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Human Rights Committee

Decision adopted by the Committee under the Optional Protocol, concerning communication No. 2296/2013*,**

Submitted by:	S.C (represented by Anna Brown, of the Human Rights Law Centre)
Alleged victims:	The author and T.J.C
State Party:	Australia
Date of communication:	3 September 2013 (initial submission)
Document references:	Decision taken pursuant to rule 97 of the Committee's rules of procedure, transmitted to the State party on 29 October 2013 (not issued in document form)
Date of adoption of decision:	2 November 2018
Subject matter:	Effectiveness and independence of investigation into fatal shooting of a minor by the police
Procedural issues:	Exhaustion of domestic remedies; level of substantiation of claims
Substantive issues:	Right to life; right to access to justice; right to an effective remedy
Articles of the Covenant:	2(3), 6(1) and 14
Articles of the Optional Protocol:	2 and 5 (2) (b)

* Adopted by the Committee at its 124th session (8 October – 2 November 2018).

** The following members of the Committee participated in the examination of the communication: Tania María Abdo Rocholl, Yadh Ben Achour, Ilze Brands Kehris, Sarah Cleveland, Ahmed Amin Fathalla, Olivier de Frouville, Christof Heyns, Bamariam Koita, Marcia V.J. Kran, Duncan Laki Muhumuza, Photini Pazartzis, Mauro Politi, José Manuel Santos Pais, Yuval Shany, Margo Waterval and Andreas Zimmermann.

1. The author of the communication is S.C., an Australian national. She submits the communication on her own behalf and on behalf of her deceased son, T.J.C., born on 20 April 1993. She claims that the State party failed to ensure an effective and independent investigation into the death of her son in violation of her and her son's rights under article 6(1), read alone and in conjunction with article 2(3) as well a violation of her rights under article 14 of the Covenant. The Optional Protocol entered into force for the State party on 25 December 1991. The author is represented by counsel.

The facts as submitted by the author

2.1 On the evening of 11 December 2008, the author's 15-year-old son was fatally shot by members of Victoria Police at All Nations Park, Northcote, Victoria. The circumstances of the shooting have been established by an inquest finding conducted by the Coroners Court of Victoria. About 11 minutes before the shooting, the author's son had armed himself with two large knives he had stolen from a store inside a shopping centre, adjacent to All Nations Park. He then moved through the shopping centre, and adjoining shops and car park, pointing the knives at people and demanding that the police be called or people would die that night. At least four people contacted emergency services advising police of the presence of a male armed with knives threatening people.

2.2 Four police officers responded to the scene and requested the author's son to drop the knives, however he did not do so. The police officers then used oleoresin capsicum foam spray on him. Refusing to obey the police calls to throw down the knives, he advanced on the police officers. During the investigation into the incident the police officers stated they were commanding him to put down the knives and stop coming towards them or he would be shot. They backed away as he was advancing before a warning shot was fired. One of the police officers became isolated from the three others. The officer stated that fearing for his life, having been backed up against a railing and having exhausted all other non-lethal options, he fired three shots directly at the author's son's chest area as the author's son walked towards him. Several other shots were fired in rapid succession at this time. In total ten shots were fired by three of the four police officers present, with five shots directly hitting the author's son, one of them fatally entering his body below his left clavicle and causing significant internal bleeding and the collapse of his right lung. He died within minutes at the scene.

2.3 The author provides information on investigative bodies in Victoria, for death associated with police contact. It is common practice for the Victoria Police Homicide Squad, the Ethical Standards Department of Victoria Police (the ESD), and the State Coroner's Office to be notified in the first instance and attend the scene. The Office of Police Integrity (OPI) has a general responsibility in relation to police misconduct and ethical and professional standards, but no specific role to play in the investigation of deaths associated with police contact. The Homicide Squad conducts the primary investigation of deaths associated with police contact. The Homicide Squad is a crime portfolio within Victoria Police. It prepares and delivers to the coroner an inquest brief of evidence on the basis of the primary investigation. The inquest brief forms the basis of the subsequent coronial inquiry. The ESD of Victoria Police oversees the investigation of deaths or serious injury incidents associated with police contact. The intended role of the ESD is to ensure there is no impediment to the investigation, and that the integrity of the investigation is maintained by active oversight.

2.4 At the time of the author's son's death the OPI was empowered to conduct an "own motion" investigation in respect of any matter relevant to the achievement of the Director of the OPI's objectives, which included objectives that arose in respect of police contact-related deaths. The OPI could conduct an investigation parallel to an investigation conducted by Victoria Police, or could conduct its own investigation into any aspect surrounding a death. However, the OPI had no authority to investigate a death associated with police contact to the exclusion, or instead, of Victoria Police. The oversight functions of the OPI have since been transferred to the Independent Broad-based Anti-corruption Commission (IBAC).[1] As with the OPI, IBAC has a general responsibility in relation to police misconduct, but no specific role to play in the investigation of deaths associated with police contact.

[1] With the establishment of IBAC on 11 February 2013, the OPI was dissolved.

2.5 The State Coroner has a statutory obligation to investigate deaths occurring in a range of circumstances. A coroner investigating a death must find, if possible: (a) the identity of the deceased; (b) the cause of death; (c) the circumstances in which the death occurred; and (d) any other prescribed particulars. A coroner may report to the Attorney-General on a death which the coroner has investigated, and may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death, including recommendations relating to public health and safety or the administration of justice.

2.6 The author refers to the Committee's Concluding Observations on the fifth periodic review of the State party in which the Committee expressed "concern at reports of excessive use of force by law enforcement officials against groups, such as indigenous people, racial minorities, persons with disabilities, as well as young people; and regrets that the investigations of allegations of police misconduct are carried out by the police itself".[2]

2.7 Following the shooting, police officers called the Emergency Services Telecommunications Authority at 9:31 pm. A total of 73 seconds elapsed between the time the police officers first saw and engaged with the author's son, and the moment they called an ambulance. The ESD was notified of the fatal shooting at 9:55 pm. The Major Crime Desk was notified at 10:32 pm, and subsequently contacted the Homicide Squad of the Victoria Police at 10:38 pm. At 10:40, a member of the Victoria Police contacted the Coroners Court. At 11:36 pm, members of the Homicide Squad commenced the primary investigation on the scene of the shooting, under the oversight of the ESD. Throughout the evening of 11 December 2008 and the morning of 12 December 2008, members of the Victoria Police were present on the scene of the shooting.

2.8 The Coroner attended a debriefing conducted by the Victoria Police on the night of the shooting, and had then no further involvement in the investigation prior to the delivery of the Inquest Brief to the Coroners Court in September 2009. A media statement tending to justify the use of force by the police officers was authorised by the Victoria Police and released a few hours after the author's son's death, in breach of the policy regarding media interaction following a critical incident, as the police failed to seek the Coroner's approval prior to releasing the statements. Further, police officers represented to the author and her family that they would not release the author's son's name without consultation with them. Despite this, early in the morning of 12 December 2008, his name was put into the public domain, followed by a significant quantity of personal information about him. The Coroner found that there was no evidence as to how his name got into the public domain.

2.9 By letter addressed to the Coroner on 23 April 2009, the author requested that the conduct of the investigation into her son's death be removed from the Victoria Police and assigned to the OPI. On 5 May 2009, the OPI declined the Coroner's request to have it take over the investigation on the grounds that it did not have the resources and necessary charter to do so. However, the Director of the OPI subsequently authorized an assessment as to the sufficiency of the police investigation into the author's son's death. The OPI conducted such an investigation from May 2009 to March 2010. The content of the OPI report is confidential. The OPI also conducted a separate inquiry into the way in which police contact related deaths are investigated in Victoria and issued a public report in June 2011, stating that "the current legislative framework for the investigation and oversight of deaths associated with police contact is not optimal". The OPI made a series of recommendations regarding improvements to the model whereby Victoria Police is responsible for investigations, but noted that it was ultimately a matter for the Government of the State of Victoria to determine whether any policy or legislative changes were appropriate.

2.10 On 30 September 2009, the Homicide Squad delivered an inquest brief of evidence on the basis of the primary investigation it conducted to the Coroners Court. The brief formed the basis of the subsequent coronial inquiry. On 23 November 2011, the Coroner issued an inquest finding. She held that the police fired at the author's son at a time when a police officer was in immediate and perilous danger of serious injury or death. She further found that there were some deficiencies in the investigation conducted by the Homicide Squad[3].

[2] CCPR/C/AUS/CO/5 (7 May 2009).

[3] See paragraph 4.14.

The complaint

3.1 The author notes that she does not request that the Committee determine whether the State party breached its substantive obligations under article 6(1) of the Covenant. Rather, she submits that the potential breach of the substantive obligations that resulted from the circumstances of her son's death engaged the State party's duty to investigate his death in accordance with its obligations under the Covenant. It is the State party's failure to fulfil this duty to investigate that is the subject of the communication.

3.2 The author submits that the current model in Victoria for the investigation of deaths associated with police contact is inconsistent with the State party's obligations under the Covenant. She argues that the State party failed to ensure an effective and independent investigation into the death of her son in violation of her and her son's rights under article 6 (1), read alone and in conjunction with article 2(3) as well as in violation of her rights under article 14 of the Covenant.

3.3 The author refers to the Committee's jurisprudence and notes that where individuals have been killed as a result of the use of force by State agents, the State party is required to ensure that there is an impartial, effective and timely investigation into the death.[4] She argues that in order to meet this requirement, the investigation must: be hierarchically, institutionally and practically independent;[5] be adequate and effective;[6] be open to public scrutiny;[7] be prompt and carried out with reasonable expedition;[8] and involve the next-of-kin.[9] The author submits that the investigation, comprising the primary investigation conducted by Victoria Police and the subsequent coronial inquiry, did not meet these requirements, resulting in a violation of her son's rights under article 6(1) of the Covenant.

3.4 The author submits that the independence of the investigation was tainted because the primary investigation was not conducted by a formally independent body and was not carried out with genuine independence. The investigation was not institutionally independent because the Homicide Squad had primary responsibility for the conduct of the investigation into her son's death. The Homicide Squad is a crime portfolio within Victoria Police. The primary investigation was therefore conducted by persons from the same body as the officers being investigated. The investigation was also not practically independent. It is not sufficient for an independent body to have oversight of an investigation that is carried out by investigators organisationally connected with those under investigation.[10] She argues that for this reason, the oversight carried out by the ESD, the OPI and the inquest were not sufficient to ensure the independence of the investigation. The lack of cultural independence is also likely to have impacted the effectiveness of the investigation because of the possibility that the investigators' objectivity and assessment may have been affected. As a result of the organisational connection between the investigators and those under investigation, the primary investigation was not culturally independent.

3.5 The author further submits that the coronial investigation into her son's death was not adequate and effective because coroners in the State of Victoria generally lack the ability to

[4] The author refers to *Pestaño v The Philippines* (CCPR/C/98/D/1619/2007), *Zhumbaeva v Kyrgystan* (CCPR/C/102/1756/2008), and to among others, the European Court of Human Rights judgments in *Fedorchenko and Lozenko v Ukraine* (application No. 387/03), *McCann v the United Kingdom* (application No. 18984/91), *Dodov v Bulgaria* (application No. 59548/00), *Vo v France* (application No. 53924/00).

[5] The author refers to, *Eshanov v Uzbekistan* (CCPR/C/99/D/1225/2003), *Pestaño v The Philippines*, ibid.; and to, among others, the European Court of Human Rights judgments in *Fedorchenko v Ukraine*, ibid.; *Hugh Jordan v the United Kingdom*, (application No. 24746/94), *Al-Skeini and others v the United Kingdom* (application No. 55721/07).

[6] *Pestaño v The Philippines*, ibid., *Amirov v Russian Federation* (CCPR/C/95/D/1447/2006), *Fedorchenko v Ukraine*, ibid., and to, among others, the European Court of Human Rights judgments in *Simsek v Turkey*, (applications Nos. 35072/97 and 37194/97), *Hugh Jordan v the United Kingdom*, ibid., and *Al-Skeini v the Kingdom*.

[7] *McCann v the United Kingdom*, ibid., *Al-Skeini v the United Kingdom*, ibid.

[8] *Pestaño v The Philippines*, ibid.

[9] *Fedorchenko v Ukraine*, ibid.

[10] *Hugh Jordan v the United Kingdom*, ibid.

control the quality of the primary investigation;[11] and there were deficiencies in the primary investigation that undermined the effectiveness of the coronial investigation and inquest into her son's death. She notes that the primary investigation included several noted deficiencies and she submits that where deficiencies such as these are associated with an investigation, legitimate doubts will be raised as to the overall integrity of the investigative process.[12]

3.6 The author also argues that certain aspects of the investigation bring into question whether the investigation was sufficiently open to public scrutiny. She notes that the conduct of coronial inquests in open court will generally satisfy this obligation of public scrutiny, however she notes that the Homicide Squad failed to inform the Coroner of the covert recordings made of conversations members had with the author and her family.

3.7 The author submits that there were delays in the investigation into her son's death which give rise to legitimate concerns about the promptness of the investigation. In this respect, she notes that: the Homicide Squad was not notified of her son's death until over an hour after it occurred; the police officers present at the shooting were not tested for drugs and alcohol until after 6 am on 12 December 2008, which impaired the test results and which the Coroner found unsatisfactory; testing for gunshot residue was not undertaken until some time after 1 am on 12 December 2008; the Homicide Squad did not focus on identifying potential witnesses and delayed canvassing the incident area until May 2010; the inquest brief was not provided to the Coroner until 30 September 2009; the inquest commenced on 19 October 2010; and the inquest finding was handed down on 23 November 2011.

3.8 The author submits that the nature of her and other members of her family's involvement in the investigation is inconsistent with the procedural obligations regarding the involvement of the next-of-kin under article 6(1), namely the fact that: the Homicide Squad made covert recordings of conversations they had with the author and her family; a media statement regarding her son's death was released at around 1 am on 12 December 2008, just a few hours after his death; her son's name was put into the public domain without consultation with the family; the victim's brother was restrained by police when he attempted to enter the scene of his brother's death; the author was separated from her partner and her son, prior to delivering notification of her son's death; and on the night of her son's death, the author, her partner, and her son were requested to attend Preston police station to make statements, without legal or welfare support.

3.9 The author submits that the breach of the procedural obligations associated with the right to life resulted in her inability to access justice throughout the investigation and the inquest. She notes that article 14 has been considered by the Committee in circumstances where the death of a civilian was allegedly related to the conduct of state agents.[13] She argues that the State party's failure to provide an independent and impartial investigation into the death of her son has meant that the subsequent inquest was itself not sufficiently independent and impartial. She submits that accordingly, her right to a fair and public hearing into her son's death was not effectively guaranteed, in violation of her rights under article 14 of the Covenant.

3.10 The author argues that the State party has further failed to ensure an effective remedy under article 2(3) of the Covenant for the breach of her son's right to have his death investigated in accordance with the procedural obligations of article 6(1). She further argues that this also constitutes a breach of her right to access to justice in violation of article 2(3), read in conjunction with article 6(1). The author submits that, if the Committee finds that the State party has breached article 6(1) of the Covenant in respect of the investigation of the death of her son, it has also breached its obligations under article 2(3).

3.11 The author requests the Committee to recommend that the State party: 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); and make a public apology and

[11] The author notes that in 2005, Victoria Police stated in connection with the review of the *Coroners Act 1985* (Vic) that "coroners do not have the power to issue directions directly to investigating police". Coroners Act Review, Victoria Police's Response to the Discussion paper, received by the Law Reform Committee on 7 October 2005.

[12] European Court of Human Rights, *McKerr v the United Kingdom* (application No. 28883/95).

[13] *Kholodova v Russian Federation* (CCPR/C/106/D/1548/2007).

reparations to the author for its failure to ensure an effective and independent investigation of her son's death.

State party's observations on the admissibility and merits

4.1 On 17 November 2014 the State party submitted its observations on the admissibility and merits of the communication. It acknowledges the tragic circumstances of the author's son's death and expresses its sympathy to the author and her family but submits that the communication should be declared inadmissible for failure to exhaust domestic remedies pursuant to article 5 (2) (b) of the Optional Protocol and under article 2 of the Optional Protocol for failure to substantiate the claims for purposes of admissibility. In the alternative, should the Committee find the communication to be admissible, the State party submits that the complaint is without merit.

4.2 The State party submits that the communication is inadmissible for failure to exhaust domestic remedies by a) appealing the inquest findings, seeking a new inquest, and seeking judicial review; b) commencing a claim against the State of Victoria, the Coroner or Victoria Police; and c) filing a complaint before IBAC.

4.3 The State party submits that the author can appeal against the Coroner's findings in the inquest into her son's death and seek a new inquest. The Coroners Act provides for appeal from the Coroners Court of Victoria to the Supreme Court of Victoria on questions of law. The Act contains appeal provisions in relation to the findings of a Coroner. 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. The Supreme Court may make any order that it thinks is appropriate, including individual relief or remedy in the nature of certiorari, mandamus, prohibition or quo warranto. The Supreme Court may also remit the matter for re-hearing. The State party argues that the author could appeal against the Coroner's findings 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.

4.4 The State party notes that the author could not appeal an error of fact in the inquest 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. If the author could establish that there were 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 chance 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 findings were tainted by an incorrect finding of a jurisdiction fact. The author could also appeal the findings on the grounds that there has been a failure to accord natural justice. 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. 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. Additionally, 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 the findings. 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, it may be available to her to pursue a claim on the grounds that there has been an insufficient inquiry.

4.5 The State party does not accept the author's submission that any new inquest would not offer a reasonable prospect of success. 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. Furthermore, the Coroners Act enables the Court to refer matters to prosecutorial bodies to consider whether criminal proceedings should be instituted.

4.6 The State party argues that the author has also not exhausted domestic remedies by failing to pursue a civil or criminal prosecution. It is open to the author to seek damages for

wrongful death or negligence at common law. A civil action could enable the author to obtain redress for any alleged wrongdoing associated with her son's death. The Victorian criminal justice system also provides a mechanism to prosecute murder and manslaughter, or offences in relation to any alleged improprieties of the investigation. Criminal prosecution can be initiated by private citizens.

4.7 The State party notes the Committee's jurisprudence in *Jonassen et al v Norway*,[14] according to which an author must make use of not only all judicial but also all administrative remedies that offer a reasonable prospect of redress. It submits that one such remedy available to the author is to make a complaint to IBAC. It notes the author's claim that IBAC only has the power to report and make non-binding recommendations and non-mandatory requests for action. It argues that to the contrary, IBAC 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. It may undertake a range of separate investigative action, including an independent investigation into all aspects of a police contact death. Its referral powers enable it to refer matters to prosecutorial bodies to consider whether or not to institute criminal proceedings. It can also initiate criminal proceedings as a prosecutorial body in its own right in relation to any matter arising out of an investigation.

4.8 The State party also submits that the communication should be found inadmissible because the author has failed to substantiate her claims that the investigation into her son's death was not independent or effective or that her and her son's right to an effective remedy was breached.

4.9 As to the merits of the communication, the State party notes that the author claims that it violated its obligation under article 6(1) of the Covenant by failing to ensure and effective and independent investigation into her son's death. It submits that the Committee should follow its previous practice in not exhaustively articulating the duty to investigate. It 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. It submits that the adequacy of an investigation should be assessed on a case-by-case basis. It notes that there is no other body external to the Victoria Police with appropriate skills or expertise to conduct these kinds of investigations in Victoria.

4.10 The State party submits that the coronial investigation into the author's son's death was a functionally separate, independent and effective investigation. It disputes the author's claim that the role played by the Homicide Squad was deficient, that the Coroner relied solely on the inquest brief prepared by Victoria Police, or is empowered to rely solely on this. The Coroner is an independent judicial officer who is in charge of, and directs, all coronial investigations. The inquest into the author's son'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 the author's son's death, which commenced at the time it was reported to the Coroner, on the night of his death. The State party submits that in Victoria, the combination of coronial control and direction, police expertise and the oversight of an independent agency such as the OPI at the time, is the most effective means of determining what occurred in a fatal incident. The inquest brief prepared by the Coroner's police investigator represents only the record of evidence gathered by the police officer. The Coroner does not regard it as either definitive or final in terms of the extent of investigations required.

4.11 The State Coroner, conducted the coronial investigation into the incident. The State Coroner presides over the Coroners Court of Victoria. The court 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 coronial investigation, which includes a mandatory public inquest. 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. A detective from the Homicide Squad was nominated as the Coroner's investigator to gather evidence for, and on behalf of, the Coroner,

[14] *Jonassen et al v Norway* (CCPR/C/76/D/942/2000).

with full access to the investigative resources of Victoria Police. The Coroner's investigator and the Institute of Forensic Medicine 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 and the Institute of Forensic Medicine formed part of the inquest brief.

4.12 The ESD and the OPI provided oversight and integrity functions relating to the conduct of the Coroner's investigator. The ESD oversaw the Homicide Squad officers conducting the investigation, ensuring that the investigation was undertaken impartially. The ESD oversight file was provided to the Coroner, who determined that the file should form part of the evidence at the inquest. The OPI oversaw the police investigation and the ESD's exercise of its function, and it was hierarchically, institutionally and practically independent of Victoria Police. The OPI reviewed the Homicide Squad investigation to inform the coronial process. The review provided independent expert opinion on the sufficiency of the police investigation and the Coroner decided that it would be admitted into evidence at the inquest.

4.13 The Coroner was in charge of and had ongoing involvement in the investigation into the author's son's death. The scope of the inquest was broad and included the circumstances of the author's son'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 inquiry addressed competency, adequacy, and impartiality in how evidence was collected, obtained or potentially compromised, as well as practices that support the coronial process itself. The Coroner conducted the inquest into the death of the author's son over 41 days of public hearings held between 19 October 2010 and 11 March 2011. The family exercised their right to be involved in the coronial investigation as interested parties. They were represented by legal counsel at the inquest. The Coroner considered a broad range of evidence at the inquest. The final inquest brief was in excess of 3670 pages, and included approximately 115 witness statements and 121 exhibits, and included statements from the police officers involved in the shooting. The officers also gave oral testimony at the inquest and were subjected to questioning and cross-examination by the Coroner, the family members and other interested parties. The Coroner published her findings on 23 November 2011, which held that the police fired at the author's son at a time when a police officer was "in immediate and perilous danger of serious injury or death". The Coroner also found no evidence of an actual conflict of interest in the police investigation. She made eight recommendations of changes to the broader investigatory system in Victoria.

4.14 The State party further notes that the Coroner addressed the alleged deficiencies in the investigation noted by the author. The reported one-hour delay in contacting the Homicide Squad of the incident was due to uncertainty as to who was responsible for notifying the squad. However, as per the inquest findings it did not have an impact on the probity of the investigation. The Coroner further 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 manner was a result of anything other than a lack of knowledge of proper procedure. However, she also found that there was no evidence to indicate that any of the officers was affected by alcohol or drugs. The Coroner also did not find the investigation lacking in probity as a consequence of the delay in undertaking gunshot residue testing as this would not have added anything to the investigation, as it was not a situation where it was unclear whether or not shots had been fired or who had fired them. The State party disputes the author's claim that witnesses were not identified in a timely manner, noting that at least 29 witness statements tendered at the inquest were obtained within 24 hours of the incident, while 65 witness statements were obtained in all. The State party further notes that many of the other deficiencies alleged by the author were also considered by the Coroner who found no evidence to indicate that the alleged deficiencies compromised the effectiveness of the coronial investigation. The State party notes that it was the coronial process itself that revealed some of the regrettable practices referred to by the author.[15] These practices did not

[15] The State party notes that these, for example, included the covert recording of discussions with the author, the one-hour delay in notifying the Homicide Squad, the police officer left unsupervised at the

compromise the effectiveness of the coronial investigation or the coronial outcomes, but rather it was the thoroughness and effectiveness of the coronial investigation that revealed said 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. In relation to the author's assertion that Homicide Squad officers covertly recorded meetings with the family, the State party notes that the State of Victoria apologises to the author for this and acknowledges that this practice was unnecessary and would have been distressing to the family. The State party however, notes that there is no evidence to indicate that the recordings interfered with the investigation.

4.15 The State party notes that following the recommendations by the Coroner in the inquest into the author's son's death, as well as the recommendations made in the OPI's overall review of the investigative process following a death associated with police contact, several changes to enhance the process and procedures of investigating deaths involving police contact were made in Victoria, including within the Coroners Court, Victoria Police, the ESD and by the establishment of IBAC.

4.16 As concerns the author's claims under article 14(1), the State party notes the Committee's jurisprudence that a suit at law is based on the nature of the right in question rather than the status of the one of the parties.[16] It argues that 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 the author's son's death and make a determination as to what happened. The State party submits that the investigation does not constitute a suit at law, and therefore article 14(1) does not apply to the communication. If the Committee considers that article 14 applies to the coronial investigation, the State party submits that it was fair, public and independent.

4.17 As concerns the author's claims under article 2 of the Covenant, the State party argues that the article does not establish independent rights. It submits that the coronial investigation into the author's son's death did not breach articles 6(1) or 14. It submits that as there has been no violation of any substantive rights, it is not under any obligation to provide an effective remedy for such a breach.

Author's comments on the State party's observations

5.1 On 10 March 2015, the author submitted her comments on the State party's observations. She maintains that the communication is admissible. She notes that the State party submits that she could appeal the inquest findings. She argues that this avenue is not open to her as she cannot raise the issues of whether there was a procedural breach of the right to life as a point of law in an application for judicial review. She submits that it is not possible under judicial review to seek a remedy regarding the nature of the investigation itself. Judicial review on a question of law is available when the Coroner has failed to exercise their jurisdiction to investigate a death and make those findings they are required to make under the Coroners Act 2008. It is not available in circumstances where the very nature of the investigation, namely by police without sufficient independence, is impugned rather than the exercise of the Coroner's power on the basis of that investigation. The author notes that the Coroner herself stated during the inquest that she would not examine the model of how deaths associated with police conduct are investigated and the fact that the inquest brief was prepared by Victoria Police. Accordingly, judicial review is unavailable on this issue.

5.2 The author further submits that the specific grounds of judicial review identified by the State party are unavailable and would not have a reasonable prospect of success. She argues that there is no suggestion that the Coroner made a finding that was not open on the evidence. The Coroner did not examine the model of investigation. It is that model that forms the basis of her submission that her and her son's rights have been breached. It would not be open to her to seek judicial review of a finding that does not exist. Although the Coroner did make comments regarding the competency, adequacy or impartiality of how evidence was obtained and treated, these matters did not examine the fundamental procedural obligations of the State party pursuant to the right to life. This ground of judicial review is

scene, the delay in conducting gunshot residue testing and the delay in conducting alcohol and drug testing.

[16] The State party refers to *Zundel v Canada* (CCPR/C/89/D/1341/2005), para. 6.8.

more appropriate where the findings being challenged relate to the cause and circumstances of the death, and not the procedural aspects of the investigation into that death. The author further argues that a failure to accord natural justice might arise where a family is not provided with an opportunity to make submissions on a possible adverse finding concerning their interests during a coronial investigation, or where the Coroner is accused of bias. These grounds are irrelevant in the case at hand as the complaint concerns the claim that the investigation upon which the Coroner relied was not sufficiently independent of Victoria Police to satisfy the procedural obligations imposed under article 6(1) of the Covenant. The author submits that she does not have access to a ground of review on the basis of the insufficiency of the inquiry. She argues that this ground of review is only available if the Coroner fails to refer to evidence central to the investigation, makes findings overwhelmingly contrary to the principal findings of fact or the findings are tainted with legal error.

5.3 The author maintains that a new inquest would not be an effective remedy. The Coroner would still rely on Victoria Police to gather evidence and conduct investigations. No matter the Coroner's level of oversight, the Coroner would still rely on an investigation that is not sufficiently independent. Additionally, a breach of the procedural obligations associated with the right to life has already occurred and cannot be remedied by another investigation. For the same reasons, even if the Supreme Court of Victoria could quash the previous inquest and order that a new one be conducted, it would still not correct the deficiencies of the original investigation.

5.4 The author notes that while she may seek damages for a wrongful death or negligence at common law, this action would relate to any substantive breach of the right to life rather than to the procedural breaches that are the subject of the communication. She further argues that any action to commence a private prosecution would suffer the same deficiency. There is no avenue for her to commence a private prosecution to redress the procedural deficiencies of the investigation. In any event, the Director of Public Prosecutions has an effective veto over any private investigation by virtue of s 22(1)(b)(ii) of the Public Prosecutions Act 1994 (Vic). Further, any private prosecution would be for criminal charges against specified persons, which is outside the scope of the author's communication to the Committee.

5.5 The author notes the State party's submission that she has failed to exhaust domestic remedies by not submitting a complaint to IBAC. She submits that this avenue is exhausted as she requested that IBAC's predecessor organisation, the OPI to assume the conduct of the investigation. This request was refused. She notes that Section 4 of the Schedule to the IBAC Act states that all debts, liabilities and obligations of the OPI became those of IBAC when the former body was abolished and any reference to the OPI in any legislation is taken to be a reference to IBAC. In those circumstances, considering IBAC completely succeeded the OPI, the author submits that she has exhausted this avenue. She further submits that if IBAC were to conduct an investigation into any police personnel misconduct, the remedies available to her would not be effective. While IBAC might recommend or initiate criminal proceedings in its own right, it may only do so in relation to a potential criminal offence. This would not remedy any breach of the State's procedural obligations regarding the sufficiency of the investigation.

5.6 The author notes that in its observations the State party refer to a number of changes which are said to have been made to the coronial system and investigative processes since the death of her son. She submits that these changes are not relevant to the question of whether the State party has breached article 6(1) in relation to the investigation of her son's death because the changes were introduced after the investigation into her son's death was completed.

5.7 The author reiterates her initial submission of 3 September 2013 and she maintains that by failing to ensure a hierarchically, institutionally and practically independent investigation the State party is in violation of article 6(1) of the Covenant, and that by failing to ensure an effective remedy for the breach of her son's right to have his death investigated in accordance with the procedural requirements the State party is in violation of article 2(3) of the Covenant.

State party's further observations

6. On 26 October 2015, the State party submitted its observations on the author's comments. It notes the author's argument that any judicial review proceedings brought by her would need to relate to the Coroner's inquiry, and that she would not be able to pursue

judicial review in relation to the nature of the police investigation itself. The State party refers to its observations of 17 November 2014 and it notes that the Coroner considered the alleged deficiencies in the way the police investigation was conducted. The Coroner found that any deficiencies, while regrettable, did not compromise the overall effectiveness of the coronial investigation or outcomes. It submits that if the author considers that the alleged deficiencies did, in fact, compromise the coronial investigation or outcomes, it is open to her to challenge the Coroner's findings on that subject, and in that way, the nature of the police investigation. As such, judicial review is open to the author.

Issues and proceedings before the Committee

Consideration of admissibility

7.1 Before considering any claims contained in a communication, the Committee must decide, in accordance with rule 93 of its rules of procedure, whether or not it is admissible under the Optional Protocol to the Covenant.

7.2 The Committee has ascertained, as required under article 5(2)(a) of the Optional Protocol, that the same matter is not being examined under another procedure of international investigation or settlement.

7.3 The Committee notes the author's claim that the current model in Victoria for the investigation of deaths associated with police contact is inconsistent with the State party's obligations under the Covenant. It notes her claim that the State party failed to ensure an effective and independent investigation into the death of her son in violation of her and her son's rights under article 6 (1), read alone and in conjunction with article 2(3) as well as in violation of her rights under article 14 of the Covenant. It also notes her claim that there were deficiencies in the investigation conducted by Victoria Police and her submission that legitimate doubts can be raised as to the overall integrity of the investigative process.

7.4 The Committee notes the State party's submission that the communication should be considered inadmissible on the grounds of non-exhaustion of domestic remedies.

7.5 The Committee notes the State party's submission that the author could challenge the Coroner's findings before the Supreme Court of Victoria and seek a new inquest on the grounds that the findings were not open on the evidence, that there was a failure to accord natural justice, or that there was an insufficient inquiry. The Committee also notes the State party's submission that the author could file a complaint with IBAC.

7.6 The Committee notes the author's argument that an application for judicial review is not available in her case, as she could not seek a remedy regarding the nature of the investigation itself in an application for judicial review. It notes her argument that the grounds for judicial review listed by the State party are irrelevant in her case as her complaint concerns the claim that the investigation upon which the Coroner relied was not sufficiently independent of Victoria Police to satisfy the procedural obligations imposed under article 6(1) of the Covenant. The Committee further notes the author's argument that a new inquest would not be an effective remedy as in the event of a new inquest the Coroner would still rely on Victoria Police to gather evidence and conduct investigations. It further notes her argument that she has exhausted the avenue of recourse to IBAC as her request for IBAC's predecessor organisation, the OPI, to assume the conduct of the investigation was denied.

7.7 The Committee further notes that the State party disputes the author's argument that any new inquest would not offer a reasonable prospect of success as the Coroner has extensive powers of investigation, which are not limited to relying on any existing evidence, and as the Coroners Act enables the Court to refer matters to prosecutorial bodies to consider whether criminal proceedings should be instituted. It further notes the State party's argument that if the author considers that the deficiencies she has referred to compromised the coronial investigation or outcomes, it is open to her to challenge the Coroner's findings on that subject, and in that way, the nature of the police investigation by way of judicial review. It further notes the State party's argument that 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, she may pursue a claim on the grounds that there has been an insufficient inquiry before the Supreme Court. The committee recalls that international standards on such an investigation are set out in the Minnesota Protocol on the investigation of potentially unlawful death (2016). Paragraph 8 (c) describes the duty to investigate as an essential part to the right to

life, paragraph 28 sets out the requirement of impartiality and independence and paragraph 35 describes the role of the family.

7.8 The Committee recalls its jurisprudence that, although there is no obligation to exhaust domestic remedies if they have no chance of being successful, authors of communications must exercise due diligence in the pursuit of available remedies and that mere doubts or assumptions about their effectiveness do not absolve the authors from exhausting them.[17] The Committee observes that, in the present case, the option of an application for judicial review of the coronial findings was open to the author. It further notes that the author has referred to a number of deficiencies that she contends raises doubts as to the overall integrity of the investigative process. It notes the State party's argument that if the author considers that these deficiencies compromised the coronial investigation or outcomes, it was open to her to challenge the findings on that subject, and in that way, the nature of the police investigation by way of judicial review. The Committee notes that the author has however not raised these deficiencies in an application for judicial review nor has she raised any other aspect related to the police investigation or the Coroner's inquest before domestic authorities. The Committee recalls that it can examine claims challenging the lack of independence of the institutions and proceedings surrounding a criminal investigation and identify legislation or practices which are inconsistent with the rights protected under the Covenant. However, claims regarding the lack of independence of a police investigation formulated in general terms and not based on concrete facts and evidence challenged before the domestic authorities have been found to be inadmissible.[18] In these circumstances, as the author has not raised her claims of deficiencies in the investigation before the domestic authorities, and taking into account the State party's submission that a potential new inquest following an application for judicial review would have, been an effective remedy considering the fact that a Coroner has extensive powers of investigation and the power to refer matters to prosecutorial bodies, the Committee is of the view that the author has failed to exhaust available domestic remedies. The Committee therefore considers that the communication is inadmissible pursuant to article 5 (2) (b) of the Optional Protocol.

8. The Committee therefore decides:

a) That the communication is inadmissible under article 5 (2) (b) of the Optional Protocol;

b) That the present decision shall be transmitted to the State party and to the author.

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[17] See, inter alia, *V.S v. New Zealand* (CCPR/C/115/D/2072/2011), para. 6.3, *García Perea v. Spain* (CCPR/C/95/D/1511/2006), para. 6.2; and *Zsolt Vargay v. Canada* (CCPR/C/96/D/1639/2007), para. 7.3.

[18] *Hickey v. Australia* (CCPR/C/111/D/1995/2010), para. 8.4.