in *General Comment No 6*, 'the law must strictly control and limit the circumstances in which a person may be deprived of his life by [State] authorities'.[66]

65. The State of Victoria provides police with powers to protect the rights of its citizens. To preserve the peace and protect the rights of people, police have the lawful authority to use force including weapons such as firearms, batons and oleoresin capsicum spray. However,

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[63] Human Rights Committee, *Van Alphen v The Netherlands* (Communication No 305/1988), 23 July 1990, paragraph 5.8.
[64] Human Rights Committee, *General Comment No 6: Article 6 (The right to life)*, paragraph 3.
[65] M Nowak, *U.N. Covenant on Civil and Political Rights: CCPR Commentary*, 2005, page 123, paragraph 4.
[66] Human Rights Committee, *General Comment No 6: Article 6 (The right to life)*, paragraph 3.

the use of force is strictly controlled and must be in accordance with the law, including section 462A of the *Crimes Act 1958* (Vic). This section provides that a person may use such force not disproportionate to the objective as the person believes, on reasonable grounds, is necessary to prevent the commission, continuance or completion of certain serious offences.

66. Victoria Police policy rules, which are mandatory for police officers to comply with, provide detailed guidance with the overarching goal of avoiding the use of force. Where force cannot be avoided, only the minimum amount of force that is reasonably necessary is to be used when responding to incidents. For instance, the use of a firearms is restricted to incidents where police reasonably believe it is necessary to protect life or prevent serious injury.

67. Australia does not dispute that article 6, read together with article 2, may oblige States Parties to carry out an investigation where there has been a deprivation of life to ensure that it was not arbitrary. It is also not contested that the duty to investigate is enlivened in this case as the circumstances and evidence indicate that Australian agents were responsible for Mr Cassidy's death. However, Australia firstly submits that the duty to investigate does not have the content asserted by the author. Secondly, Australia submits that the investigation of Mr Cassidy's death met its obligations under the Covenant.

The content of the duty to investigate under article 6(1)

68. Australia submits that the Committee should follow its previous practice in not exhaustively articulating the content of the duty to investigate. Australia contends that it is not possible to formulate a single model for investigating deaths, as this will depend on the legal system in place in each State. In different contexts, the indicia of an effective investigation are likely to be very different, and States have different legal systems and resources. Australia submits that the adequacy of any investigation should be assessed on a case-by-case basis by looking at the steps taken by the State with the information available at that time.

69. The Committee should reject the author's central argument that 'independence' always requires all functions and aspects of an investigation to be conducted in its entirety by an entirely separate body. The author has been unable to identify any Committee views where the Committee has stated that complete institutional separation of an investigating agency is

required for all investigations, at all stages of the investigation.[67] The author has relied on ECHR and IACHR decisions to outline an expansive and specific definition of what constitutes an independent investigation. As stated at paragraph 62, Australia's obligations under the Covenant cannot be determined by reference to regionally-based treaty bodies to which Australia is not a party. Furthermore, the Committee's assessment of other jurisdictions' investigation mechanisms is of little relevance because Victoria's system of coronial investigation differs significantly from the systems to investigate deaths in other countries. Australia notes that there is no other body external to the Victoria Police with the appropriate skills or expertise to conduct these kind of investigations in Victoria.

b. The coronial investigation into Mr Cassidy's death

70. Australia submits that the coronial investigation into Mr Cassidy's death was a functionally separate, independent and effective investigation. Australia strongly rejects the author's submissions that the role played by the Victoria Police Homicide Squad was deficient, that the Coroner relied solely on the inquest brief prepared by Victoria Police, or is empowered to rely only on this, and that the coronial investigation was tainted as a result.

71. The Coroner is an independent judicial officer who is in charge of, and directs, all coronial investigations. The inquest into Mr Cassidy's death was not a *separate* investigation by the Coroner after an *initial* investigation by the Homicide Squad investigator. Rather, the inquest was part of a continuum of the Coroner's investigation into Mr Cassidy's death, which commenced at the time that the death was reported to the Coroner. This was on the night of Mr Cassidy's death, 11 December 2008.

72. In Victoria, all police shooting deaths are investigated by way of a coronial investigation, including a mandatory public inquest.[68] For the purposes of the coronial investigation, the Coroner directs the investigation and receives assistance from specialist medical investigators and specialist police investigators who are appointed pursuant to current and

[67] Australia refers to the only three Committee views cited by the author at paragraph 158 of her submissions: Human Rights Committee, *Eshanov v Uzbekistan* (Communication No 1225/2003), 18 August 2010, paragraph 9.7; Human Rights Committee, *Pestano v The Philippines* (Communication No 1619/2007), 23 March 2010, paragraph 7.5; Human Rights Committee, *Amirov v Russian Federation* (Communication No 1447/2006), 2 April 2009, paragraphs 11.6 and 13.

[68] *Coroners Court Act 2008* (Vic), section 52.

longstanding practice.[69] The coronial investigation into Mr Cassidy's death was conducted by the then-State Coroner, Judge Jennifer Coate, pursuant to the Coroners Act. The Coroner led the investigation from the initial reporting of Mr Cassidy's death to the conclusion of the inquest.

73. This section will set out the separate institutions involved in the coronial investigation into Mr Cassidy's death and demonstrate how they each played a role in contributing to an independent and effective investigation. Contrary to the author's submissions, Australia asserts that Victoria Police possesses the necessary expertise to gather the evidence for, and on behalf of, the Coroner following a police shooting death. It is also asserted that the oversight of the investigating police officers by the Ethical Standards Department and the Office of Police Integrity, the active investigatory role played by the Coroner, and the subsequent testing of all evidence gathered at the public inquest were all sufficient to ensure that the investigation of Mr Cassidy's death was independent and effective, such that it fulfilled Australia's obligations under article 6(1).

Assistance provided to the Coroner in her investigation

74. The Coroner was supported in her investigation by an independent Counsel Assisting, a barrister from the Victorian Bar, as well as solicitors instructing to Counsel Assisting the Coroner appointed by the Coroners Court.[70] Specialist death investigators from the Victoria Police Homicide Squad and specialist medical and forensic investigators from the Victorian Institution of Forensic Medicine gathered and produced evidence for, and on behalf of, the Coroner. The Victorian Institution of Forensic Medicine conducted Mr Cassidy's autopsy and prepared the autopsy report for, and at the direction of, the Coroner. The lines of inquiry that the Coroner directs the Victorian Institution of Forensic Medicine to pursue, and the timing and approach taken in doing so, were matters for the

[69] At the time of Mr Cassidy's death, the reporting relationship between the Coroner and the Coroner's investigator was not codified in legislation, but defined through convention and partially codified through policy directions. Convention recognises that a co-operative working relationship exists between Coroners and the Coroner's investigator. The Victoria Police Manual sets out the relevant policies and procedures to investigating all death or serious injury incidents involving police. As described below, following Mr Cassidy's death, changes were made to legislation and to the policy rules to codify and clarify the relationship between the Coroner and the Coroner's investigator.

[70] Since the inquest into Mr Cassidy's death, the Coroners Court has established an 'in-house' legal team to act as solicitors instructing. This facilitates the development of in-house legal skills that are permanently available to the Coroners.

Coroner's discretion as a judicial officer. Also at the discretion and direction of the Coroner, information and reports from the Victorian Institution of Forensic Medicine formed part of the inquest brief.

The Homicide Squad's involvement

75. A police officer from the Homicide Squad was appointed as the Coroner's investigator and, with the assistance of detectives from the Victoria Police Homicide Squad, gathered evidence and investigated Mr Cassidy's death on behalf, and at the direction, of the Coroner. In respect of the coronial investigation into Mr Cassidy's death conducted for the Coroner, the Victoria Police Homicide Squad operated under the Coroners Act. The Homicide Squad investigators had full access to the investigative resources at Victoria Police, however, the particular lines of inquiry pursued, and timing and approach taken in doing so, were a matter for the Coroner's discretion as a judicial officer.[71] Also at the discretion and direction of the Coroner, information and reports prepared by the police investigator formed part of the inquest brief. At the time of Mr Cassidy's death, the relationship between the Coroner (as the judicial officer in charge of the coronial investigation) and the Coroner's investigator (as the specialist providing investigative services for, and on behalf of, the Coroner) was dictated by:

- legislation and jurisprudence
- convention, and
- police policy rules.

76. Australia reiterates its submission that ECHR jurisprudence cannot be used to expand the obligations in the Covenant. However, even if it is followed by the Committee, it does not support the author's submissions about the content of the duty to investigate. For example, the ECHR confirmed in *Giuliani and Gaggio v Italy* that there was no violation of the duty to investigate where the police undertook initial searches and recording of items.[72] In fact, the ECHR noted that it would 'impose unacceptable restrictions in many cases' to exclude the police from involvement in an investigation, and upheld the lawfulness of the investigator's decision to give members of the Police Force responsibility for seizing the

[71] See, eg, *Coroners Act 2008* (Vic), sections 22, 23, 25, 39, 40, 42, 47, 52. See also *Priest v West and Percy* [2012] VSCA 327, paragraph 96 (Maxell P & Harper JA).
[72] European Court of Human Rights, Application no. 23458/02, 24 March 2011.

police weapon involved, carrying out an initial inspection of the victim's body and of police vehicles, seizing a vehicle, compiling photographic evidence, examining audiovisual material and drawing up statements'.[73] In Australia, relevant State and Territory police agencies have precisely the expertise, experience and powers necessary to gather evidence for the Coroner in a timely and effective manner to support the Coroner's investigation. This combination of coronial control and direction, police expertise and the oversight of an independent agency, such as the Office of Police Integrity at the time of Mr Cassidy's death (which has been replaced by the Independent Broad-based Anti-corruption Commission), is the most effective means of determining what occurred in a fatal incident.

77. The inquest or coronial brief prepared by the Coroner's police investigator represents only the record of the evidence gathered by that police officer. The Coroner does not regard such a brief as either definitive or final in terms of the breadth or extent of investigations required. The Coroner examined critically both the evidence gathered by the Homicide Squad and the process by which the evidence was obtained. This line of enquiry touched upon issues of competency, adequacy and impartiality in how evidence was collected, obtained and whether it was compromised as it was produced.[74] In this regard, the Coroner was able to rely on her own inquiries, the entire Ethical Standards Department oversight file, evidence from Ethical Standards Department staff, the entire Office of Police Integrity oversight report, evidence from Office of Police Integrity staff, written statements from police investigators and Ethical Standards Department members, and oral testimony presented at the inquest, including testimony given under cross-examination, to ensure that an independent assessment of all the evidence was undertaken.

78. Any interested party seeking access to information prepared by the Victorian Institution of Forensic Medicine or the Coroner's investigator must direct the request to the Coroners Court. The decision about whether to release that information or document, and the timing of release, is at the discretion of the Coroner, further demonstrating the control that the Court has over the investigation.[75] Furthermore, the

[73] European Court of Human Rights, Application no. 23458/02, 24 March 2011, paragraphs 290, 322.
[74] Inquest Findings, paragraph 572.
[75] *Coroners Act* 2008 (Vic), section 115.

Coroner must accord procedural fairness to parties who appear in an inquest.[76] This duty includes a requirement that a Coroner's decision-making process be free from actual or apprehended bias and be independent or impartial.[77] The judicial officer is required to bring an impartial mind to the resolution of the question that must be decided.

Victoria Police oversight and integrity functions in respect of the Victoria Police Homicide Squad investigator

79. The independence of the investigation was assured, not only by the independent operation of separate areas of Victoria Police, but also by the checks and balances that exist to monitor each area. The structure of the Victoria Police command provides a check and balance over functions of Victoria Police. Victoria Police command consists of the Chief Commissioner, Deputy Commissioners (statutory office holders[78] who report to the Chief Commissioner), and Assistant Commissioners (who report to Deputy Commissioners). Each of the three areas of Victoria Police that were involved in the events prior and subsequent to Mr Cassidy's death came under the command of three different Assistant Commissioners:

    - the area where the individual police officers who were involved in the shooting of Mr Cassidy worked
    - the Homicide Squad, which gathered evidence for, and on behalf of, the Coroner, and
    - the Ethical Standards Department, which oversaw the conduct of the Homicide Squad.

80. Ethical Standards Department police officers oversaw the Homicide Squad officers conducting the investigation into Mr Cassidy's death on behalf of the Coroner, ensuring compliance with police practices and policies, and ensuring that the investigation was undertaken impartially,[79] by:

    - attending the scene on the night of the shooting, noting that the scene was secured

[76] *Annetts v McCann* (1990) 170 CLR 596, 598, 600; *Danne* [2012] VSC 454 [20]
[77] *Firman v Lasry* [2000] VSC 240 (9 June 2000) [12]; *Honda Australia Motorcycle & Power Equipment Pty Ltd v Johnstone (As State Coroner)* [2005] VSC 387 (29 September 2005) [16].
[78] They are appointed by the Governor in Council and can only be removed by the Governor in Council under a statutory process.
[79] Inquest Transcript, T3089.10-30.

- confirming that the officers involved in the shooting were separated[80]
- participating in meetings and debriefs
- making formal requests for drug and alcohol testing, and
- seeking information regarding the investigation.

81. Ethical Standards Department received a copy of the inquest brief, copies of the statements of the four members involved, post-mortem findings, and gunshot residue, blood preservation and capsicum foam/spray preservation reports. Ethical Standards Department personnel were also present at the Homicide Squad interviews of the officers involved in the shooting to ensure that there was no collusion or conflicts of interest. No conflicts of interest were identified at the time by Ethical Standards Department. The Ethical Standards Department file and reports were provided to the Coroner and, exercising her discretion as a judicial officer, she determined that the Ethical Standards Department file should form part of the evidence at the inquest.

82. Victoria Police also conducted several broader operational reviews into Mr Cassidy's death, as well as training and other matters, that formed part of the evidence at the Coronial inquest.[81] While the Coroner determined that these reviews should be admitted into evidence, the reviews were conducted or commissioned by Victoria Police for the purposes of the good governance and management of Victoria Police, and not for the purposes of the coronial investigation itself. This is evidence of the powers that the Coroner has to obtain sensitive operational police documents to inform the coronial investigation. It is also further evidence of how seriously Australia considers, and the steps it takes to implement, the duty to investigate.

External oversight and integrity functions in respect of the Victoria Police Homicide Squad investigator

83. The Office of Police Integrity oversaw the police investigation and the Ethical Standards Department's exercise of its function, and was hierarchically, institutionally and practically independent of Victoria Police, due to officers reporting and providing advice to the

[80] Inquest Transcript, T3123.17.
[81] For example, the *Fontana Review*, the *Examination of Police Shooting Critical Incidents between 2005-2008* and Operational Safety Tactics and Training evaluation.

Director of the Office of Police Integrity, not to Victoria Police. The Coroner and Office of Police Integrity agreed that the Office of Police Integrity would review the Homicide Squad investigation to inform the coronial process.[82] The *Review of investigation by Victoria Police of fatal shooting of Tyler Jordan Cassidy* provided independent expert opinion on the sufficiency of the police investigation, including an examination of compliance with Victoria Police operating procedures, instruction, directions and policies, and best practice, and the Coroner decided that it would be admitted into evidence at the inquest.[83]

84. Details of these reviews are discussed below, in highlighting the advances in the Victorian coronial and investigative procedures. However, they are relevant here as they demonstrate the high degree to which the Coroner critically considered and assessed the sufficiency of the initial police investigation. They also demonstrate her reliance on expert reports from an organisation that is institutionally independent from Victoria Police.

The Coroner's independent investigation

85. Contrary to the author's claim that the Coroner was not involved in the investigation beyond the delivery of the Inquest Brief to the Coroner's Court in September 2009, the Coroner was not only in charge of, but also had direct and ongoing involvement in, the investigation into Mr Cassidy's death.[84] The Coroner attended the scene of Mr Cassidy's shooting with the initial investigation team on the night of the incident. The Coroner was also present during the initial briefing of the Homicide Squad on that night. The Coroner visited the scene on a number of other occasions during the investigation, including on at least one occasion where all interested parties were also invited to attend. A coronial investigation became the primary investigation into the death of Mr Cassidy because the Homicide Squad had formed the view that the police involved in the shooting of Mr Cassidy were not suspected of a criminal offence in relation to his death and, accordingly, did not treat it as a criminal investigation.[85]

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[82] The Coroner also assisted in settling the terms of reference of the review.
[83] Office of Police Integrity, *Review of investigation by Victoria Police of fatal shooting of Tyler Jordan Cassidy*, January 2010.
[84] Author's submissions, page 10.
[85] The Court is required to refer the matter to prosecutorial agencies if, at *any time* in the investigation, it forms the opinion that an indictable offence may have been committed.

86. The Coroner's investigation into Mr Cassidy's death was supported by a great deal of evidence and factual analysis beyond the initial brief of evidence gathered by the Homicide Squad investigator. For example, the first draft of the inquest brief (the first formal record of the evidence gathered by the Homicide Squad that was provided to the Coroner) was 1720 pages in length. The final inquest brief was in excess of 3670 pages. This demonstrates the level of involvement the Coroner had in directing the Homicide Squad investigator's lines of inquiry. The inquest brief is a dynamic document. At the Coroner's discretion, documents are added to the brief throughout the coronial investigation. The final inquest brief included approximately 115 witness statements and 121 exhibits, and included statements from the police officers who were involved in the shooting. This still does not represent the totality of evidence before the Coroner prior to the inquest. The Coroner also obtained other documents including the Office of Police Integrity *Review of investigation by Victoria Police of fatal police shooting of Tyler Jordan Cassidy* and other sensitive operational police reviews.

87. Mr Cassidy's next-of-kin were involved in the investigation of Mr Cassidy's death. The Coroners Act obliges the Coroner to provide certain appropriate information about the coronial process to the family of the deceased and other persons with an interest in the investigation of a death.[86] The Coroner must conduct an inquest in a way that makes it comprehensible to family members and any interested parties who are present.[87] As the next-of-kin of the deceased has a right to be an interested party to a coronial investigation,[88] the family:

- is provided with a copy of the inquest brief (provided at the State's expense)
- is provided with exhibits and other materials tendered as evidence during the inquest
- has a right to appear at directions hearings and the inquest
- has a right to make submissions as to all aspects of the inquest, including which witnesses are called to give evidence, the scope of the inquest and what findings ought be made, and

[86] *Coroners Act 2008* (Vic), section 21. These persons or entities are known as 'interested parties'.
[87] *Coroners Act 2008* (Vic), section 65(b).
[88] See *Coroners Act 2008* (Vic), section 56; *Barci and Asling v Heffey* Unreported VSC 1/2/1995; *Annetts v McCann* [1990] 170 CLR 596.

- has a right to question witnesses. This may be done directly, through the family's legal counsel or through the Counsel Assisting the Coroner.

88. The author was in contact with the Coroners Court shortly after Mr Cassidy's death until the conclusion of the inquest. The Coroner determined that the author and her representatives in these proceedings, the Human Rights Law Centre, were interested parties in the inquest.[89] Both parties were provided with copies of the full inquest brief, exhibits and other documents tendered at the inquest. These documents were provided at the State's expense. As described in Judge Coate's *Ruling on applications to be granted leave to participate as interested parties* dated 4 March 2010:

> Ms Cassidy is represented by senior and junior counsel. The legal team for Ms Cassidy has been extremely engaged and active to date, sending considerable amounts of correspondence to the Court, setting out a large and comprehensive array of questions and issues and concerns that they wish to have addressed in this investigation, calling for large amounts of documents and material to be obtained and produced...

At the discretion of the Coroner, the solicitors instructing and Counsel Assisting directed those assisting the Coroner to pursue appropriate lines of inquiry in response to this correspondence and these requests.

89. Furthermore, as an interested party to the inquest, the author (in person and/or through her legal team) had the right to make submissions to the Coroner on matters relating to the inquest, including in relation to its scope, potential witnesses, lines of enquiry and evidence presented at the inquest. For example, most submissions made by solicitors for the Cassidy family, including for *inter alia* closed-circuit television (CCTV) footage, witness statements, records of police communications, police running sheets and diary notes, information from police databases relevant to the death, operational safety and tactical training and assessment, were ultimately included in the final inquest brief. The author was also able to cross-examine witnesses and suggest possible lines of cross-examination for the Coroner to pursue.

[89] Matter of Inquest into the death of Mr Cassidy, *Ruling on applications to be grated leave to participate as interested parties*, 4 March 2010. There were other interested parties to the inquest.

90. From 19 October 2010 until 11 March 2011, the Coroner presided over the hearing of the public inquest into the death of Mr Cassidy. The inquest is a public examination of the available material, a transparent process and open to a high degree of public scrutiny, contrary to the author's submission.[90] All inquest evidence in a coronial investigation is heard and tested in open court, and parties, including the family and Counsel Assisting, are able to cross-examine witnesses. In this case, this process was important in addressing any perceived conflict or bias in the involvement of police investigators in gathering evidence for the Coroner. The inquest constituted 41 days of public hearings and generated approximately 4499 pages of transcript. This demonstrates the significant amount of evidence considered by the Coroner, which facilitated significant public scrutiny. In Australia's view, this process further addresses any perceived conflict of interest in having a Homicide Squad investigator gather evidence for, and on behalf of, the Coroner following Mr Cassidy's death. The police officers involved in the shooting gave oral testimony at the inquest and were subjected to questioning and cross-examination by the Coroner and interested parties, including counsel for Mr Cassidy's family.

91. The Coroner published her findings on 23 November 2011, which held that police fired at Mr Cassidy at a time when a police officer was 'in immediate and perilous danger of serious injury or death'.[91] The Coroner also found that there was no evidence of an actual conflict of interest in the police investigation.[92] The Coroner also made eight recommendations pursuant to section 72(2) of the *Coroners Act 2008* (Vic) which suggested changes to the broader investigatory system in Victoria.

92. The Coroner's 129-page written findings into Mr Cassidy's death, published on 23 November 2011, are available publicly on the Coroners Court website.[93] Victoria Police, like other agencies that assist the Coroners Court, was also properly open to scrutiny by the Court.[94] The deficient practices that were revealed through the thoroughness and effectiveness of the coronial investigation, discussed below at paragraphs [102]-[105] were made publicly known due to the public nature of the coronial

[90] Author's submissions, paragraph 176.
[91] Inquest Findings, paragraph 461.
[92] See Inquest Findings, paragraphs 556–691.
[93] www.Coronerscourt.vic.gov.au.
[94] Inquest Findings, paragraph 575. Victoria Police Manual 208-2. Release of information to media – information can only be released in line with the Media Protocols for Incidents Involving Police & the Coroner.

investigation. As a result of the identification of certain deficiencies by the Coroner, the changes outlined at paragraphs [106]-[122] below have been implemented in Victoria. While Australia accepts that there were deficiencies in practice, these did not compromise the independence and effectiveness of the investigation, and in Australia's view, met its obligations under article 6(1).

Examination into the coronial investigation during the inquest

93. As part of the investigation into Mr Cassidy's death, the Coroner also examined aspects of the coronial investigation itself. This line of enquiry touched upon the competency, adequacy and impartiality in the way in which evidence was collected, obtained and whether it was compromised as it was produced.[95] The inquest findings not only addressed the circumstances of Mr Cassidy's death, they also made broad comments and recommendations in respect of changes that ought to be made in response to Mr Cassidy's death. This has contributed to Australia discharging its positive obligations to ensure the right to life under article 6(1).

94. In her findings related to Mr Cassidy's death, the Coroner made the following comments pursuant to section 67(3) of the Coroners Act:

- youth mental health services must be tailored to the needs of youth[96]
- previous inquiries and reviews on police use of force have identified the need for Victoria Police to address issues involved in dealing with vulnerable people[97]
- Victoria police should consider chains of command and control in light of the model of responding to critical incidents[98]
- evaluation and examination of the effectiveness of Victoria Police Operational Safety and Tactics Training would be appropriate[99]
- a 'safety net' approach, imposing obligations on more officers to notify, could reduce delays in notifying of fatal shootings[100]

[95] Inquest Findings, paragraph 572.
[96] Inquest Findings, paragraphs 634–635.
[97] Inquest Findings, paragraphs 636–642.
[98] Inquest Findings, paragraphs 643–644.
[99] Inquest Findings, paragraph 645.

- a 'checklist' of services to contact, regularly monitored and updated, is a valuable initiative to enhance attendance of forensic services in a timely way[101]
- although the investigation into Mr Cassidy's death was not compromised by a failure to make a public call for witnesses, this should occur in situations similar to this case[102]
- there were some instances of family welfare issues, including poor or insensitive practices[103]
- assistance must be given to members in the delivery of the death message[104]
- the Office of Police Integrity review contains valuable suggestions to enhance the model of police investigating police for the Coroner and Judge Coate undertook to develop Coroner's guidelines for coronial investigations into police contact related deaths[105]
- issues of both perceptions of collusion and bias, and compromise of detail and coherence of accounts, would be best resolved by an institutionally independent and legally-trained person being present during the taking of statements[106]
- issues were raised about the control of the Coroner's investigation and timeliness of the delivery of the inquest brief, and[107]
- sensitivity surround police statements to media in the wake of a police-related fatality and the current protocol will be revisited.[108]

95. The seven recommendations directed to Victoria Police by Judge Coate in her inquest findings are outlined at paragraph 117 below.

96. Where coronial recommendations are directed towards organisations, they are required to provide a written response to the Coroner within three months.[109] The response must

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[100] Inquest Findings, paragraphs 646–649.
[101] Inquest Findings, paragraphs 650–652.
[102] Inquest Findings, paragraph 653.
[103] Inquest Findings, paragraphs 654–656.
[104] Inquest Findings, paragraph 657.
[105] Inquest Findings, paragraphs 658–675.
[106] Inquest Findings, paragraphs 676–684.
[107] Inquest Findings, paragraphs 685–691.
[108] Inquest Findings, paragraphs 692–696.
[109] *Coroners Act 2008* (Vic), section 72.

specify a statement of action (if any) that has, is or will be taken in relation to the recommendation made by the Coroner. The Coroners Court publishes the responses on its website, enhancing the openness of the investigation.[110]

97. The outcomes of these recommendations are dealt with below.

Promptness and reasonable expedition of the investigation

98. Australia submits that any delays that occurred in the investigation of Mr Cassidy's death did not compromise the overall effectiveness of the investigation. The reported one-hour delay in advising the Homicide Squad of Mr Cassidy's death[111] was due to uncertainty as to who was responsible for notifying the Homicide Squad. The Homicide Squad ought to have been notified of Mr Cassidy's death in a timely manner by the Police Commander, in accordance with the police policy rules in force at the time. However, the Coroner considered this matter, and her findings did not suggest that the one hour delay impacted on the probity of the investigation. As a result of this issue, Victoria Police has implemented a notification protocol with the Emergency Services Telecommunications Authority to ensure that the Major Crime Desk is notified immediately in certain critical incidents, including a fatal police shooting or a death involving police contact.[112]

99. The Coroner found that there was no evidence to suggest that the failure to conduct drug and alcohol testing of the police officers involved in the shooting in a timely way was a result of anything other than a lack of knowledge of proper procedure.[113] Notwithstanding the delay, the Coroner found that there was no evidence that any of the members involved in the incident were affected by drugs or alcohol.[114] The Coroner also did not find the investigation to be lacking in probity as a consequence of the delay in undertaking gunshot residue testing.[115] The Coroner also noted that, in this particular instance, 'instant gunshot residue testing would have added nothing' to the investigation, as 'it was not a situation where it was unclear whether or not shots had been fired and who fired them'.[116] The delay

[110] www.Coronerscourt.vic.gov.au.
[111] Inquest Findings, paragraph 515.
[112] Inquest Findings, paragraph 647.
[113] Inquest Findings, paragraph 502.
[114] Inquest Findings, paragraph 502.
[115] Inquest Findings, paragraph 514.
[116] Inquest Findings, paragraph 514.

in conducting gunshot residue testing was due to a misunderstanding by the Police Commander and investigator of the relevant procedure for making such a request. Furthermore, all of the police officers involved subjected themselves to gunshot residue testing, notwithstanding that there was no requirement for them to do so.

100. Contrary to the author's submission, Australia argues that Victoria Police, including members of the Critical Incident Unit and Homicide Squad detectives, was highly successful and efficient in identifying material witnesses and prioritising the taking of statements immediately following the incident.[117] At least 29 of the statements that were tendered at the inquest were obtained by Victoria Police within 24 hours of the incident. By the end of December 2008, three weeks after Mr Cassidy's death, Victoria Police had identified and taken statements from at least 65 witnesses.[118] Furthermore, the Office of Police Integrity found that witness statements were taken competently and sufficiently, and the Coroner did not make any adverse findings in relation to the identification, and taking statements, of witnesses.

101. As noted by the Coroner, at the time that the investigation commenced, there was no process in place for setting the timing for the delivery of the Inquest Brief, or for the Court taking control of the process at an early stage.[119] The State Coroner has since issued a Practice Direction to address the concerns of the family raised during the inquest regarding the timing for the delivery of the inquest brief.[120]

Deficiencies in the investigation

102. The author outlines aspects of the investigation that allegedly demonstrate deficiencies in the model used to investigate Mr Cassidy's death, as well as the model's vulnerability to actual or perceived improper interference.[121] Australia submits that many allegations were already considered and discounted by the Coroner and, as outlined in the admissibility submissions above, the author has failed to appeal these findings under the Coroners Act or to seek judicial review. Most importantly, any deficiencies identified by the Coroner were

[117] Author's submissions, paragraph 199(h).
[118] Closing on behalf of the Chief Commissioner, paragraph 69.
[119] Inquest Findings, paragraph 684.
[120] Practice Direction 8 of 2011 of the *Coroners Act 2008* (Vic), which was subsequently replaced by Practice Direction 1 of 2012, and then by Practice Direction 4 of 2014.
[121] Author's submissions, paragraph 199.

found not to have compromised the investigation into Mr Cassidy's death. In furtherance of its efforts to comply with its obligations under article 6(1), the State of Victoria has implemented changes to its systems, policies and procedures to investigate deaths.

103. In relation to the author's submission that Homicide Squad officers covertly recorded meetings with Mr Cassidy's family, the State of Victoria apologises to the author, and acknowledges that this practice was unnecessary and would have been distressing for Mr Cassidy's family.[122] It does note however that there is no evidence that the covert recordings interfered with the investigation.[123]

104. Many of the deficiencies alleged by the author were considered by the Coroner, who made findings in relation to them, including:

Allegation of deficiency in the investigation by the author	Finding by the Coroner
One of the four officers present at the time of Mr Cassidy's death was left unsupervised at the scene and had contact with a number of witnesses. (Author's submissions, [199(a)])	It was an error and not appropriate for the investigation. However, the Coroner stated that 'there is no evidence that it did cause an actual compromise in the investigation'. (Inquest Finding, [488])
The interviews of the police officers involved in the shooting were not audio or video recorded. (Author's submissions, [199(g)])	There was no evidence that anything improper occurred during the process of the Homicide Squad taking statements from the four members. (Inquest Finding, [607]-[609])
No general call for witnesses was made and the Homicide Squad did not focus on identifying potential witnesses (Author's submissions. [199(H)] and [210(d)])	The investigation was not compromised by a failure to make a general call for witnesses, due to Mr Cassidy's death happening in a public place, the number of witnesses giving accounts of what they saw and heard and the considerable amount of media attention the incident received. (Inquest finding, [612])
The police media statement was released by Victoria Police in breach of the policy	The evidence is that the media releases did not contain exculpatory statements. [Inquest

[122] Author's submissions, paragraph 199(k).
[123] Inquest Findings, paragraphs 632, 633.

Allegation of deficiency in the investigation by the author	Finding by the Coroner
regarding media interaction following a critical incident, as the Police failed to seek the Coroner's approval prior to releasing the statements. (Author's submissions, [199(j)])	finding, [565])
Mr Cassidy's computer was not examined until some days after its collection from the Cassidy home, resulting in the loss of internet messenger conversation evidence. (Author's submissions, 210(c)])	There is no evidentiary basis to conclude this was other than a lack of understanding on the part of the police member that time was of the essence when it came to the possibility of recovery of detail of internet messenger conversations. (Inquest finding, [600])

105. In fact, it was the coronial process itself that revealed some of the regrettable practices referred to by the author (for example, the covert recording of Homicide Squad discussions with the author, the one-hour delay in notifying the Homicide Squad of Mr Cassidy's death, the Constable left unsupervised at the scene, the delay in conducting gunshot residue testing of the police officers, and the delay in conducting drug and alcohol testing of the police officers). These practices, while regrettable, did not compromise the effectiveness of the coronial investigation or the coronial outcomes.[124] It was the thoroughness and effectiveness of the coronial investigation that revealed these practices. It was because of the public nature of the coronial investigation that these practices are publicly known. It was through the coronial recommendations and other reviews that systems are now in place to minimise the risk of these practices happening again.

c. *Advances in the coronial system and investigative processes and procedures since Mr Cassidy's death*

106. The Victorian Government responded to recommendations relating to specific parts of its investigatory system, and has made the following changes to enhance the process and procedures of investigating deaths involving police contact. Both Mr Cassidy's coronial investigation and the Office of Police Integrity's *Review of the investigative process*

[124] Inquest Findings, paragraphs 488, 518–519, 502.

following a death associated with police contact (2011) were catalysts for these changes. This demonstrates the commitment of Australia to adhering to its obligations under article 6(1).

107. The Office of Police Integrity *Review of the investigative process following a death associated with police contact* (2011) and Mr Cassidy's coronial investigation were catalysts for all parties involved to gain a greater understanding of, and to implement changes to, the system of investigating deaths involving police contact. Most of these changes were as a direct result of issues raised and lessons learned during Mr Cassidy's inquest.

108. This section outlines some of the changes that have been made following Mr Cassidy's inquest in order to enhance the positive measures undertaken by Australia to adhere to its obligations under article 6(1) of the Covenant.

The Office of Police Integrity Review

109. In November 2009, the then Director of Office of Police Integrity announced that he would conduct an inquiry into the way in which deaths associated with police contact were investigated, which would include examining what existed both nationally and internationally and what was considered best practice in the context of the coronial jurisdiction. The review team hosted a range of forums and workshops, called for and received submissions, and conducted its own research.[125]

110. The *Review of the investigative process following a death associated with police contact* was tabled in the Victorian Parliament in June 2011 and is a public document.[126] The Review identified the following principles that underpin an optimal framework for investigating police contact deaths in Victoria:

- independence
- effectiveness
- promptness (timeliness)
- next of kin involvement, and

[125] The Human Rights Law Centre participated in the review process.
[126] The document is available at: www.ibac.vic.gov.au.

- sufficient public scrutiny (transparency).[127]

A second key area of focus was the improvement of current processes, in particular:

- investigative responsibility
- incident management
- obtaining police account of events
- police media management
- transparency of process, and
- informing and caring for next of kin.

111. As a result of the process of the review, Victoria Police developed a more consistent procedure through codification for the investigation of deaths associated with police contact, with the Homicide Squad or the Major Collision Investigation Group responsible for gathering evidence for, and at the direction of, the Coroner in the majority of police contact deaths.[128] The Office of Police Integrity and Victoria Police developed a routine notification protocol and Professional Standards Command utilise an enhanced oversight with a clear set of guiding principles. Essentially, changes introduced by the *Victoria Police Act 2013* (Vic) and changes to policies and procedures by Office of Police Integrity, Victoria Police and the Coroners Court have made responsibilities and obligations clearer, more transparent and open to greater public input and scrutiny.

Changes within the Coroners Court

112. The Coroner implemented changes in relation to the coronial process to address issues that were identified during the inquest into Mr Cassidy's death. During the course of the inquest it was identified that, as an administrative process, there was a lack of clarity and transparency about the role of police investigator *vis-a-vis* the Coroner. The Coroner was also critical of the timeliness attached to the delivery of the inquest Brief.[129] To address these issues, the Coroner issued a Practice Direction to all Coroners requiring an early

[127] These principles mirror those developed by the European Court of Human Rights.
[128] Office of Police Integrity, *Review of the investigative process following a death associated with police contact* (2011), page 14.
[129] Inquest Findings, paragraph 686.

directions hearing to be conducted for police contact deaths. Practice Direction 4 of 2014, *Police Contact Deaths*, provides that the Coroner, unless he or she orders otherwise, will hold a directions hearing within 28 days of a police contact death being reported to the Coroner.[130] The directions hearing is intended to ensure consistency of practice among Coroners and, importantly, to provide transparency and accountability in the relationship between the Coroner and the Coroner's investigator. The Professional Standards Command member overseeing the investigation must be present at the directions hearing so that the member can ensure that the Coroner's investigator adheres to the Coroner's directions.[131]

113. As described above, at the time of Mr Cassidy's death, the relationship between the Coroner (as the judicial officer in charge of the coronial investigation) and the Coroner's investigator (as the police officer providing investigative services for and on behalf of the Coroner) was dictated by:

- legislation
- convention, and
- police policy rules.

114. Changes have been made to all three of these areas as a direct response to the issues raised in Mr Cassidy's inquest and in the Office of Police Integrity Report, *Review of the Investigative Process following a death associated with police contact*. These changes largely seek to codify practices into legislation and policy rules, thereby making the relationship clearer and more transparent.

115. The *Victoria Police Act 2013* (Vic) commenced on 1 July 2014 and is the new principal Act for the administration and governance of Victoria Police. The Act largely repealed the *Police Regulation Act 1958* (Vic), including section 18A of the *Police Regulation Act 1958* (Vic), which provided for police assistance to Coroners. Section 59 of the *Victoria Police Act 2013* (Vic) is the equivalent provision, and provides that a police officer may assist a Coroner in the investigation of a death or fire under Part 4 of the Coroners Act.

[130] This practice direction is the latest version of the initial Practice Direction 8 of 2011. The first version of this practice direction stated that the directions hearing must occur within 14 days. This was difficult to implement in practice as families were often still involved in funeral preparations, and initial reports from the Victorian Institution of Forensic Medicine might not have been known.

[131] Victoria Police Manual, *Oversight of death or serious injury incidents involving police*.

The new provision removes ambiguity that existed in the wording of the former provision, which provided that the Chief Commissioner, upon the request of the Coroner, shall direct a sufficient number of police to be present at a place where an inquest may be held. Section 36 of the Coroners Act requires a police officer to give relevant information to a Coroner in an investigation into a death or a fire and section 60 provides that a Coroner may be assisted at an inquest by a police officer.

116. The Victoria Police Manual has also been comprehensively updated to better clarify the various roles of Victoria Police following a police shooting and to codify some conventions. It is now clear that police investigators are to cooperate with, and follow the direction of, the Coroner and Coroners Court staff at all times. To further address any future perceptions of bias, the Victoria Police Manual provides clearer direction about conforming with the Victoria Police and the Coroners Court 'Media protocols for incidents involving police and the Coroner' governing the release of information to the public. The protocol emphasises that the investigation is for the Coroner and that it is imperative that any comment released to the media must be made in consultation with the Coroner's Office.[132]

Changes within Victoria Police

117. The Coroner directed seven coronial recommendations to Victoria Police, all of which were accepted, and have been implemented. The recommendations included:

- development of a youth specific component to Victoria Police's Operational Safety and Tactics Training
- development of a specific component on use of force with vulnerable people to the Operational Safety and Tactics Training
- maintaining adherence to the Operational Safety and Tactics Training
- evaluation of the effectiveness of the Operational Safety and Tactics Training
- timely attendance of forensic services, and
- attendance of a welfare person to assist family at the scene and afterwards.[133]

Other changes were precipitated by the Office of Police Integrity review.

[132] Inquest Findings, paragraph 559.
[133] Inquest Findings, pages 127–8.

118. Changes at Victoria Police in response to the issues raised during the inquest into Mr Cassidy's death fit broadly into four categories:

- the relationship between the Coroner's investigator and the Coroner
- the role of Ethical Standards Department/Professional Standards Command
- improving the quality and timeliness of investigations, and
- minimising the risk of further police shooting deaths.

119. To respond to the regrettable practices identified by the Coroner during her coronial investigation, including: Constable Ferrante being left unsupervised for a period of time following Mr Cassidy's death;[134] the delay of several hours in conducting drug and alcohol testing of the police officers;[135] and the delay in conducting forensic gunshot residue testing of the police officers;[136] the following guidelines in the Victoria Police Manual (VPM) were created:

- *VPM – Death or serious injury incidents involving police – initial action – Initial Action Checklist for managing Death or Serious Injury Incidents*

  This is an information sheet that is provided to the relevant parties involved in a death or serious injury incident involving police to provide an overview of the investigation and oversight process.
- *VPM – Scene Management*

  This details effective initial management and investigation of crime scenes and the discovery and preservation of all available evidence.

[134] Note that the Coroner held that there was no evidence that this oversight 'did cause an actual compromise in the investigation' – a sentence that was omitted from the quotation in Ms Cassidy's communication: Inquest Findings, paragraph 488.
[135] Note that the Coroner held that 'there is no evidence to suggest that the failure was as a result of anything other than a lack of knowledge or proper procedure', a sentence that was omitted from the quotation in Ms Cassidy's communication: Inquest Findings, paragraph 502.
[136] Note that the Coroner did not find the investigation to be lacking in probity as a consequence of the delay in undertaking gunshot residue testing: Inquest Findings, paragraph 519. The Coroners recommendation to include this in the checklist has been adopted.

- *VPM – Restriction Notices under the Coroners Act*

  These authorise the Coroner to restrict access to certain areas associated with an incident resulting in death or expected death. In a police contact death, only the Coroner is able to restrict access.

120. In response to the one hour delay in notifying the Homicide Squad, Victoria Police have entered into a notification protocol with the Emergency Services Telecommunication Authority (the body responsible for emergency phone calls – i.e. '000' or '911').

Changes in the Ethical Standards Department

121. The Ethical Standards Department developed a set of 'Oversight Principles' to be used when undertaking oversight responsibilities to maintain the integrity of investigations into deaths following police contact. Overarching Victoria Police policies were then reviewed and changes made to ensure policies were in line with the oversight principles. Oversighting is a process that allows for a comprehensive, independent, unbiased and critical review of the circumstances and the investigation surrounding a police contact death.

Establishment of the Independent Broad-based Anti-corruption Commission

122. In February 2013, the Independent Broad-based Anti-corruption Commission replaced the Office of Police Integrity and broadly took on the Office of Police Integrity's former functions, as well as a broader remit across the Victorian public sector. While the jurisdiction of the Independent Broad-based Anti-corruption Commission has broadened, its role in respect of police shooting deaths is akin to the former role of the Office of Police Integrity. Under section 64(1)(c) of the *Independent Broad-based Anti-corruption Commission Act 2011* (Vic), the Independent Broad-based Anti-corruption Commission can commence an own motion investigation into a death, serious injury or risk of death or serious injury associated with police contact to determine whether the death, injury or risk were as a result of police personnel conduct or police personnel misconduct.[137]

[137] 'Police personnel conduct' and 'police personnel misconduct' are defined at section 5 of the *Independent Broad-based Anti-corruption Commission Act 2011*.

Article 14 – The right to a fair hearing

123. Article 14(1) of the Covenant relevantly provides:

> All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.

Allegations

124. The author claims that the guarantee of equality before courts and tribunals under article 14 of the Covenant must be respected by any judicial body that has been entrusted with a judicial task under domestic law.[138] The author also claims that article 14(1) guarantees the right to a fair and public hearing by a competent and independent tribunal and that this is an absolute right.[139]

125. According to the author, Australia has breached article 14 of the Covenant due to the alleged:

> failure to provide an independent and impartial investigation into the death of [Mr Cassidy] [meaning] that the subsequent Inquest was itself not sufficiently independent and impartial. This is confirmed by the fact that the Coroner did not have sufficient and independent oversight of the investigation ... Accordingly, the author's right to a fair and public hearing into her son [Mr Cassidy's] death was not effectively guaranteed.[140]

Australian Government Response

126. For all the reasons discussed above, Australia's primary submission is that the communication is inadmissible. However, if the Committee finds that the author's claims under article 14 are admissible, Australia respectfully submits that these claims are without merit.

a. The scope and content of article 14 of the Covenant

127. Australia agrees with the author that article 14(1) provides for the right to equality before the courts and tribunals and the right to a fair and public hearing. All remaining subclauses of article 14, article 14(2)–(7), set out the minimum guarantees for an accused in criminal

[138] Author's submissions, paragraph 224.
[139] Author's submissions, paragraph 226.
[140] Author's submissions, paragraphs 229-230.

proceedings. As the coronial investigation into Mr Cassidy's death does not constitute criminal proceedings, only article 14(1) is engaged in this case. Article 14(1) applies to the determination of either any criminal charge against a person or of the person's rights and obligations in a suit at law. The first limb does not apply because a criminal charge was not being determined in the coronial investigation into Mr Cassidy's death. It is only relevant to assess whether or not the investigation was a determination of *rights and obligations in a suit at law* to assess whether or not the right to a fair and public hearing by a tribunal is applicable to the circumstances of this case.

128. According to the Committee's previous views, the concept of *suit at law* is 'based on the nature of the right in question rather than on the status of one of the parties'.[141] In this communication, the investigation did not relate to a particular right, and the Coroner was not engaged in a determination of rights and obligations in a suit at law. The Coroner was only required to investigate the circumstances of Mr Cassidy's death and make a determination as to what happened. For these reasons, Australia respectfully submits that the investigation into Mr Cassidy's death does not constitute a suit at law, and therefore article 14(1) does not apply to this communication before the Committee.

b. The coronial investigation into Mr Cassidy's death

129. If the Committee considers that article 14 does apply to the coronial investigation into Mr Cassidy's death, Australia submits that the investigation into Mr Cassidy's death was fair, public and independent. As outlined above in relation to the author's submissions on article 6(1), the Victorian State Coroner's investigation into Mr Cassidy's death was conducted by a competent and independent tribunal as part of the coronial process. Article 14(1) provides that the rights and obligations in a suit of law must be heard by a *competent, independent and impartial tribunal established by law*. Australia submits that as the Coroners Court is established under the Coroners Act, it meets the requirement under article 14(1) that a tribunal be established by law.

130. The requirement that a tribunal be independent seeks to ensure that the legislative and executive branches of Government are separate and neither are able to direct the judiciary

[141] Human Rights Committee, *Zundel v Canada* (Communication No 1341/2005), 4 April 2007, paragraph 6.8.

in the execution of its functions.[142] Australia respectfully submits that its judicial system satisfies this requirement. The requirement for independence also relates to systematic safeguards aimed at ensuring the independence of judges, including through security of tenure, and fixed, transparent rules on remuneration and promotion.[143] Australia argues that the Coroners Court meets this criteria. All Victorian Coroners are independent judicial officers with a legal background and work as full-time specialist investigators into deaths. As judicial officers, Coroners are afforded all the protections afforded to judicial officers, including:

- tenure (their position is guaranteed insofar as they may only be removed by joint resolution of both Houses of Parliament)
- powers and immunities, and
- legislatively protected remuneration that drawn directly from a special appropriation.[144] This means that Coroners' remuneration is effectively guaranteed and cannot be interfered with by any Executive Government action.

131. Impartiality of a tribunal is concerned with judges being free, and perceived to be free, from bias. As argued above, the investigation into Mr Cassidy's death was fair, independent and impartial.

132. Australia further submits that there are appeal mechanisms available, as set out at paragraphs 37–40 of these submissions.

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[142] Human Rights Committee, *General Comment No 32: Article 14: Right to equality before courts and tribunals and to a fair trial*, 23 August 2007, paragraph 18.
[143] Human Rights Committee, *General Comment No 32: Article 14: Right to equality before courts and tribunals and to a fair trial*, 23 August 2007, paragraphs 19–20.
[144] The protected remuneration and high remuneration rates demonstrate the importance and independence of the role of Coroners in the Victorian jurisdiction.

Article 2 – The right to an effective remedy

133. Article 2 of the Covenant relevantly provides:

> (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 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.

Allegations

134. The author claims that, under article 2(3) of the Covenant, Australia is obliged to provide Mr Cassidy and the author with 'an effective remedy in the form of an impartial, thorough and diligent investigation' into the circumstances of Mr Cassidy's death.[145]

135. According to the author, Australia has breached 'the author's right to access to justice under article 2(3) of the Covenant', in conjunction with article 6(1), by failing 'to ensure an effective remedy under Article 2 of the ICCPR for the breach of Mr Cassidy's right to have his death investigated in accordance with the procedural obligations of Article 6(1)'.[146] The author's submission is that '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 obligations to ensure an effective investigation'.[147] The author also submits that the coronial investigation did not provide the author with an effective remedy because the Coroner has only recommendatory powers and the Coroners Act does not provide for any remedy where a written response to recommendations is not provided or is inadequate.[148] Finally, the author submits that the alleged violation 'has not been remedied

[145] Author's submissions, paragraph 232.
[146] Author's submissions, paragraph 230.1.
[147] Author's submissions, paragraph 236.
[148] Author's submissions, paragraph 237.

by sufficient changes in law, practice and procedure, by payment of compensation or by apology'.[149]

Australian Government Response

136. For all the reasons discussed above, Australia's primary submission is that the communication is inadmissible. However, if the Committee finds that the author's claims under article 2 are admissible, Australia respectfully submits that these claims are without merit.

a. The scope and content of article 2 of the Covenant

137. Australia does not dispute that, where a violation of a Covenant article has occurred, it is under an obligation to provide an effective remedy under article 2. However, a violation of article 2 itself can only occur in conjunction with the concrete exercise or violation of one of the substantive rights ensured by the Covenant. It is clear that article 2 of the Covenant does not establish independent rights, but rather, duties of States Parties based on the rights recognised in the Covenant.[150] As articulated by the Committee at paragraph 8 of General Comment No. 31, it is necessary 'to provide effective remedies *in the event of breach*' under article 2(3) (emphasis added). This statement indicates that the requirement to provide effective remedies is triggered by a breach of a substantive article of the Covenant. The Committee has also held in *K.L. v Denmark* that there can be no violation of article 2(3) unless a remedy has been sought for the violation of a right under the Covenant.[151] In *C.F. et al v Canada*:

> 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 prescribe preventive protection, but confines itself to requiring effective redress ex post facto.[152]

138. In Australia's view, article 2(3) provides an accessory right to an effective remedy for violations of the Covenant. It is necessary to consider whether or not a substantive right has been violated, before a violation of article 2(3) can be found. Australia submits that the

[149] Author's submissions, paragraph 242.
[150] M Nowak, *U.N. Covenant on Civil and Political Rights: CCPR Commentary*, 2005, page 34.
[151] Human Rights Committee, *K L v Denmark* (Communication No 81/1980), 27 March 1981. In this case, the Committee rejected the communication because the author did not indicate which substantive right of the Covenant had been violated.
[152] Human Rights Committee, *C F v Canada* (Communication No 113/1981), 12 April 1985, paragraph 6.2.

Victorian State Coroner's investigation into Mr Cassidy's death did not breach article 6(1) or article 14 of the Covenant. As there has been no violation of any substantive rights under the Covenant, Australia submits that it is not under any obligation to provide an effective remedy for such a breach.

b. The coronial investigation into Mr Cassidy's death

139. If the Committee considers that there has been a violation of article 6(1) or article 14, Australia argues that the investigation into Mr Cassidy's death was 'impartial, thorough and diligent',[153] such that it provided the author and Mr Cassidy an effective remedy. Australia submissions at paragraphs 70–92 above outline the independence and effectiveness of the investigation.

[153] Author's submissions, paragraph 232.

CONCLUSION

140. Australia expresses its sympathy to the author for the tragic circumstances of Mr Cassidy's death. Victoria has acknowledged the inefficient practices identified by the coronial investigation, and apologises for them. Australia notes the Coroner's findings that these did not impact on the investigation. Furthermore, many of the Coroner's institutional recommendations have been implemented. This demonstrates Australia's commitment, not only to the duty to investigate, but also to the positive measures required to protect the right to life under article 6(1) of the Covenant.

141. Having given careful consideration to the allegations made by the author that are the subject of this communication, Australia respectfully submits that each of the author's claims under articles 2, 6(1) and 14 of the Covenant are inadmissible under the Optional Protocol and should be dismissed without consideration of its merit. Should the Committee be of the view that any of the allegations are admissible, Australia further submits that each of the claims should be dismissed for lack of merit.