IN THE CORONERS COURT OF VICTORIA **No. 5542 of 2008**

INQUEST INTO THE DEATH OF TYLER CASSIDY

SUBMISSIONS OF THE HUMAN RIGHTS LAW RESOURCE CENTRE

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A. Introduction

The HRLRC's role in the inquest into the death of Tyler Cassidy

1. The Human Rights Law Resource Centre (***HRLRC***) was granted leave to intervene in this inquest as an interested party for the purpose of assisting the Coroner by making submissions in respect of the application of the *Charter of Human Rights and Responsibilities 2006* (Vic) (***Charter***) to the issues raised in the inquest.

2. These submissions focus primarily upon systemic issues raised in this inquest. The purpose of these submissions is to:

   (a) identify the human rights and State obligations under the Charter relevant to the issues raised in the inquest;

   (b) assist the Coroner in the proper application of Charter rights and State obligations to the issues raised in this inquest;

   (c) assist the Coroner to discharge her obligations under the Charter; and

   (d) propose recommendations which the Coroner may adopt in order to ensure the State complies with its obligations under the Charter.

B. Framework established by the Charter

The human rights relevant to the inquest

3. In 2006, Victoria enacted the Charter, which enshrines peoples' human rights and sets out the obligations on the State to protect those rights.

4. Most relevantly in this inquest, the Charter protects the right to life (s 9 of the Charter) and the right of children to protection in their best interests (s 17(2) of the Charter). These rights are to be enjoyed without discrimination in accordance with ss 8(2) and 17(2) of the Charter.

5. Pursuant to s 32(2) of the Charter, international law and the judgments of domestic, foreign and international courts and tribunals are able to be used to interpret Charter rights. This is particularly important given that the Charter has only been in operation for a short time and there is limited Victorian jurisprudence on Charter rights.

   The right to life

6. Section 9 of the Charter provides that 'Every person has the right to life and has the right not to be arbitrarily deprived of life'.

7. The right to life imposes two broad substantive obligations on the State and also a procedural obligation.

8. The substantive obligations require the State to ensure that:[1]

   (a) no one is arbitrarily deprived of life, including at the hands of State law enforcement officers; and

   (b) appropriate legislative and administrative measures are taken to protect life and to guard against the arbitrary deprivation of life.

9. Tyler was shot and killed by the Victoria Police, engaging the State's obligation not to arbitrarily deprive Tyler of his life. Tyler's death also engages the right to life as it concerns the issue of whether Victoria Police, and the State more broadly, had proper systems in place to protect life - such as appropriate training for police in the use of force including non-violent and less than lethal responses to critical incidents as well as the provision of accessible youth mental health services. Safe and non-violent resolution of conflict is clearly in the interests of protecting both the police and the broader community.

10. The application of the substantive obligations to the issues in this inquest is discussed in detail in section C below.

11. An actual or potential breach of the substantive obligations engages the 'procedural obligation'.

12. The procedural obligation requires States to ensure that there is an independent, impartial, effective and open investigation of deaths, particularly where individuals have been killed as a result of the use of force by State agents.[2] Put broadly, the purpose of the investigation is to ensure the effective implementation of domestic laws that protect life and to ensure accountability for deaths occurring in State custody.

13. Under the right to life, the State of Victoria therefore has a positive obligation to ensure an independent investigation is conducted into Tyler's death. As part of that investigation, inquiry must be made into whether the State breached Tyler's rights under the Charter.

14. The existing system for investigation of deaths in police custody, the manner in which the investigation of Tyler's death was carried out, and the compatibility of those processes with the right to life, is discussed in detail in section D below.

Children's rights

15. Section 17 of the Charter provides that 'Every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child.'

16. It is established in international jurisprudence that the rights of the child require every legislative, administrative and judicial body or institution to systematically consider how

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[1] *R (Humberstone) v Legal Services Commission* [2010] EWHC 760, [44]; *Savage v South Essex NHS Trust* [2009] 1 AC 681, [76]. See also *R (Gentle) v The Prime Minister* [2008] 1 AC 1356; *Hertfordshire Police v Van Colle* [2009] 1 AC 225.

[2] *McCann v United Kingdom* (1996) 21 EHRR 97, [161]; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [20].

children's rights and interests are or will be affected by their decisions and actions[3] and to treat the best interests of the child as paramount or as the 'primary consideration'.[4]

17. It follows that the obligation to respect children's rights requires administrative bodies such as Victoria Police to consider in advance how children's rights may be affected by the actions of that body, and (by implication) implement policies that address the potential effect of their actions upon children.

18. In considering the actual or potential effect a decision or action may have on children's rights, the best interests of the child must be a primary consideration.[5]

19. Tyler's death raises issues of how Victoria Police processes take into account and impact upon the rights of children, particularly the right to life.

Right to non-discrimination

20. Section 8(2) of the Charter provides that 'Every person has the right to enjoy his or her human rights without discrimination.'

21. The right to non-discrimination is therefore interconnected with all of the other Charter rights, ensuring that every person has a right to enjoy their human rights without discrimination.

22. 'Discrimination' in the Charter is defined with reference to the *Equal Opportunity Act 1995* (Vic) (the ***EOA***), in which 'protected attributes' relevantly include 'age' and 'impairment'.[6] 'Impairment' is defined in the EOA to include a mental or psychological disease or disorder.[7]

23. The obligation to respect the right to non-discrimination requires the State to ensure that the protection afforded in respect of human rights recognised in the Charter is afforded to all persons equally, without discrimination.

24. It follows that, in acting in accordance with its obligations in respect of the human rights protected by the Charter (including the right to life and the rights of the child), the State must ensure that it does not discriminate between persons on the basis of protected attributes such as age and mental impairment. In some instances, this may require that the State take special measures to protect and advance the rights of persons or groups disadvantaged because of discrimination (s 8(4) of the Charter).

25. In light of the State's positive duties under s 9 (the right to life) and s 8 (equality and non-discrimination), it is clear that police and mental health systems must be developed and implemented in a non-discriminatory way and cater for the vulnerability and special needs of young people and people with mental health issues.

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[3] Committee on the Rights of the Child, *General Comment No 5*, UN CRC, 34th sess, [12], UN Doc CRC.GC.2003/5 (2003). See also *Case of Bulacio v Argentina – Series C No. 100* [2003] IACHR 3.

[4] See, eg, *ZH (Tanzania) FC (Appellant) v Secretary of State for the Home Department* [2011] UKSC 4 (1 February 2011); *R v Ashman* [2010] ACTSC 45 (21 May 2010).

[5] *Bakhtiyari v Australia*, Communication No. 1069/2002, UN HRC, 79th sess, UN Doc CCPR/C/79/D/1069/2002 (2003).

[6] *Equal Opportunity Act 1995* (Vic), s 6.

[7] *Equal Opportunity Act 1995* (Vic), s 4.

The Coroner's Role

26. The HRLRC submits that the Charter engages, binds and must be applied by the Coroner in four ways:

    (a) as a court acting administratively (and therefore as a public authority);

    (b) by its application to courts and tribunals under s 6(2)(b);

    (c) by the construction that the interpretive provision in s 32(1) requires be placed on Victorian statutes including the provisions of the *Coroners Act 2008* (Vic) (***Coroners Act***); and

    (d) in making findings and recommendations in respect of Victoria Police which is a public authority.

As a court acting 'administratively'

27. The HRLRC submits that, as a general rule, the Coroner is a public authority when undertaking its functions under the *Coroners Act 2008* (Vic) (***Coroners Act***) of investigating reportable deaths and conducting inquests into those deaths.[8]

28. As a court for the purposes of the Charter (s 3(1) of the Charter), the Coroners Court is not a public authority except when it is acting in an 'administrative' capacity (s 4(1)(j)).[9] A note to s 4(1)(j) provides some guidance, stating that committal proceedings, the issuing of warrants, listing cases or adopting practices and procedures by a court or tribunal are examples of when a court or tribunal is acting in an administrative capacity.

29. The meaning of 'administrative capacity' is primarily a question of statutory construction. However, the exercise of powers under the Coroners Act are properly characterised as administrative in nature for two reasons.

    (a) The role of the Coroners Court is inquisitorial[10] and has traditionally been characterised as non-judicial or quasi judicial.[11] A coroner conducting an inquest has functions more administrative in nature than a magistrate's functions on a committal hearing, as the coroner's role involves the bare finding of facts without the power to expose a party to committal to stand trial.[12]

    (b) The role of coroners can be characterised as administrative in contrast to the features of judicial power as described in Commonwealth constitutional jurisprudence. The Coroner is not empowered to make binding determinations of

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[8] It may be that in some circumstances the Coroner is not acting administratively, such as where she issues a certificate under s 57 of the Coroners Act that determines the rights of a person in respect of self-incrimination.

[9] See *Coroners Act 2008* (Vic), s 89(3) which states that the coroner or registrar constitutes the Coroners' Court when exercising the functions under the Act.

[10] See s 89(4) Of the *Coroners Act 2008* (Vic)

[11] See *Bilbao v Farquhar* [1974] 1 NSWLR 377 at 387.

[12] See *Annetts v McCann* (1990) 170 CLR 596 at 617.

legal right and is confined to making findings of fact and recommendations.[13] In *Sabet v Medical Practitioners Boad of Victoria* [2008] VSC 346, Hollingworth J determined the meaning of 'administrative capacity' by applying the distinction between administrative power and judicial power established by the High Court.[14]

30. When acting administratively, the Coroner is bound by s 38(1) of the Charter which provides that it is unlawful for a 'public authority' to:

    (a) act in a way that is incompatible with a human right;[15] and

    (b) in making a decision, to fail to give proper consideration to a relevant human right.[16]

31. Further, the Coroner has a discretion under s 67(3) of the Coroners Act to comment on any matter connected with the death, including matters concerning public health and safety. That discretion should be exercised in accordance with the Coroner's obligations under s 38. So for example, the Coroner should give proper consideration to human rights including whether there are proper systems in place to prevent deaths.

Discharging functions under the right to life

32. The Coroner's second source of obligation under the Charter is s 6(2)(b) and Part 2 of the Charter.[17] That is, the Charter applies to the Coroners Court pursuant to s 6(2)(b) because of the duties the Coroner exercises in furtherance of the right to life. In the Statement of Compatibility for the Coroners Bill 2008, the Attorney-General stated:

> In other jurisdictions [the right to life] has been interpreted to include an obligation on government to ensure an effective investigation into certain deaths. As the most significant investigative mechanism into reportable and reviewable deaths, the coronial system gives effect to this right.[18]

33. It follows that the Charter applies to the Coroner to the extent that she is exercising her functions as the system for investigation of deaths in State custody.

34. Even when acting in a judicial capacity, courts remain bound to the extent specified in s 6(2)(b). As Bell J stated in *Secretary to the Department of Human Services v Sanding*:

> By excluding courts and tribunals from the definition of a public authority (except when acting administratively), while at the same time making the Charter apply directly to them in respect of the specified functions, the legislation has preserved the substantive legal

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[13] *Coroners Act 1008* (Vic), s 67; *Sabet v Medical Practitioners Board of Victoria* [2008] 20 VR 414, [126] citing *Albarran v Companies Auditors and Liquidators Disciplinary Board* (2007) 231 CLR 350, 358, [16] per Gleeson CJ, Gummow, Hayne, Callinan, Heydon and Crennan JJ; 377-378, [94] per Kirby J.

[14] There her Honour held that the Medical Practitioners Board of Victoria was a tribunal but that the disciplinary proceedings in which it was involved were administrative not judicial in nature. See also *Kracke v Mental Health Review Board* [2009] VCAT 646, [283]ff.

[15] 'Act' is defined in s3 (1) of the Charter to include a failure to act and a proposal to act.

[16] See also Bell J in *Kracke v Mental Health Review Board* [2009] VCAT 646, [283]ff.

[17] Section 6(2)(b) provides that the Charter applies to courts and tribunals to the extent that they have functions under Part 2 (Human Rights) and Part 3 (Application of Human Rights in Victoria – including interpretation of legislation).

[18] Charter of Human Rights and Responsibilities Statement of Compatibility, Coroners Bill 2008, found at Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4030 (Rob Hulls, Attorney-General).

> foundation of the jurisdiction of courts and tribunals, while making it obligatory for them to act compatibly with the Charter in respect of those matters which are within their own direct control...[19]

Statutory Interpretation

35. When interpreting statutes the Coroner is bound to apply s 32(1) of the Charter, which provides:

> *So far as it is possible to do so consistently with their purpose, all statutory provisions must be interpreted in a way that is compatible with human rights.*

36. The interpretive obligation in s 32 of the Charter is 'a statutory directive'[20] which requires all persons engaged in the task of statutory interpretation to 'explore all "possible" interpretations of the provision(s) in question, and adopt that interpretation which least infringes Charter rights'.[21]

37. The interpretive obligation requires that the Coroners Act – including the nature and scope of the Coroner's function in s 67– must be interpreted in the manner that is most protective of human rights, subject to the purpose of the legislation and what is 'possible'.

38. It is both possible and consistent with the purposes of the Coroners Act to give the provisions of the Act an interpretation compatible with the right to life, the right to protection of children and the right to non-discrimination.

39. The Preamble and s 1 of the Coroners Act make clear that the purposes of the Victorian coronial system include contributing to the reduction of the number of preventable deaths, and promoting public health and safety and the administration of justice. The purpose of prevention of deaths is closely aligned with the examination by the Coroner of the systemic issues relevant to the right to life, such as whether the State has appropriate systems in place to protect life in the form of laws, police policies, and training.

Considering the role of the Victoria Police

40. Victoria Police and individual officers are public authorities.[22] Accordingly, Victoria Police and individual officers of Victoria Police are bound by the s 38 Charter obligations.

41. Therefore, in commenting on Victoria Police's conduct, the Coroner will necessarily have to have regard to the Charter, because Victoria Police is a public authority bound to act in a way which is compatible with Charter rights.[23]

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[19] Secretary to the Department of Human Services v *Sanding* [2011] VSC 22 (22 February 2011), [166]. See also *Kracke v Mental Health Review Board* [2009] VCAT 646, [241].

[20] *R v Momcilovic* [2010] VSCA 50, [102]. This decision is currently the subject of an appeal to the High Court (No. M134 of 2010).

[21] *R v Momcilovic* [2010] VSCA 50, [103]. This decision is currently the subject of an appeal to the High Court (No. M134 of 2010).

[22] See Charter, ss 4(1)(b) and (d); *Interpretation of Legislation Act 1984*(Vic), s 38.

[23] Charter, s 38(1).

The Coroner's task in the Cassidy inquest

42. Under the Coroners Act, the Coroner's role includes determining the circumstances in which Tyler's death occurred. In order to discharge the State's obligation to conduct an independent investigation into Tyler's death, the Coroner must also determine whether these circumstances involved any breach of the substantive obligations on the State to protect Tyler's human rights – namely his right to life, his rights to special protection as a child, and his right to non-discriminatory enjoyment of his human rights. It is also necessary to consider the system of laws, policies and training that are in place to protect life, including an assessment of whether those systems adequately reflect the special needs and vulnerabilities of children and people in mental health crisis.

43. Accordingly, in order for the Coroner to fulfill her role, the HRLRC submits that it is necessary for her to consider:

    (a) the regulatory framework controlling the use of force, particularly lethal force;

    (b) the policies, procedures, practices and training of Victoria Police in relation to the use of force, including the range of non-violent and non-lethal options;

    (c) the policies, procedures, practices and training of Victoria Police in relation to engagement with children;

    (d) the policies, procedures, practices and training of Victoria Police in relation to engagement with people in mental crisis;

    (e) the precise nature of the force used;

    (f) who used such force;

    (g) why that person used lethal force, including what was known or reasonably suspected or feared about the threat posed to life at the time, and the availability of alternatives to the use of lethal force;

    (h) the immediate circumstances leading up to Tyler's death, including the actions and response of emergency services, police officers and others that led to the use of lethal force;

    (i) whether the use of force by members of Victoria Police was both absolutely necessary and strictly proportionate;

    (j) whether Victoria Police took appropriate steps to safeguard life;

    (k) whether steps could have been taken by members of Victoria Police which would have avoided the deprivation of life without putting the lives of others at risk;

    (l) whether the incident was managed and controlled by Victoria Police in a way which sought to avoid the unnecessary use of lethal force;

    (m) whether the response was appropriate in light of Tyler's status as a child and what, if any, special measure were adopted to protect Tyler and his human rights;

    (n) whether the circumstances of Tyler's death have been investigated in a manner which is consistent with the Charter obligations of independence;

(o) whether the system of investigation of deaths in custody in Victoria is properly independent in accordance with the right to life.

C. The Right to Life

Introduction

44. As set out in section B above, the right to life imposes substantive obligations on the State of Victoria, and its agents, the Victoria Police, to protect life and to ensure that no one is arbitrarily deprived of life.

45. These substantive obligations include a negative obligation to refrain from taking life 'intentionally".[24] Importantly, both the State and Victoria Police have a positive obligation to take steps to safeguard life.[25] This positive obligation is of particular relevance to the circumstances of Tyler's death. The investigation into Tyler's death must, therefore, address each of the following questions to determine whether the State and Victoria Police discharged this obligation in relation to Tyler:

(a) Did the State, through its agents the Victoria Police, take appropriate steps to safeguard Tyler's life?

(b) Did the framework of laws and procedures in place at the relevant time protect Tyler's life to the greatest extent practicable?

(c) Was the law regulating the use of lethal force by Victoria Police sufficiently clear and detailed? Was this law in accordance with the right to life?

(d) Was the force used by Victoria Police against Tyler 'absolutely necessary' and 'strictly proportionate'?

(e) Could the use of lethal force have been avoided? Were there steps that could have been taken which might have avoided the deprivation of Tyler's life without putting the lives of others at risk?

(f) In particular, taking into account the information which was available to Victoria Police on the evening, could the police members who engaged with Tyler have planned and executed this engagement differently so that the use of lethal force was not required?

(g) Had the police members who engaged with Tyler received appropriate training to assess whether there was an absolute necessity to use force? Did this training equip them with the skills to avoid any unnecessary use of lethal force, in particular, when confronted with someone suffering from a mental illness?

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[24] *McCann v United Kingdom* (1996) 21 EHRR 97; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [19]; *Osman v United Kingdom* (1998) 29 EHRR 245, [115].

[25] *McCann v United Kingdom* (1996) 21 EHRR 97; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [19]; *Osman v United Kingdom* (1998) 29 EHRR 245; *LCB v United Kingdom* (1998) 27 EHRR 212, [36]; *Keenan v United Kingdom* (2001) 33 EHRR 913, [88]-[90]; *Edwards v United Kingdom* (2002) 35 EHRR 487, [54].

46. In order to answer these questions the Coroner is required to critically assess the actions taken by all relevant members of Victoria Police on the evening of 11 December 2008 as well as the broader laws, policies and other systems in place to protect Tyler and other young people or people in mental health crisis. These actions fall to be assessed in light of all of the relevant circumstances including the information available to the police members and the nature of the threat posed by Tyler.

47. When assessing whether the relevant procedures and training discharged the obligation to safeguard life, the Coroner will also have regard to the fact that Tyler was 15 years old. The Coroner should, therefore, consider whether the safeguards gave particular consideration to the special protection of children, and to providing those safeguards in a non-discriminatory manner, whether on the basis of his age, or mental impairment.

Was the law regulating the use of lethal force by Victoria Police in accordance with the right to life?

48. States have a positive duty to:

    (a) establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent practicable, protect life;[26] and

    (b) adopt clear and detailed domestic law on the use of lethal force which should strictly regulate its use in accordance with the right to life.[27]

49. The circumstances in which members of Victoria Police are lawfully permitted to use force are regulated at both common law and by legislation. More specific policies and procedures governing the use of force are contained in Victoria Police policies and procedures, in particular, the Victoria Police Manual.

50. Section 11 of the *Police Regulation Act 1958* (Vic) confers on all sworn members of the Victoria Police the powers, privileges and duties given to police by the common law and by any Act of Parliament.

51. Section 462A of the *Crimes Act 1958* (Vic) (***Crimes Act***) provides

> A person may use such force not disproportionate to the objective as he believes on reasonable grounds to be necessary to prevent the commission, continuance or completion of an indictable offence or to effect or assist in effecting the lawful arrest of a person committing or suspected of committing any offence.

52. Section 463B of the Crimes Act justifies the use of such force as may reasonably be necessary to prevent the commission of suicide or any act which the person using force believes on reasonable grounds would, if committed, amount to suicide.

53. A member of Victoria Police may also use such force as may be reasonably necessary for the purpose of apprehending a person under s 10(1) of the *Mental Health Act 1986* (Vic).

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[26] *McCann v United Kingdom* (1996) 21 EHRR 97, [150], [156]; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, [2]; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [30]; *Osman v United Kingdom* (1998) 29 EHRR 245; *LCB v United Kingdom* (1998) 27 EHRR 212, [36]; *Keenan v United Kingdom* (2001) 33 EHRR 913, [88]-[90]; *Edwards v United Kingdom* (2002) 35 EHRR 487, [54]..

[27] *Leonidis v Greece* [2009] ECHR 5, [56]; *Simsek v Turkey* [2005] ECHR 546, [104]. See also *McCann v United Kingdom* (1996) 21 EHRR 97, [151]-[156]

Section 10(1) permits a member of the police force to apprehend a person who appears to be mentally ill if the member has reasonable grounds for believing that the person has recently attempted suicide or has attempted to cause serious bodily harm to themselves or to anyone else, or is likely to do so.

54. At the time of Tyler's death, the Victoria Police Manual (***VPM***) contained the following relevant policies and procedures :

VPM 101-1 Operational Safety Principles[28]

- Section 1 – Policy: apply the following philosophy, including occupational health and safety considerations to the planning, implementation and evaluation of police operations: "the success of an operation will be primarily judged by the extent to which the use of force is avoided or minimised".
- Section 4 – Principles: when responding to incidents or planning operations that may involve any potential use of force, apply the following principles:
    - Safety first – the safety of police, the public and offenders or suspects is paramount
    - Risk assessment – is to be applied to all incidents and operations
    - Take Charge – exercise effective command and control
    - Planned response – take every opportunity to convert an unplanned response into a planned operation
    - Cordon and containment – unless impractical, adopt a "cordon and containment" approach
    - Avoid confrontation – a violent confrontation is to be avoided
    - Avoid force – the use of force is to be avoided
    - Minimum force – where use of force cannot be avoided, only use the minimum amount reasonably necessary
    - Forced entry searches – are to be used only as a last resort
    - Resources – it is accepted that the "safety first" principle may require the deployment of more resources, more complex planning and more time to complete.

VPM 101-3 Operational Safety and other equipment[29]

- Section 1 – Policy:
    - operational safety equipment must only be used in accordance with Victoria Police Policies

[28] IB2678.

[29] IB2692.

- only sworn employees with current OSTT qualifications can carry operational safety equipment

- Section 6 – Firearms
    - sworn employees are issued with firearms to protect themselves and the public and for the lawful destruction of animals (clause 6.1)
    - to be issued with or to carry a firearm, sworn employees must have a current OSTT qualification (clause 6.2.1)
    - except for the lawful destruction of animals, a sworn employee issued with a firearm:
        - must not draw the firearm unless extreme danger is anticipated
        - may only discharge the firearm when they reasonably believe it is necessary to protect life or prevent serious injury. Warning shots should not be fired (clause 6.3).
- Section 7 – OC spray/foam
    - OC spray/foam must only be issued to sworn employees who hold a current OSTT qualification and have been specifically trained in the use of OC spray/foam (clause 7.1.1)
    - members may only use OC spray/foam where they believe on reasonable grounds it is necessary:
        - in situations of violence and serious physical confrontation;
        - in situations where a member believes on reasonable grounds that a violent or serious physical confrontation is imminent;
        - in situation where a person is involved in violent or other physical conduct likely to seriously injure themselves or result in suicide; or
        - to deter attacking animals (clause 7.2.1).
    - members must not use OC spray/foam when a person is passively resisting eg hanging limp or refusing to comply with instructions (clause 7.2.1)

55. At the time of Tyler's death, the VPM did not contain any reference to s 462A, or to the circumstances in which members of Victoria Police are lawfully entitled to use force.

56. The VPM did not (and does not) contain any specific policies, rules or guidance for the use of force in relation to children or young people, or people in mental crisis.

57. The VPM also did not (and does not) contain any reference to the Charter and the obligations which the Charter, and in particular the right to life, places on Victoria Police in relation to the use of force.

58. In February 2010, the VPM was effectively re-written.[30] The revised VPM includes a 'Policy - Operational Safety and Equipment'.[31] This Policy set out the rules and responsibilities of members of Victoria Police in relation to the use of force and replaced VPM101-3 (as set out above). The Policy notes that any force used by a member must be in line with s 462A of the Crimes Act and quotes that section. The Policy also repeats the philosophy that "the success of an operation will be primarily judged by the extent to which the use of force is avoided or minimised".

59. The Policy contains the following rules and responsibilities relating to the use of force:

> The use of force, including the use of operational safety equipment, must be in accordance with s.462A, Crimes Act...or other specific legislative provisions.
>
> - The level of force required to bring an incident under control may need to increase or decrease depending on the situation. Members are trained in a range of techniques and a variety of equipment to enable them to have options when responding to an incident. Refer to VPMG Operational safety and equipment for a representation of the Tactical Options Model.
> - Operational safety equipment must be used in line with the principles or techniques taught in the relevant operational tactics training (OSTT). Refer VPMG Operational Safety and equipment for additional guidance on the use of specific operational safety equipment.

60. The Policy also states expressly that, in addition to complying with s 462A of the Crimes Act, members must apply the operational safety principles (as set out in paragraph 54 above) when responding to incidents or planning operations that may involve any potential use of force.

61. VPMG Operational safety and equipment refers to the Tactical Options Model.[32] The VPMG states that this Model is designed to assist members in understanding the range of tactical options that must be considered. The VPMG emphasises the importance of risk assessment, planning, making all possible inquiries and requesting all assistance necessary prior to choosing an option.

62. The VPM no longer provides any explicit guidance to members in relation to the circumstances in which particular force may be lawfully used (ie similarly to the old VPM 101-3 set out in paragraph 54 above), relying instead on the broad terms of s 462A of the Crimes Act.[33]

63. As noted above, the amendments to the VPM do not contain any reference to the obligations created by the Charter and the VPM did not (and does not) contain any specific

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[30] The amendments to the VPM introduced "Policy Rules" (VPMP) which are mandatory and provide the minimum standards the employees must apply and "Procedures and Guidelines" (VPMG) which are provided to support the interpretation and application of rules and responsibilities and include recommended good practices and assessment tools to help employees make lawful, ethical and professional decisions.

[31] IB2671 (Date of first issue: 22/02/2010).

[32] IB2717-18; Williams Report #4 IB3621, 3649.

[33] Miles T3566.4-8, T3573.27-29.

policies, rules or guidance for the use of force in relation to children or young people, or people in mental health crisis.

64. It is essential that the laws and procedures governing the use of force by Victoria Police fully and explicitly reflect the human rights standards imposed by the right to life. In relation to the use of force by police, these standards require that:

    (a) police may use force only when strictly necessary and to the extent required for the performance of their duty;[34]

    (b) lethal force should only be used:[35]

        (i) where there is an imminent threat of death or serious injury;

        (ii) as a last resort;

        (iii) after provide a clear warning of the intent to use lethal force; *and*

        (iv) after sufficient time for the warning to be observed (unless to do so would unduly place police or other persons at risk or would be clearly inappropriate or pointless in the circumstances of the incident).

65. While requiring that the use of force is both necessary and proportionate to the objective, s 462A alone provides inadequate guidance about use of force because:

    (a) it does not clearly or fully reflect the human rights standards imposed by the right to life or provide sufficient guidance on when lethal force may or may not be used by police officers;

    (b) it does not reflect the obligation to consider pro-active incident management strategies which are critical to avoiding the use of force; and

    (c) it applies to all persons and does not reflect the special position of police officers (as reflected in the Code of Conduct for Law Enforcement Officials and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials).

66. It is highly desirable that these standards are enshrined in legislation, and fully and explicitly set out in the policies, procedures and guidelines regulating the use of force by Victoria Police.

Recommendations

Recommendation 1:

The State of Victoria amend the *Crimes Act 1958*, or enact other legislation, to explicitly and comprehensively guide and regulate the circumstances in which Victoria Police may lawfully use lethal force in accordance with the right to life protected by s9 of the Charter.

[34] Code of Conduct for Law Enforcement Officials (***Code of Conduct***), Article 3.

[35] Basic Principles on the Use of Force and Firearms by Law Enforcement Officials (***Basic Principles***), principles 9 and 10.

Recommendation 2:

Victoria Police should amend the Victoria Police Manual to include specific reference to:

- the Charter, in particular the right to life;
- the obligation of members of Victoria Police to act in accordance with the Charter and to give proper consideration to human rights; and
- the circumstances in which firearms may be lawfully used, in accordance with the human rights standards governing the use of lethal force as set out in the Code of Conduct for Law Enforcement Officials and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, namely:
  - (a) where there is an imminent threat of death or serious injury;
  - (b) as a last resort;
  - (c) after provide a clear warning of the intent to use lethal force; *and*
  - (d) after sufficient time for the warning to be observed (unless to do so would unduly place police or other persons at risk or would be clearly inappropriate or pointless in the circumstances of the incident).

Was the use of lethal force 'absolutely necessary' and 'strictly proportionate'?

67. The use of force by State officials which has resulted in a deprivation of life must have been 'absolutely necessary' and 'strictly proportionate' to the achievement of the permitted purpose.[36] In assessing whether the use of force is strictly proportionate, regard must be had to the nature of the aim pursued, the dangers of life and limb inherent in the situation, and the degree of risk that the force employed might result in loss of life.[37]

68. Relevantly:

    (a) the use of force will be disproportionate if the authorities failed, whether deliberately or through lack of proper care, to take steps which would have avoided the deprivation of life without putting the lives of others at risk;[38]

    (b) the State has a responsibility to ensure that the way in which an operation is planned and executed does not require the use of unnecessary lethal force;[39]

    (c) in planning and executing operations, police must consider alternative strategies to using force and firearms, particularly non-violent strategies such as negotiation. Even in situations that require a quick reaction there should be a clear chain of command and the operation should not be uncontrolled. The overall control of an

[36] *McCann v United Kingdom* (1996) 21 EHRR 97, [148]-[149].

[37] *McCann v United Kingdom* (1996) 21 EHRR 97, [193]-[194].

[38] *McCann v United Kingdom* (1996) 21 EHRR 97, [193]-[194].

[39] *Leonidis v Greece* [2009] ECHR 5, [55].

operation can result in the breach of the right to life if it creates a situation where recourse to firearms is inevitable.

69. It is not the HRLRC's role in this inquest to advocate a position as to whether the force used by the officers involved in this incident was absolutely necessary and strictly proportionate. However the HRLRC has identified the following issues, together with relevant opinions and evidence from the hearing, to assist the Coroner in performing this task. It is of course for the Coroner in her fact finding capacity to accept or reject any such evidence (including the expression of expert opinions), and the Coroner may accept only part of a witness's evidence.

(a) Were adequate risk assessments undertaken by the responding officers?

Superintendent Williams concluded in his initial review of the incident that insufficient risk assessment was applied at the point where members decided to approach Tyler.[40] After reviewing the Inquest Brief, including the four officers' statements, Williams identified 8 occasions on which risk assessments had been undertaken.[41] During examination, however, Williams clarified that these risk assessments were appropriate in light of the training provided at that time,[42] but that he would be "disappointed if there wasn't some change" and "different decisions" made in light of the training which was in place in December 2010.[43]

(b) Was there sufficient planning of the incident?

In his initial review, Williams concluded that very little planning took place.[44] After reading the statements of the four officers, however, Williams stated that "the planning undertaken by Northcote 303 and the supervision role of Northcote 251 was in accordance with procedures in place at the time,[45] and that he did not think there was much more that they could have done in terms of planning.[46] This was consistent with the officers' own evidence that there had been little or no time to plan.[47]

During examination, Williams clarified that in light of the training in place in December 2010, it might have been possible to turn what was an unplanned event into a planned event, for example, by establishing a rendezvous point and that doing so may also have given the opportunity to create a command structure.[48]

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[40] Williams Report #1 IB2423.

[41] Williams Report #4 IB3627.

[42] Williams T3261.24.

[43] Williams T3266.29 to 3267.11.

[44] Williams Report #1 IB2423.

[45] Williams Report #4 IB3626.

[46] Williams Report #4 IB 3622; T3265.19.

[47] Dods T3631.19-28, T3632.14-17, Ferrante T4073.29-T4074.7.

[48] Williams T3268.1-17.

The officers' evidence was that a rendezvous point would not be of use because they did not have an idea of where Tyler was,[49] the risks Tyler posed to the public at that time[50] and the urgency of locating Tyler.[51]

In assessing the level of planning and control, the Coroner should also consider the role played by supervising officers and the level of communication between officers.

(c) Was the decision to engage Tyler appropriate?

In his initial review, Williams concluded that the initial direct approach effectively created a stand off and precipitated the use of force.[52] Williams also referred to the practise of reverting to the 'must resolve quickly' style of managing critical incidents.[53] Williams identified as a reoccurring issue the fact that members were not considering whether it was an operational imperative to immediately engage the subject as a matter of urgency as opposed to creating time to form a basic plan and seek support.[54]

After reading the statements of the four officers, Williams separated the decision to engage into two time frames: (i) the first sighting of Tyler and (ii) the pursuit into the park.[55] Given the over-emphasis on the use of 'safety equipment' to resolve incidents with armed subjects in the pre July 2009 Operational Safety Tactics Training (***OSTT***), Williams stated that the decision to engage on both occasions was not unexpected.[56]

Williams's opinion that the decision to engage was not unexpected appears to have been based on the training that was in place at the time. Williams's evidence was that prior to this incident the training focussed more on confronting a person and there was little evidence of time being devoted to building capability in skills such as tactical communication and conflict resolution.[57]

The evidence of Dods was that the risk of engagement was outweighed by the risk to the public of not approaching.[58]

(d) Was the manner of engagement appropriate?

The evidence to the inquest is that, upon the initial engagement with Tyler, both Dods and Blundell yelled at him to drop the weapons. Dods approached Tyler with

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[49] Dods T3625.23-T3626.5.

[50] De Propertis T3982.15-31, T3984.26-T3984.8.

[51] Blundell T3851.4-20; Ferrante T4074.18-24, T4077.7-13.

[52] Williams Report #1 IB2424

[53] Williams Report #1 IB2428.

[54] Williams Report #1 IB2437.

[55] Williams Report #4 IB3630.

[56] Williams Report #4 IB 3632.

[57] Williams T3274.15.

[58] Dods T3647.23-T3649.11; Dods T3647.13-T3648.4.

the OC foam which he had removed from the vehicle, and Blundell drew his firearm when he got out of the car.[59] Following the pursuit into the park, the officers continued to yell at Tyler to put the weapons down.

In his initial report, Williams suggests that this manner of engagement 'with the inference of presumed rationality on the part of the subject who in many instances is totally irrational, seems to inflame the situation'.[60] In his subsequent evidence, Williams stated that this style of communication, involving yelling and shouting, was "commensurate with established procedure at the time".[61]

Professor McGorry's evidence identified the particular issues which arise when dealing with 'young people' who are still experiencing progressive brain development and, as a result, have less moderation of impulsivity and emotional response.[62] Professor McGorry noted the need for a greater patience, maturity, genuine empathy with, and understanding of, the mindset of the young person. Relevantly, he stated that, when interacting with young people who are in crisis or highly emotional states "it certainly cannot be assumed that they will be able to engage in the same way as a mature adult".[63] In providing specific comments about police dealing with young people in crisis, Professor McGorry noted that it is "typically counterproductive to confront, threaten, shout at or rapidly approach the young person in [a] threatening or anxious manner".[64] His evidence was that in cases where a person is armed, immediately disarming the person should not always be the first priority. The first step is to establish a connection with the person which may lead to disarming them after a period of time.[65]

(e) Could the officers have disengaged?

In his initial review, Williams states that the officers had the opportunity to disengage but did not do so.[66]

In his subsequent evidence, Williams stated, in relation to the second OC foaming, that "an option of maintaining communication and disengaging further to allow a more tactical approach to the cordon may have briefly diffused *[sic]* the situation thereby allowing time for the police dog, 251 supervisor and other resources to arrive".[67] Williams also gave evidence that there was an absence of in-depth training over the past decade of utilising the skill of disengagement.[68]

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[59] Blundell T3868.10-20.

[60] Williams Report #1 IB2439.

[61] Williams Report #4 IB3633.

[62] McGorry, p 3.

[63] McGorry, p 4.

[64] McGorry, p 12.

[65] McGorry T2643.10-29.

[66] Williams Report #1 IB2425.

[67] Williams Report #4 IB3635.

[68] Williams T3337.6.

The officers' evidence was that there was no opportunity to disengage, or that to have done so would have placed members of the public at risk.[69]

(f) The nature and circumstances of each use of force by the police officers, including the threat posed by Tyler to the officers and to members of the public.

Each use of force, and the circumstances existing at the time of that use, should be considered, namely:

(i) First deployment of OC foam;

(ii) Second deployment of OC foam;

(iii) Warning shot;

(iv) Shots to legs; and

(v) Shots to centre mass.

Each use of force should be assessed in light of the evidence to the inquest acknowledging the deficiencies in training prior to July 2009 (see paragraphs 80 to 84 below) and the impact that these deficiencies may have had on the officers' decision to resort to the use of force on each occasion.

The use of non-lethal force – OC spray/foam

70. As noted above, human rights standards require that lethal force is used as a last resort. This requires, among other things, that States and law enforcement agencies develop a range of options to equip police to resolve critical incidents, including non-lethal incapacitating weapons for use in appropriate situations.[70]

71. In Victoria, all operational police now carry OC spray/foam as part of their operational safety equipment.[71] In addition, members of the Force Response Unit (FRU), the Special Operations Group (SOG) and Critical Incident Response Team (CIRT) carry electronic control devices, or "Tasers".

72. In considering the circumstances that resulted in Tyler's death, the Coroner must consider each deployment of OC foam, including whether the deployment was in accordance with VPM 101-3 (as set out at paragraph 54 above) and otherwise appropriate in the circumstances.

73. In undertaking this assessment, the Coroner should take into account the evidence to the inquest regarding the over-reliance on "tactical safety equipment", in particular OC spray/foam, to resolve incidents. Williams's evidence is that, prior to July 2009, the relevant training over-emphasised the use of safety equipment to resolve incidents with armed subjects, with the result that there was a tendency to deploy OC spray as a first resort.[72]

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[69] Dods T3654.17-29, T3674.28-T3675.26; Blundell T3881.28-T3822.7; De Propertis T4002.31-T4003.7, T4032.9-18, T4034.15-20; Ferrante T4091.10-21, T4129.25-T4130.2.

[70] Basic Principles, principle 2.

[71] IB2694.

[72] Williams Report #4 IB3632; Williams Report #2, IB3571.

74. Williams also emphasised during his evidence the need for a risk assessment to be undertaken prior to each use of OC foam. Prior to the second deployment, this risk assessment should have included consideration of whether Tyler fell within the "high pain tolerance" category of persons who are able to resist the effects of OC foam, by reason of his mental state.[73]

75. OC spray/foam provides police with an option for the resolution of critical incidents without the use of lethal force. Its use must, however, be explicitly regulated and officers must be properly trained in relation to the circumstances in which it may be used. The HRLRC is concerned that, notwithstanding the numerous warnings about the overuse of OC spray/foam, the Victoria Police Manual no longer provides any explicit guidance to members in relation to the circumstances in which OC spray/foam may be lawfully used. Explicit policies controlling the use of OC spray/foam are essential to ensure that this tactical option is only deployed when strictly necessary, after all non-violent means have been exhausted in accordance with human rights standards governing the use of force by police.[74]

76. Although OC spray/foam is a less than lethal option, its use must be properly regulated to ensure that it is not deployed unnecessarily or for compliance reasons. It is concerning that the evidence given by Williams is that one of the impacts of training deficiencies over at least the last 10 years is that OC spray/foam is used as a first option, particularly in dealing with public order or street offences. OC foam was used against Tyler twice. The first use did not successfully enable an arrest or disarming of Tyler and the second deployment may have exacerbated the situation and been used where an opportunity existed to communicate and defuse the situation. The Victoria Police Manual should be amended, and there should also be ongoing monitoring of the use of OC spray/foam to ensure that it is not being overused.

Recommendations

Recommendation 3:

Further to recommendation 2 above, Victoria Police should amend the Victoria Police Manual to include specific reference to the circumstances in which OC spray/foam may be lawfully used, in accordance with the human rights standards governing the use of force as set out in the Code of Conduct for Law Enforcement Officials and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, namely:

- where there is an imminent threat of death or injury; and
- only after all non-violent means have been exhausted.

[73] Williams Report #4 IB3634, T3336.5.

[74] Basic Principles, principles 3 and 4.

Recommendation 4:

The use of OC spray/foam by Victoria Police should be monitored by an independent public body, such as the Independent Body discussed below, the OPI or the Victorian Equal Opportunity and Human Rights Commission. To enable this monitoring to occur, Victoria Police should provide regular reports which include:

(a) data on who OC spray/foam is used against, disaggregated by sex, age, gender, race, ethnicity, disability and vulnerability (including whether the person was affected by mental illness/crisis, drugs or alcohol);

(b) a qualitative element that draws upon the Use of Force Reports submitted to the Use of Force Register to give a clear picture of the circumstances in which OC spray/foam is used; and

(c) analysis of who is using OC spray/foam, disaggregated by geographic region, police service areas, police stations and police departments.

Was the training provided to Victoria Police in accordance with the right to life?

77. As stated above, the right to life requires that States must take appropriate steps to safeguard life,[75] which imposes a positive duty to establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent practicable, protect life.[76]

78. The right to life thereby requires that law enforcement agents are trained to protect life by assessing whether there is an absolute necessity to use firearms, not only on the basis of the relevant regulations, but also with due regard to the pre-eminence of respect for human life as a fundamental value.[77] Effective systems for safeguarding life also require police to be trained in a range of non-violent and non-lethal responses, including communication and negotiation. In order to ensure the right to life is upheld, the State of Victoria and Victoria Police must ensure that police are trained:

(a) in the use of alternatives to use of force and firearms, including the peaceful settlement of conflicts;[78]

(b) (if police will be using firearms) in the use of firearms;[79] and

(c) generally, to respect and uphold human rights.[80]

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[75] *McCann v United Kingdom* (1996) 21 EHRR 97; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [19]; *Osman v United Kingdom* (1998) 29 EHRR 245, [115].

[76] *McCann v United Kingdom* (1996) 21 EHRR 97, [150], [156]; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, [2]; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [30]; *Osman v United Kingdom* (1998) 29 EHRR 245; *LCB v United Kingdom* (1998) 27 EHRR 212, [36]; *Keenan v United Kingdom* (2001) 33 EHRR 913, [88]-[90]; *Edwards v United Kingdom* (2002) 35 EHRR 487, [54].

[77] *Leonidis v Greece* [2009] ECHR 5, [57].

[78] Basic Principles, principle 20.

[79] Basic Principles, principle 19.

79. The Coroner should consider whether the training undertaken by the police members was sufficient to discharge this obligation. This includes training in relation to the use of force and, importantly, in the use of alternatives to the use of force, including peaceful settlement of conflicts, as well as training in relation to engagement with children and with people in mental health crisis.

Training in the period up to Tyler's death

80. The evidence to the inquest was that all four police members received Operational Safety Tactics Training, or OSTT.

81. Acknowledged inadequacies relating to training content were:

(a) There was an absence of theory or principles-based modules and instead there was exclusive focus on skills training rather than conflict resolution.[82] Training focused on 'martial arts type defence tactics, scenario training promoting a confrontationist style and the use of "paint ball" close quarter scenario "gun fights", all of which contributed to a move away from the organizational philosophy of safety first.[83]

(b) There was a shift away from the 10 Safety Principles and the 'minimum force' principle adopted under Project Beacon.[84]

(c) Insufficient attention was given to strategies specific to dealing with vulnerable people[85] including people in mental health crisis.[86] For example, between 2006 and 2009, OSTT did not focus on mental health or provide police with training required to identify and respond to people in mental health crisis.[87]

(d) Insufficient attention was given to communication skills[88] and no attention to information gathering and command and control.[89]

(e) There was no training specific to the phenomenon of 'victim precipitated homicide'.[90]

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[80] Code of Conduct, article 2; Basic Principles, principle 20; *Simsek v Turkey* § 108.

[82] Miles gave evidence that by 2007 OSTT had become a one day package focused purely on skills and not on any theory or conflict resolution components: T3540.2. He agreed that, as a trainer, he was disturbed by the lack of a theory component: T3541.12.

[83] Williams Report #2 IB3582.

[84] Williams Report #2 3591.

[85] Williams Report #2 IB3581.

[86] OPI Report *Review of the Use of Force by and against Victorian police* July 2009, p 14.

[87] OPI Report *Review of the Use of Force by and against Victorian police* July 2009, p 14.

[88] Williams Report #2: See further at IB3575-6.

[89] Williams Report #2 IB3577. Fontana T2601.11.

(f) There was 'an absence of strategic planning in terms of OSTT'[91] [redacted]

(g) OST training did not provide clear guidance on the use of warning shots.[93]

82. Acknowledged inadequacies relating to training coverage were:

(a) There were gaps and inconsistencies in the training each member received.[94] [redacted]

(b) Newly promoted sergeants were not given critical incident management training.[96]

83. Acknowledged inadequacies relating to the methods of delivery of training were:

(a) There were concerns about the effectiveness of instructors, their attitudes and credibility.[97]

(b) The time allocated to a standard OSTT package had been reduced from two days to one.

(c) The teaching of skills through scenario training emphasized physical approaches, and culminated in the individual 'resolving' 'bad case' mock incidents by a confrontation approach.[98]

(d) There was no testing or reinforcement of learned principles. Williams gave evidence that assessment at the end of OSTT 'stopped about 4 years ago'.[99]

84. The impact of this approach on the Victoria Police operations has been to diminish the range of non-violent and non-lethal options used by police. According to Williams there was:[100]

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[90] Miles T3570.21.

[91] Williams Report #2 IB3585.

[redacted]

[93] Miles T3573.74. The failure to train at all in relation to warning shots was an alarming gap in training about a potentially fatal practice – and at odds with the clear terms of section 6 of VPM 101-3 (see paragraph 54 above).

[94] Williams T34418.2-6,12 [redacted]

[redacted]

[96] It was accepted that a training void had developed at inspector and senior sergeant level; and that senior sergeants were required to perform roles for which they had received no training: Williams Report #2 IB3578. The 251 patrol supervisor, Gevaux, had not received critical incident management training: T2202.19.

[97] Williams Report #2 IB3585-IB3586 [redacted]

[98] Williams Report #2 IB3582.

[99] Williams T3380.31.

[100] Williams Report # 2 IB3570-3571.

(a) a decade in which operational police were not exposed to fundamentals underpinning police operational safety training;

(b) consequential impacts on policing style, 'creating a culture that on occasions was no longer supportive of the strategic direction and organisational safety policy'; and

(c) an impact on style often seen in responses to street offences 'where there is a tendency to deploy OC spray as a first option'.

How did the four members' training play out?

85. Each of the four members present had current OSTT qualifications at the time of Tyler's death.

86. The members' reports of training they had undertaken relevant to the incident were inconsistent in the aspects they chose to focus on as relevant.

87. The officers were said to have conformed to their training,[101] (although the warning shot appears to have directly contravened s 6 of VPM 101-3) and experts in training were reluctant to criticize the decisions they made.[102] There was no independent expert opinion of whether the four members' actions conformed to their training or whether their decisions reflected training failures.

88. The following principles / aspects of OSTT were of particular relevance to the incident:

(a) Command and control: Did a member explicitly assume command of the situation?

(b) Planned respons[redacted] Did the members evaluate their options and communicate a plan before alighting from vehicle with weapons drawn? Did they do so while Tyler was distracted by a phone call?

(c) Cordon and contain: Were the members equipped by their training to execute an appropriate cordon and containment strategy as they were instructed to do?

(d) Communication: Was the issue of ultimatums as distinct from open ended commands appropriate?

(e) Avoidance of force[redacted] Were the decisions:

(i) to deploy OC foam a second time after its apparent failure;

(ii) to fire a warning shot; and

(iii) to shoot to wound.

appropriate deployments of force?

Training since Tyler's death

89. Williams's evidence indicated that progress had been made in improving the quality, content and coverage of OSTT. Improvements included:

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[101] Williams IB3637; see also at T3475.4, T3259.22, T3265.5, T3322.19, T3467.19, T3474.12, T3474.15.

[102] Miles T3274.11

(a) The reinstatement of a two day OSTT package;[105]

(b) The commencement of a 'back to basics' refresher package in July 2009 re-oriented to the 10 safety principles;[106]

(c) The delivery of a four hour vulnerable persons training module in January 2010;[107]

(d) Some increase in participation in training at higher levels of police command;[108]

(e) The consultation of experts in the field of mental health in the formulation of policy and training packages.[109]

90. Areas in which the evidence of improvement was more qualified were as follows:

(a) There is a lack of positive guidance as to the circumstances in which use of firearms complies with the obligation to protect life. Instead, witnesses referred repeatedly to s 462A of the Crimes Act (which only deals with the use of force generally) as the 'overarching rule'.[110]

(b) No formal system of evaluation of training has been adopted.[111]

(c) There was no evidence of the establishment of a formal procedure for the incorporation of review recommendations into training,[112] or third party oversight or audit of such a process.[113]

(d) No training specific to the issues presented by 'victim precipitated homicide' has commenced.[114]

(e) No specific training in responding to the needs of children in crisis has been adopted.[115]

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[105] Miles T3541.24.

[106] Williams Report #3 IB3551-2. focussing on conflict resolution and communication skills, information gathering, risk assessment, and tactical options.

[107] Williams Report #3 IB3552; 'vulnerable person' in this context means a person suffering the effects of a mental disorder or substance abuse.

[108] Williams Report #3 IB3556.

[109] Williams Report #3 IB3552, [17].

[110] Miles T3566.4-8; Victoria Police 'has seen fit to remove all of the underlying, other precursor rules ... and gone back fundamentally to 462A of the Crimes Act'. At T3573.27-29, Miles said in relation to warning shots: 'there [currently] is no policy, 462A of the Crimes Act is the overarching law in relation to the application of force.'

[111] Williams Report #3 IB3559: 'a review continues as to the best means of [evaluating OSTT]'. Williams relied on the ad hoc approach of 'daily perusal of the incident fact sheets' as a basis for verifying training outcomes.

[112] In this respect Williams merely referred to 'new reporting lines' by which he reported to the executive on whether recommendations have been met: at IB3558. There was no evidence whether this takes place in practice or with any regularity.

[113] Williams also referred to the requirement to respond to recommendations in the Coroners Act: IB3558. It is to be hoped that a Coronial inquest is not the occasion for future review of, and recommendations relating to training.

[114] Miles T3570.21.

[115] Williams T3349.20.

(f) It was not clear when or with what frequency the vulnerable persons training would be repeated.[116]

(g) There was no evidence of the resumption of testing or assessment at the conclusion of training sessions.

(h) Ambiguity persisted in the guidance offered about the firing of warning shots.[117]

(i) With the exception of the consultation with mental health services in the formulation of the vulnerable persons training, the practice of consultation with affected communities has not been adopted as a principle in the development of training modules.

91. Further, there was no evidence that police member training includes consideration or even mention of the human rights obligations owed by police members.

Recommendations

92. In a rapidly unfolding incident, police members are forced to rely on their training. Effective training is therefore critical to Victoria Police discharging its obligation to protect life.

93. To achieve the objective of protecting life, training must emphasise principles of minimum force, and provide practical strategies for avoiding the use of force. Those strategies exist and have been known to Victoria Police at least since the time of Project Beacon.

94. Discrete sets of issues arise in dealing with young people and people experiencing mental illness. Victoria Police members must be trained to deal with people in those groups in a way that does not place those people at a disadvantage by reason of these attributes. As well as being a practical imperative, this is a legal obligation on the Victoria Police arising under ss 8, 9 and 17(2) of the Charter, which requires that Victoria Police ensure that the systems in place for the protection of life are in the best interests of children and do not discriminate on the basis of age or impairment. This is addressed further at paragraphs 96 to 114 below.

95. History shows that the importance of training within Victoria Police can be supplanted by competing organisational priorities. The decline in the coverage and content of OSTT received by Victoria Police members after Project Beacon is well documented.[119] External oversight is needed to ensure that the delivery of training meets standards consistent with Victoria Police's obligation to protect rights.

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[116] Under cross examination, Williams conceded that members would not receive the vulnerable persons module every six months and said 'the cycles … aren't static': T3358.

[117] Miles T3573.27-29: there [currently] is no policy, 462A of the Crimes Act is the overarching law in relation to the application of force.

[119] See OPI Report *Review of the Use of Force by and against Victorian police* (July 2009); OPI, *Review of fatal shootings by Victoria Police* (November 2005) and Williams Report # 2.

Recommendation 5:

Victoria Police should ensure that minimum use of force is promoted as an organisational value, and is the central principle informing OSTT.

Recommendation 6:

Victoria Police should ensure that its training:

(a) is grounded in human rights principles;

(b) reflects the value of minimum use of force, through the reinforcement of practical strategies; and

(c) is adequately resourced and effectively delivered to all of its members.

Recommendation 7:

Victoria Police should ensure that its training modules are informed by relevant human rights, and make explicit mention of those rights and reinforce the standards connected to those rights.

Recommendation 8:

Police training should be developed in consultation with relevant experts, civil society groups and members of communities that are particularly affected by the exercise of police powers.

Recommendation 9:

Where possible, training on specialist areas should be provided by external specialists, for example, by mental health practitioners.

Recommendation 10:

Victoria Police should resume the practice of testing or assessment of trainees at the conclusion of OSTT sessions.

Recommendation 11:

Victoria Police should adopt a formal structure of review and evaluation of training, involving external review and auditing of its content, coverage and delivery methods. The external review should track and measure the adoption and implementation of recommendations emanating from external and internal reviews and inquiries.

Recommendation 12:

Victoria Police should ensure that OSTT incorporates strategies for dealing with possible 'victim precipitated homicide'.

Meeting the needs of vulnerable people

The legal obligations on the Victorian Government

96. The obligation to respect the right to non-discrimination is a positive and cross-cutting obligation which requires the State to ensure that it protects the human rights of all persons equally, without discrimination on the basis of protected attributes.[120]

97. States must not discriminate between persons on the basis of protected attributes, which relevantly include age and impairment (including mental or psychological disease or disorder).[121]

98. People experiencing mental ill health and mental health crisis have particular sets of issues and needs which require a deliberate and specific response at many levels of government, including the police and health systems. The obligation on the State is to ensure that there are systems in place to properly respond to the needs of people with mental ill health and in mental health crisis and also to ensure that this group of people are not more likely to suffer adverse outcomes in existing systems and processes by virtue of their particular needs and issues that arise as aspects of their condition.

99. States have a separate stand-alone obligation to act in the best interests of the child. This requires:

    (a) every legislative, administrative and judicial body or institution to systematically consider how children's rights and interests are or will be affected by their decisions and actions;[122]

    (b) administrative bodies to consider in advance how children's rights may be affected by the actions of that body, and implement policies that address the potential effect of their actions upon children;[123] and

    (c) in considering the actual or potential affect a decision or action may have on children's rights, to have the best interests of the child as a primary consideration.[124]

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[120] Charter, s 8(2).

[121] EOA, ss 6 and 4.

[122] Committee on the Rights of the Child, *General Comment No 5*, UN CRC, 34th sess, [12], UN Doc CRC.GC.2003/5 (2003). See also *Case of Bulacio v Argentina – Series C No. 100* [2003] IACHR 3.

[123] See *General Comment No 17*, UN HRC, 35th sess, [1] (1989).

[124] *Bakhtiyari v Australia*, Communication No. 1069/2002, UN HRC, 79th sess, UN Doc CCPR/C/79/D/1069/2002 (2003).

100. In ensuring the protection of their human rights (including the right to life), States have a positive and cross-cutting obligation to not discriminate against children on the basis of age or other protected attributes.[125]

101. A failure to provide mental health services capable of reducing the likelihood of harm in the community is a failure to take steps to protect and preserve life.

102. The same can be said of a failure to equip police to deliver services in a manner which does not introduce additional risk of harm by reason of the attributes of a person in mental health crisis or a child. It constitutes a failure to permit a mentally ill person to enjoy their human rights without discrimination,[126] or to provide a child with the protection they need by reason of being a child without discrimination.[127]

103. This inquest squarely raises the issues of how Victoria Police and Victoria's mental health system respond to children and young people, and also to people in mental health crisis. By addressing these matters in findings and recommendations, the Coroner will be enhancing the preventative role of her office. These are also human rights issues that the Coroner is bound to take into account when exercising her powers under s 67, including her discretion to comment on any matter connected with the death relating to public health and safety or the administration of justice.[128]

Evidence

104. The evidence before the Coroner is that 'Police see the effects of mental disorders on individuals and communities every day'.[129] Responding effectively and appropriately to people with mental health issues was described as a 'complex and demanding aspect of policing', given the breadth in range of mental health conditions and interactions as well as the varied way in which police respond.[130] People in mental health crisis form a high proportion of deaths resulting from police use of force.[131]

105. Fundamentally, significant investment is needed in mental health service delivery to actively manage mental ill health and reduce the risk of development of acute disturbances.[132]

106. A different set of professional skills and strategies are essential in the delivery of mental health services to young people.[133] This is because young people's brains and maturity

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[125] Charter, ss 4, 6 and 17.

[126] Required by s 8(2) of the Charter.

[127] Required by s 17(2) of the Charter.

[128] See s 38(1) of the Charter and s 67 of the Coroners Act.

[129] Perez IB3686 [2].

[130] Perez IB3686 [2].

[131] OPI, *Review of Fatal Shootings by Victoria Police* (2005) at p 42 'Seventeen of the 32 people fatally shot by Victoria Police since 1 January 1990 were considered to have a mental disorder at the time of the shooting; p 9: 'the proportion of victims who have had a history of mental disorder has increased from 31 per cent to 44 per cent'.

[132] McGorry, p 13 [32].

[133] McGorry, p 3 [8]. 'Young people' refers to the period in life between puberty and the mid 20s, notionally aged 12-25 with some flexibility either side': McGorry, p 2 [6].

are still developing from puberty through to the age of 25 and there is less moderation of impulsivity and emotional responses.[134]

107. Evidence before the Coroner suggested that there are significant improvements that need to be made to ensure that people in mental health crisis are treated appropriately. Professor McGorry gave evidence that, in his opinion, the following were appropriate strategies to reduce the likelihood of harm in contact between police and people in mental health crisis:

   (a) training to equip police members with an understanding of the likely mental state of persons they encounter and the strategies likely to be effective (and those which are likely to be counterproductive) in their engagement with persons experiencing mental health crisis;[135]

   (b) joint attendance by mental health experts trained in emergency psychiatry;[136]

   (c) the availability of regular police members[137] with crisis negotiation skills;[138] and

   (d) an initial focus on establishing communication with a person in crisis, even if delaying disarming the person is necessary to achieve it.[139]

108. There was evidence that training in strategies for dealing with persons experiencing mental health crisis within Victoria Police had commenced,[140] and that a protocol existed for police members to request mental health assistance.[141] Whilst improved police training is necessary and welcome, Victoria Police members need to be able to count on support and assistance from trained mental health professionals to meet the demands and complexity of dealing with persons affected by mental illness.[142]

109. There is still a gap in provision of proper mental health assistance to police. Apart from evidence about PACER, a pilot mental health intervention model,[143] Victoria Police are not set up to respond to critical incidents in joint attendance with mental health experts. The PACER model is a good initiative, however it is limited to three local government areas and is only operating from 3pm to 11pm. The pilot is due to run until August 2011 so we are yet to see the results.

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[134] McGorry, p 3 [8].

[135] McGorry, p 14 [36]-[37].

[136] McGorry, p 10 [27].

[137] As distinct to members of Critical Incident Response (CIRT) teams.

[138] McGorry T2658.7.

[139] McGorry T2664.25.

[140] Williams IB3552 [17]. Under cross examination, Williams could not say when the vulnerable persons training would be repeated and said that 'the cycles ... aren't static': T3358.1. Training is discussed in more detail at paragraphs C.77 to C.95.

[141] Mendez IB3687. There was no evidence as to the frequency of the protocol being used or about any evaluation of its effectiveness.

[142] McGorry, p 10 [27].

[143] Described by Perez IB3698-9.

110. Further, evidence shows that it is still Victoria police policy and practice to disarm a person prior to establishing communication, which was the approach taken by the police involved in Tyler's death.

111. It was acknowledged that no training specific to the issues confronting young people is currently offered to police,[144] and Williams said he was not involved in any discussions in regards to training responding to children's needs. Williams also said that some sort of data or evidence was needed to support the shaping of a new training package.[145]

112. There is clear evidence that young people are vulnerable by reason of their heightened impulsivity and emotional responses.[146] Victoria Police should not wait for data indicating that force is being used on children.

113. The Charter requires Victoria Police's systems to take account of the vulnerability of young people and the need to protect them. This includes police policies, practices and training. As stated above, the vulnerability of children and their need for protection should be systematically assessed by Victoria Police in the development of all their policies, procedures and training in the discharge of the Victoria Police's obligations to ensure the right of children to protection.

Recommendations

114. The HRLRC supports the recommendations made by Professor McGorry.

Recommendation 13:

Victoria's mental health system should be strengthened across the board; including specifically strengthening of emergency mental health delivery; but also much stronger investments upstream in a well-resourced and responsive community mental health scheme.[147]

Recommendation 14:

The Victorian Government should invest urgently in 24 hour mobile and community mental health treatment teams with capacity:

(a) to provide 24 hour access and care in the community; and

(b) to provide emergency collaborative back up for Victoria Police in the management of potentially risky or dangerous situations involving acute episodes of mental illness.

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144 Williams T3349.20.

145 Williams T3350.9.

146 McGorry, p 3 [8].

147 McGorry, p 12 [31].

Recommendation 15:

The Victorian Government should establish a mobile and community mental health treatment team with the same capacity as described in Recommendation 14 above but with a specific focus on the delivery of services appropriate to young people (ages 12-25).

Recommendation 16:

The Victorian Government should support Victoria Police to respond appropriately to people in mental health crisis by ensuring that the mental health teams described in Recommendations 14 and 15 above are adequately resourced and tasked to provide support to Victoria Police in interactions with people (including young people) experiencing mental health crisis, including travelling with police to attend critical incidents to appropriately defuse situations, make appropriate referrals and arrange access to the appropriate mental health services.

Recommendation 17:

Victoria Police should commission a thorough external review of how its policies and procedures, including training, impact on young people and people in mental health crisis with a view to amending those policies and procedures to ensure that police provide young people with the protection they need. This should include consideration of establishing a policy of police initially focusing on establishing communication with a person in crisis, even if delaying disarming the person is necessary to achieve it, as a means by which to minimise harm.

The review should include consultation with young people, youth workers, community legal centres and other experts on youth issues.

Recommendation 18:

Police should establish youth-focussed training programs designed to train police personnel in relation to all issues affecting their work with young people, including special consideration of adolescent brain development and other special considerations for young people.

D. The Right to Life – Independent Investigations

The legal obligations on the Victorian Government

115. The right to life requires (among other things) that the Victorian Government ensure that where individuals have been killed as a result of the use of force by Victoria Police there is an effective and official investigation.[148]

116. The investigation must be independent[149] and effective.[150]

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[148] *McCann v United Kingdom* (1996) 21 EHRR 97, [161]; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [20].

117. The right to life requires the State to conduct an investigation into a possible violation of the right to life that is sufficiently open to ensure public scrutiny and accountability,[151] and involves the next-of-kin[152] as far as is possible and appropriate.[153]

118. In October 2010, at the Coroner's request, the HRLRC made a preliminary submission on methods of investigation of deaths associated with police contact (***Preliminary Submission***). The HRLRC adheres to that submission and the recommendations set out in it.

119. The HRLRC explains below how the evidence before the Coroner supports the conclusion and recommendations in the Preliminary Submission.

The investigation into Tyler's death

120. The following entities and personnel were, at various times, responsible for conducting and overseeing the investigation into Tyler's death.

(a) The Homicide Squad had responsibility for conducting the primary investigation into the circumstances of Tyler's death, including preparing the Inquest Brief of Evidence for the Coroner. Detective Sergeant Allan John Birch was the lead investigator into Tyler's death from Homicide Squad.[154] Birch's evidence was that, while preparing an Inquest Brief, the Homicide Squad does not seek direction from the Coroner.[155] He said that it was only subsequent to the production of the Inquest Brief that any further investigations would be conducted at the direction of the Coroner.[156]

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[149] *Jordan v United Kingdom* (2001) 37 EHHR 52, [106]; *McKerr v United Kingdom* (2002) 34 EHRR 20, [112]; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [20].

[150] *McKerr v United Kingdom* (2002) 34 EHRR 20, [159], [161]; *Simsek v Turkey* [2005] ECHR 546, [116]; *Tahsin Acar v Turkey* [2004] ECHR 149, [223], [229]-[234]; *Jordan v United Kingdom* (2001) 37 EHRR 52, [107].

[151] *Jordan v United Kingdom* (2001) 37 EHHR 52, [109]; *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51, [20(8)].

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

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

[154] Members of Homicide Squad who assisted Birch on 11 December 2008 and following include Detective Senior Constable Warren Chapman, Detective Senior Constable Victor Anastasiadis, Detective Senior Constable David Barry, Detective Senior Constable Nigel L'Estrange and Detective Senior Constable David Leveridge.

[155] T4185.3.

[156] See generally T4182.9 – T4185.20, T4218.21 – T4219.11. In regards to the other members of the Homicide Squad involved in the investigation, as of the date he gave evidence, Detective Senior Constable Chapman considered that he was conducting the investigation on behalf of the CoronerT3197.2. Detective Senior Constable Barry made the comment that he was acting on behalf of the Coroner at the time of taking the statement of De Propertis at T2870.17. Detective Acting Sergeant L'Estrange made the comment that he was acting on behalf of the Coroner at T2990.3.

A number of additional deficiencies are set out at paragraph 130 below

(b) The ESD maintains oversight responsibility of the investigation.[158] Aristidou was the on-call Superintendent for ESD at the time of Tyler's shooting on 11 December 2008.[159] The ESD has a responsibility to **actively oversee** investigations into all deaths.[160] 'Active oversight' includes:

- continuous monitoring of the investigation;
- making any relevant comment or directing further inquiries if it is considered necessary to satisfy any future internal or external examination of the adequacy and probity of the investigation. Any comment or direction for further enquiries must be done by the ESD Officer responsible for the active oversight through a Homicide Inspector or to the independent Detective Sergeant;
- ensuring the member investigating the incident advises the ESD Officer of developments during the investigation;
- ensuring the investigation is conducted without bias for or against any police or civilians involved;
- early proactive identification of both internal and external policy issues; and
- ongoing case management and liaison with the relevant investigator.

The key policies and procedures that govern the oversight role performed by ESD are contained in the ESD Investigation Oversight Framework (the ***Framework***) in Appendix Q of the Discipline Investigation Manual[161] and the Memorandum of Understanding between the Assistant Commissioner (ESD) and the Assistant Commissioner (Crime), signed on 18 July 2003 (the ***MOU***).[162] The following steps were either inconsistent with the policies and procedures existing at the time, or otherwise raise concerns regarding the appropriateness of the actions or inactions undertaken.

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[158] IB2383 (VPM 104-2).

[159] IB1763. Detective Acting Inspector Grant was responsible for ESD oversight for an interim period from 8 am on 12 December 2008 until 17 December 2008: T3096.2. Acting Senior Sergeant Mick Wells was performed oversight responsibility from 17 December 2008 to October 2009, when Detective Inspector Steve White took oversight responsibility: see Exhibit 118 (ESD Allocation and Recommendations Report).

[160] See IB 2405, Memorandum of Understanding between the Assistant Commissioner (ESD) and the Assistant Commissioner (Crime) signed on 18 July 2003; and IB 2389, ESD Investigation Oversight Framework in Appendix Q of the Discipline Investigation Manual.

[161] IB2389.

[162] IB2408.

(i) Aristidou relied upon information given to him at the scene by Homicide Squad and other police members that correct procedures were followed, rather than making independent enquiries himself.[163]

(ii) Aristidou relied upon information presented to him by Detective Inspector Clark of the Homicide Squad to prepare the account of the facts in the ESD briefing paper for the Assistant Commissioner (ESD) dated 12 December 2008.[164]

(iii) Timely and regular case management meetings were not held during the investigation.[166] The ESD file does not contain any minutes of 'case management meetings' or of any meetings.[167]

(iv) The ESD file contains little documentation relating to ESD's oversight role after December 2008 other than a small number of administrative documents and correspondence.[168] Accordingly, the ESD file does not demonstrate any of the following:

- examination of the adequacy or integrity of the investigation;
- evidence of continuous monitoring;
- discussion of whether the investigation is conducted without bias.

(v) The Inquest Brief was not submitted to ESD for review or comment prior to delivery to the Coroner.[170]

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[163] See T3114.26 – T3116.12, T3121.5-31.

[164] T3098.6-27.

[166] See T4273.26 – T4277.8. According to Birch's diary, he had meetings with ESD and OPI on three occasions between December 2009 and June 2010: May 2009 (IB3490), 29 September 2009 (IB3492), 4 December 2009 (IB3495). These meetings can be inferred to have occurred as a result of the OPI Review discussed below.

[169] Exhibit 118.

(vi) There was no further evidence of updates being provided to ESD by the Homicide Squad, other than two minor interventions by ESD[171] and the meetings mentioned by Birch in his oral evidence.

(c) The OPI has a general responsibility to detect, investigate and prevent police corruption and serious misconduct, and to ensure Victoria Police maintain the highest ethical and professional standards in accordance with the *Police Integrity Act 2008* (Vic). Following letters to the Coroner from the Cassidy family and the HRLRC,[172] the Coroner wrote to the OPI seeking a response to a request that they take over the investigation into Tyler's death from Victoria Police.[173] The OPI responded that it would not investigate Tyler's death.[174] Rather, the Director, Police Integrity requested Gerry Feltus and John Ashby of the OPI conducted a review of the sufficiency of the police investigation into the fatal shooting of Tyler (the ***OPI Review***).[175] There were a number of limitations and deficiencies with the OPI Review.

(i) The scope of the OPI Review was limited to the sufficiency of the police investigation, and did not include review of the circumstances of the shooting or of the conduct of police involved.[176] Further, the OPI Review did not comment on whether the police officers involved acted in accordance with their training.[177]

(ii) There was no comment made regarding the drug and alcohol and gunshot residue testing of the four police officers involved.[178] Feltus was unaware of the delay in that testing.[179]

(iii) While the issue was discussed, the OPI Review did not directly consider the welfare of the Cassidy family in relation to the investigation.[180]

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[172] See letter from the Cassidy family to the Coroner dated 23 April 2009; Letter from the HRLRC to the Coroner dated 14 May 2009.

[173] Exhibit 118 (Letter from Coroner to OPI dated 24 April 2009).

[174] Letter from OPI to Coroner dated 5 May 2009.

[175] Exhibit 87.

[176] Exhibit 87, 1.

[177] Exhibit 87, 5.

[178] T2940.13.

[179] T2938.26.

[180] T2948.15.

(iv) The OPI Review did not consider the issue of whether or not the police involved in the incident should have their interviews video or audio recorded.[181]

(v) The OPI Review team was unaware that the family had been covertly recorded by members of the Homicide Squad.[182] Feltus did not know about the recordings until the day he gave evidence.[183]

(vi) While the OPI Review did note the separation of the four police officers when reviewing their statements, they did not make further enquiries, or report on, how the separation was conducted. Feltus was unaware that a police officer involved in the shooting remained at the scene for a longer period, and had discussions with potential witnesses.[184]

(d) The Coroner, apart from attending the de-briefing conducted by Inspector Therese Walsh on the night of 11 December 2008, did not have any direct role or involvement in the investigation prior to the Inquest Brief being delivered to the Coroner's Court. The Coroner has largely relied on the Homicide Squad to conduct the primary investigation into Tyler's death. In terms of the interaction between the Homicide Squad and the Coroner, it does not appear there is any formal policy in place governing the relationship between the Coroner's Office and the Victoria Police conducting the investigation.[185]

Independence of Investigations

121. To avoid any perceived or real risk of collusion, corruption or bias, bodies and individuals investigating potential breaches of the right to life must be truly independent from the individuals they are investigating.[186]

122. The rationale for this position is described by the Queensland Crime and Misconduct Commission in its report on the death of Mulrunji on Palm Island, where it identified the possibility of police officers being 'handicapped in the performance of their professional duties by their over-identification with fellow officers who were under examination'.[187] Similarly, the Royal Commission into Aboriginal Deaths in Custody stated:

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[181] T2957.26.

[182] T2949.12.

[183] T2949.21.

[184] T2961.12.

[185] The HRLRC wrote to those assisting the Coroner suggesting that any Memorandum of Understanding between the Coroner and the Victoria Police should be part of the Inquest Brief, given that the independence of the investigation was part of the express scope of the Coroner's inquest; see letter from Allens Arthur Robinson to DLA Phillips Fox, copied to Galbally & O'Bryan and Victoria Legal Aid dated 4 May 2010; letter from Allens Arthur Robinson to DLA Phillips Fox dated 25 June 2010; letter from Allens Arthur Robinson to DLA Phillips Fox dated 20 July 2010; letter from Allens Arthur Robinson to DLA Phillips Fox dated 27 August 2010. No Memorandum or other document was produced.

[186] The rationale for this proposition is explained in Crime and Misconduct Commission, *CMC Review of the Queensland Police Service's Palm Island Review*, June 2010, xxvii and E Johnston, *National report: Royal Commission into Aboriginal Deaths in Custody*, vol 1, Australian Government Publishing Service, Canberra, 1991, 121.

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

> The essential problem of the expertise of specialist, operational police investigators being employed in post-death investigations derives from the possibility of bias. In blunt terms, they may wish to protect other police from blame. They may wish to protect them from exacting scrutiny. More subtly, they may sympathetically project themselves into the position of the custodial officers and regard their explanations as having a credibility which they do not deserve.[188]

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

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

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

   (c) the investigators do not uncritically rely on the version of events they have received from members of the body being investigated.[189]

124. This means, for example, that investigations of the excessive use of force by police will lack sufficient independence if they are carried out by other members of the same police force, even if the investigators work in a different department or an independent body oversees the investigation.[190]

125. Further, a formally independent body may not be genuinely independent if it employs a significant number of former police officers who still identify culturally as police because there is a risk that, consciously or otherwise, police investigators will be sceptical of complainants and 'softer' on the police concerned.[191]

126. Neither internal nor external oversight can cure the deficiencies of an investigation of a death associated with police contact that is conducted by a department of the police or an associated body of the police. The investigative body itself must be independent.[192]

127. This proposition has been continually supported by European courts, which have established that it is not sufficient for an independent body to have oversight of an investigation, where the investigation itself is carried out by police officers connected organisationally with those under investigation:[193]

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

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

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

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

[192] *Jordan v United Kingdom* (2001) 37 EHHR 52, [120]; *McKerr v United Kingdom* (2002) 34 EHRR 20, [128]; *Kelly v United Kingdom* application no. 30054/96, 4 August 2001, [114]; *Ramsahai v The Netherlands* [2007] ECHR 393, [337]; *Bati v Turkey* [2004] ECHR, [135].

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

> Supervision [of the police investigation] by another authority, however independent, has been found not to be a sufficient safeguard for the independence of the investigation.[194]

128. For this reason, the current oversight by the ESD of the Homicide Squad's investigations into deaths associated with police contact does not make the current system of investigating such deaths Charter compliant. Nor does the conduct of a coronial investigation and inquest, where that investigation and inquest is reliant upon the Homicide Squad's investigations.

129. A key rationale for having an investigation which is independent (in the Charter sense of being hierarchically, institutionally and practically independent) is that it allays perceptions of wrongdoing, both by the deceased's family and the public generally. An independent framework for investigation ensures there is confidence that matters are properly investigated and that any wrongdoing is exposed, or equally, any conduct by officers is effectively exonerated. For that reason, where there is no independent investigation, weaknesses or errors in the investigation lead to the perception of bias.

130. The structure of the model of investigation adopted in respect of Tyler's death – whereby police investigate the actions of police with limited oversight by ESD, the Coroner, and in this case the OPI – is one that cannot sufficiently dispel concerns about institutional or systemic bias.

131. The deficiencies of that model, and its vulnerability to improper interference, or the perception of improper interference, are illustrated by the following aspects of this investigation.

    (a) Contrary to best practice and acknowledged as regrettable,[195] Ferrante was left unsupervised and did not, and was not requested to, leave the scene of Tyler's death for approximately half an hour following the shooting.[196] During the time she remained at the scene, Ferrante had contact with a number of witnesses.[197]

    (b) Senior Sergeant Geoffrey Joshua, hierarchically superior to Dods, contacted Dods on his mobile while Dods was still at the scene of the shooting.[198]

    (c) There were delays in contacting the Major Crime Desk and the Homicide Squad. On the night of Tyler's death, the attending Crime Investigations Unit,[199] were responsible for contacting the Major Crime Desk but failed to do so. The Major Crime Desk did not become aware that the shooting was fatal until 10.32 pm.[200]

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

[195] See Walsh T2397.1; Delle-Vergini T2722.5-31, Ferrante T4100.17. Delle-Vergini, who was delegated to supervise Ferrante, stated that he did not believe Ferrante's contact with witnesses impacted on the integrity of the investigation: T2723.1.

[196] IB417; Ferrante T4098.29 – T4099.15.

[197] Ferrante T4099.24 – T4102.8. The witnesses Ferrante had contact with subsequent to the shooting were James Wendt, Daniel Gregory, Nick Skordos and Karan Sood: IB2221-5. Ferrante gave evidence that at the time she recognised it was not preferable for her to have contact with witnesses, however, there were no other officers in the vicinity she could direct witnesses to: T4100.9-16.

[198] Dods T4284.10-14.

[199] Senior Constable Catherine Sadler and Leading Senior Constable Leigh Cole.

[200] IB3683.

They proceeded to contact the Homicide Squad at 10.38 pm, over one hour after the shooting.[201]

(d) There were delays in conducting drug and alcohol testing of the officers. The evidence shows that there was confusion regarding who was required to organise and demand drug and alcohol testing.[202] Following a number of conversations between Detective Senior Constable L'Estrange and various agencies,[203] at approximately 4.05 am on 12 December 2008, Jo Hearch from the Victoria Institute of Forensic Medicine arrived.[204] Ms Hearch did not have the proper equipment for either a blood, urine or breath test.[205] The attendance of another nurse was arranged, and at 6.00 am Jan O'Connell attended.[206] The importance of drug and alcohol testing has added significance in the context of three of the four police officers having attended a police function where alcohol was consumed on the night of 10 December 2010.[207]

(e) There were delays in conducting gunshot residue testing of the officers. Birch wrongly assumed that by contacting the Forensic Services Department, someone from the Gunshot Residue Section would attend to conduct gunshot residue testing of the officers involved in the shooting.[208] When Birch realised no one had attended to conduct the testing, Harald Wrobel from the Gunshot Residue Section of the Forensic Services Department was contacted.[209] This was some time after 1am on 12 December 2008.[210] Due to a lack of gunshot residue particles detected, Wrobel was unable to ascertain a distance between the police officers and Tyler when they discharged their weapons.[211]

(f) There were a number of indications that the police officers were not treated as suspects during the investigation. Birch stated that there was no evidence to doubt that the four police officers had discharged their firearms in defence of themselves or defence of another, and, therefore, it was inappropriate to suspect them of having committed any offence.[212] However, the evidence was that this conclusion

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[201] IB614; IB3683.

[202] See L'Estrange T2915.16; Birch T4152.6 – T4153.26. Birch believed it was Inspector Walsh's responsibility as Operations Commander: T4151.5-12. Evidence was given that a new drug and alcohol policy (VP 1338) had been introduced which made it compulsory for police officers involved in a critical incident to be drug and alcohol tested, however, a demand of such testing had to be made by an officer of Inspector rank or above: IB1763, L'Estrange T2914.23 – T2915.3.

[203] L'Estrange T2915.16; Exhibit 86 (Notes of Detective Senior Constable L'Estrange).

[204] IB1763.

[205] IB1763; T4161.12-21.

[206] IB1763.

[207] See IB378; IB380; IB395.

[208] Birch T4147.20 – T4149.27.

[209] Birch T4148.11.

[210] Birch T4247.16.

[211] IB549.

[212] Birch T4222.18.

was drawn largely from the statements of the police officers themselves.[213] Blundell and Ferrante stated they did not consider the four police officers to be suspects.[214]

(g) Most significantly, in contrast to the policy regarding interviews of significant witnesses of homicides, the interviews of the police officers involved in the shooting were not audio or video recorded. Each police officer was asked to agree to have their statement audio or video recorded, but each refused and stated they would prefer to give a written statement.[215] This was contrary to the preference of Birch.[216]

(h) There was criticism of the focus placed and the time taken by the police to identify all relevant witnesses and to take their statements.[217] In particular, the Homicide Squad did not focus on identifying potential witnesses around Alphington station and delayed canvassing the area until May 2010.[218] Further, the officer who identified Tomce Muzoski as a potential witness relayed that information to Dods rather than the Homicide Squad.[219]

(i) In breach of the policy regarding media interaction following a critical incident, Victoria Police failed to seek the Coroner's approval prior to releasing a media statement on 11 December 2008.[220] The media statements released tended to justify the use of force by the four members, and had the potential to lead an observer to believe that Victoria Police (and its investigators) had reached a concluded view that the use of force *was* justified.[221]

(j) Conversations between members of the Homicide Squad of interviews and meetings with Cassidy family were recorded without their knowledge or permission. When Tyler's mother, Shani Cassidy, learnt of this fact, she felt betrayed and lost trust in the police.[222] In secretly recording the conversations, the investigators had the purpose of protecting Victoria Police from anticipated criticism, including, it could be deduced, that the investigation had sought to exonerate Victoria Police members.[223]

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[213] Birch T4222.16.

[214] Blundell T3901.13; Ferrante T4103.6-16, T4103.30-T4104.11.

[215] BirchT4229.1 – T4230.12.

[216] Birch T4170.6 – T4171.10.

[217] See for example L'Estrange T2969.10, T4223.27 – T4227.10, Exhibit 87, 4-5.

[218] See IB1810; Birch T4173.27 – T4176.30, T4260.18 – T4261.19.

[219] Statement of Leading Senior Constable M J Stewart p 2.

[220] IB1807 & Exhibit 72; Cartwright T2450.3-9.

[221] See Cartwright T2454.21 – T2455.21.

[222] Exhibit 4, [95]-[98].

[223] See Birch T4189.13, T4294.15.

Recommendations[224]

> **Recommendation 19**
>
> The Victorian Government should establish a body independent of Victoria Police to investigate deaths associated with police contact (the **Independent Body**). The Independent Body should be hierarchically, institutionally and practically independent from Victoria Police.

Adequacy and Effectiveness

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

133. In order adequately to discharge the State's responsibilities in respect of the right to life, an investigation into a death at the hands of state agents should be aimed at:

    (a) bringing the full facts to light;

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

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

    (d) rectifying dangerous practices and procedures; and

    (e) ensuring that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from their death may save the lives of others.[225]

134. To be effective, the investigation must be capable of achieving these outcomes. It must be capable of leading to a determination of whether the force used was justified and the identification and punishment of those responsible.[226]

Interaction with the Coroners Court

135. A coronial inquest is a method of investigation capable of achieving these outcomes. But the effectiveness of a coronial inquest is undermined where there is a deficiency in the primary investigation.[227]

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

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[224] Further recommendations detailing the powers and resources that should be conferred upon the Independent Body are set out in the Peliminary Submission.

[225] *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, [31]; *McKerr v United Kingdom* (2002) 34 EHRR 20, [111]; *Edwards v United Kingdom* (2002) 35 EHRR 487, [69]; *Jordan v United Kingdom* (2001) 37 EHRR 52, [105]; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182; *Leonidis v Greece* [2009] ECHR 5, [67].

[226] (2001) 37 EHRR 52.

[227] *Menson v United Kingdom* [2003] 37 ERR CD 220. See also *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 [10]; *McKerr v United Kingdom* (2002) 34 EHRR 20 [113]; *Jordan v United Kingdom* (2001) 37 EHRR 52, [107]; *Leonidis v Greece* [2009] ECHR 5, [68]. See also Royal Commission into Aboriginal Deaths in Custody 1991, National Report, Australian Government Publishing Service, Canberra, Vol. 1, 130, available at: http://www.austlii.edu.au/au/other/IndigLRes/rciadic/; Boronia Halsted, November 1995, Australian Deaths in Custody, No. 10 Coroners Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study, available at http://www.aic.gov.

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

137. The Royal Commission Report emphasised the general inability of Coroners to control the quality of preliminary police investigations which 'lay the foundation for the subsequent coronial inquest'.[229]

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

> The investigating members have competing interests that they must consider, whereas the Coroner's focus may not take all competing interests into consideration. Therefore it is important for Victoria Police to remain as an independent body whilst assisting the Coroner with investigations.
>
> ... The ability for the Coroner to provide direction therefore would create the potential to hinder other competing interests for which police are accountable.[230]

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

Recommendations

Recommendation 20
The Independent Body should conduct the primary investigation into deaths associated with police contact on behalf of, and at the direction of, the Coroner and prepare the brief to be used in coronial proceedings.

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

140. An Independent Body conducting a primary investigation should be capable of promptly collecting and preserving relevant evidence, so as to limit its loss and to limit the possibility (and the perception of a possibility) of fabrication of evidence and collusion.[231] In practice, this means that the investigative body must be empowered and resourced to attend the scene of an incident as soon as practicable, gather evidence, interview witnesses, search premises and seize relevant materials and documents.

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

[229] Quoted in Boronia Halsted, November 1995, Australian Deaths in Custody, No. 10 Coroners Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study, available at http://www.aic.gov.

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

[231] Submission to the Parliamentary Joint Committee on the Australian Commission for Law Enforcement Integrity's Inquiry into Law Enforcement Integrity Models, House of Representatives, Commonwealth of Australia, 2008 (Tamar Hopkins), 18-19; see *Ramsahai and Others v The Netherlands* [2007] ECHR 393 where the European Court held at 330 that, although there was no evidence of collusion, the fact that two officers were not kept separate after an incident involving police use of force and were only questioned three days later resulted in a 'significant shortcoming in the adequacy of the investigation'.

141. This does not mean that police must play no role in the investigation. It may be necessary to involve police in securing the scene, collecting evidence, and identifying potential witnesses in the event of death or injury involving police.[232]

142. However, control of the investigation should be placed in the hands of the Independent Body at the earliest point it is practicable to do so.[233] The Independent Body should be in a position to assume control of an investigation within an hour of a relevant incident occurring.

Recommendations

Recommendation 21

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

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

Recommendation 22

The Independent Body must be adequately empowered and resourced to attend the scene of an incident as soon as practicable, gather evidence, interview witnesses, search premises and seize relevant materials and documents.

Promptness

143. Having a timely and efficient investigation assists in dispelling fears of attempts to cover up any misconduct, which in turn instills confidence in the integrity of investigations.[234] This, of course, means an investigative body must be adequately resourced to carry out such prompt and full investigations. It might also require legislative time limits for the conduct of an investigation.[235]

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[232] *Ramsahai v Netherlands* [2007] ECHR 393 (15 May 2007), 337-338, 340-341; *Jordan v United Kingdom* [2001] ECHR 327 (4 May 2001), 118-119. An example of how this has been implemented in practice is set out below in paragraphs Error! Reference source not found. and following.

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

[234] Tamar Hopkins, *'An Effective System for Investigating Complaints Against Police'*, a study conducted for the Victoria Law Foundation of human rights compliance in police complaint models in the US, Canada, UK, Northern Ireland and Australia (August 2009).

[235] Tamar Hopkins, *'An Effective System for Investigating Complaints Against Police'*, a study conducted for the Victoria Law Foundation of human rights compliance in police complaint models in the US, Canada, UK, Northern Ireland and Australia (August 2009).

Recommendations

Recommendation 23
Investigations of deaths associated with police contact should be conducted promptly and, if necessary, time limits should be set to minimise delay in investigations.

Openness of investigations via the coronial process

144. The duty to investigate requires investigations of deaths associated with police contact to be sufficiently open and publicly accountable. There must be sufficient public scrutiny of investigations into deaths associated with police contact to 'secure accountability in practice as well as in theory, maintain public confidence in the authorities' adherence to the rule of law and prevent any appearance of collusion in or tolerance of unlawful acts'.[236] An investigation which is not open to public scrutiny and fails to give a convincing explanation of events may engender mistrust of investigating authorities.[237]

145. The conduct of coronial inquests in open court will generally satisfy this obligation of public scrutiny. However, it will be necessary for the Coroner, where necessary in the interests of justice, to conduct a full examination of the primary investigation during the coronial process. Where police officers are not required to give evidence, or are instructed to conceal information, it will raise legitimate doubts as to the overall integrity of the investigative process.[238] It is noted that in this inquest, the Coroner granted each of the four police officers involved in the shooting a certificate pursuant to s 57 of the Coroners Act providing protection against self-incrimination arising from evidence given pursuant to the certificate in other proceedings. Each of the four police officers involved in Tyler's shooting then gave evidence at the inquest.

146. The failure of the Homicide Squad to inform the Coroner of the covert recordings made of conversations members had with the Cassidy family brings into question whether the investigation was sufficiently open as required by the right to life.[239]

Recommendations

Recommendation 24
Investigations into deaths associated with police contact must be conducted in a manner that is open to public scrutiny, such as through a full examination of the investigation in the coronial process.

Involvement of the next-of-kin

147. The next-of-kin have a legitimate interest in an investigation capable of leading to a determination of whether the force used was justified and the identification and punishment of those responsible. Further, the investigation has among its purposes to ensure, so far

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

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

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

[239] Birch T4294.15.

as possible, that 'those who have lost their relative may at least have the satisfaction of knowing that lessons learned from [his or her] death may save the lives of others'.[240]

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

149. It is noted that the requirement that the next-of-kin be involved does not necessarily mean that the next-of-kin must be granted access to all documents and files of police, if there are operational reasons for refusing that access.[241]

150. As noted at paragraph 131(j), the Homicide Squad made covert recordings of conversations they had with the Cassidy family. This action did not foster the co-operation and confidence of the Cassidy family, rather, the evidence shows it led to a distrust of the investigation into Tyler's death.[242]

Recommendations

Recommendation 25

Investigations into deaths associated with police contact should involve next-of-kin to the extent necessary to safeguard their legitimate interests. Policies and procedures should be developed and implemented to ensure next-of-kin are dealt with in a sensitive and appropriate manner.. Such policies and procedures should, where possible, be developed in consultation with families who have been party to the coronial process.

Management of police officers involved in the incident

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

152. To treat police members more favorably could impact upon the effectiveness of investigations into deaths associated with police contact. Further, any preferential treatment of police witnesses or suspects undermines public trust in the system of justice and creates perceptions of corruption and collusion.

153. It will occasionally be necessary for police involved in a death to secure the evidence at the scene. This should only occur where no other police are present, only for the purpose of preserving evidence, and only for the limited period of time necessary for other police officers or the Independent Body to arrive. They should not discuss their observations with other potential witnesses, whether fellow police members or members of the public. They should be relieved of this task and separated as soon as other officers arrive at the scene.

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

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

[242] See Exhibit 4, [95]-[98]; T581.29.

As mentioned above, the Independent Body should be able to attend the scene of deaths in custody and take carriage of the investigation within the first hour of the incident.

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

155. In this case, as discussed at paragraphs 131(f) to 131(g), the police officers involved were not at any stage treated as suspects, largely on the basis of their own evidence. Police officers were able to choose not to be video or audio recorded, even though this may not have been the preference of the lead investigator.

Recommendations

Recommendation 26

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

Recommendation 27

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

DATED 25 February 2011

B WALTERS SC
S URE

ALLENS ARTHUR ROBINSON
Solicitors for the HRLRC

Appendix 1 – Consolidated table of Recommendations

Recommendation 1:

The State of Victoria amend the *Crimes Act 1958*, or enact other legislation, to explicitly and comprehensively guide and regulate the circumstances in which Victoria Police may lawfully use lethal force in accordance with the right to life protected by s9 of the Charter.

Recommendation 2:

Victoria Police should amend the Victoria Police Manual to include specific reference to:

- the Charter, in particular the right to life;
- the obligation of members of Victoria Police to act in accordance with the Charter and to give proper consideration to human rights; and
- the circumstances in which firearms may be lawfully used, in accordance with the human rights standards governing the use of lethal force as set out in the Code of Conduct for Law Enforcement Officials and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, namely:
  - (a) where there is an imminent threat of death or serious injury;
  - (b) as a last resort;
  - (c) after provide a clear warning of the intent to use lethal force; *and*
  - (d) after sufficient time for the warning to be observed (unless to do so would unduly place police or other persons at risk or would be clearly inappropriate or pointless in the circumstances of the incident).

Recommendation 3:

Further to recommendation 2 above, Victoria Police should amend the Victoria Police Manual to include specific reference to the circumstances in which OC spray/foam may be lawfully used, in accordance with the human rights standards governing the use of force as set out in the Code of Conduct for Law Enforcement Officials and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, namely:

- where there is an imminent threat of death or injury; and
- only after all non-violent means have been exhausted.

Recommendation 4:

The use of OC spray/foam by Victoria Police should be monitored by an independent public body such as the VEOHRC. To enable this monitoring to occur, Victoria Police should provide regular reports which include:

(a) data on who OC spray/foam is used against, disaggregated by sex, age, gender, race, ethnicity, disability and vulnerability (including whether the person was affected by mental illness/crisis, drugs or alcohol);

(b) a qualitative element that draws upon the Use of Force Reports submitted to the Use of Force Register to give a clear picture of the circumstances in which OC spray/foam is used; and

(c) analysis of who is using OC spray/foam, disaggregated by geographic region, police service areas, police stations and police departments.

Recommendation 5:

Victoria Police should ensure that minimum use of force is promoted as an organisational value, and is the central principle informing OSTT.

Recommendation 6:

Victoria Police should ensure that its training:

(a) is grounded in human rights principles;

(b) reflects the value of minimum use of force, through the reinforcement of practical strategies; and

(c) is adequately resourced and effectively delivered to all of its members.

Recommendation 7:

Victoria Police should ensure that its training modules are informed by relevant human rights, and make explicit mention of those rights and reinforce the standards connected to those rights.

Recommendation 8:

Police training should be developed in consultation with relevant experts, civil society groups and members of communities that are particularly affected by the exercise of police powers.

Recommendation 9:

Where possible, training on specialist areas should be provided by external specialists, for example, by mental health practitioners.

Recommendation 10:

Victoria Police should resume the practice of testing or assessment of trainees at the conclusion of OSTT sessions.

Recommendation 11:

Victoria Police should adopt a formal structure of review and evaluation of training, involving external review and auditing of its content, coverage and delivery methods. The external review should track and measure the adoption and implementation of recommendations emanating from external and internal reviews and inquiries.

Recommendation 12:

Victoria Police should ensure that OSTT incorporates strategies for dealing with possible 'victim precipitated homicide'.

Recommendation 13:

Victoria's mental health system should be strengthened across the board; including specifically strengthening of emergency mental health delivery; but also much stronger investments upstream in a well-resourced and responsive community mental health scheme.[243]

Recommendation 14:

The Victorian Government should invest urgently in 24 hour mobile and community mental health treatment teams with capacity:

(a) to provide 24 hour access and care in the community; and

(b) to provide emergency collaborative back up for Victoria Police in the management of potentially risky or dangerous situations involving acute episodes of mental illness.

Recommendation 15:

The Victorian Government should establish a mobile and community mental health treatment team with the same capacity as described in Recommendation 14 above but with a specific focus on the delivery of services appropriate to young people (ages 12-25).

Recommendation 16:

The Victorian Government should support Victoria Police to respond appropriately to people in mental health crisis by ensuring that the mental health teams described in Recommendations 14 and 15 above are adequately resourced and tasked to provide support to Victoria Police in interactions with people (including young people) experiencing mental health crisis, including travelling with police to attend critical incidents to appropriately defuse situations, make appropriate referrals and arrange access to the appropriate mental health services.

Recommendation 17:

Victoria Police should commission a thorough external review of how its policies and procedures, including training, impact on young people and people in mental health crisis with a view to amending those policies and procedures to ensure that police provide young people with the protection they need. This should include consideration of establishing a policy of police initially focusing on establishing communication with a person in crisis, even if delaying disarming the person is necessary to achieve it, as a means by which to minimise harm.

The review should include consultation with young people, youth workers, community legal centres and other experts on youth issues.

Recommendation 18:

Police should establish youth-focussed training programs designed to train police personnel in relation to all issues affecting their work with young people, including special consideration of adolescent brain development and other special considerations for young people.

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[243] McGorry, p 12 [31].

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

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Recommendation 26

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

Recommendation 27

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