caxton legal centre inc.

15 March 2007

Susan Johnson
Director of Research
Crime and Misconduct Commission
Level 3 Terrica Place,
140 Creek Street
Brisbane Q 4000

By Email: susan.johnson@cmc.qld.gov.au

Re: Investigations into Deaths in Custody

Dear Ms Johnson

It is significant that in the last two coronial inquests into deaths in custody, those of *Mulrunji*[1] and *Eddy*[2], the Deputy State Coroner and the Coroner respectively have seen fit to comment adversely on the procedures which were undertaken in relation to the initial police investigation into the deaths.

Coroner Michael Barnes suggests, at p5 para 6 of *Eddy*, that the failure of the investigators to ensure that the relevant police officers were not segregated amounted to "poor practice" which might easily give rise to suspicions about the integrity of the process. Despite this observation, the Coroner (perhaps surprisingly) did not make any recommendations in relation to the investigation process or to any relevant training issues. Additional issues of concern in the Eddy investigation, to which the Coroner did not necessarily refer, include:

- the failure of investigating police to fingerprint a gun allegedly grabbed by the deceased or to swab the clothing of the officers;
- a lack of thoroughness in following up leads that supported the lay witnesses' accounts (e.g. neighbour);
- possible concoction of the police officers' versions (not decided by the Coroner but suspected) in circumstances where this was never tested by the investigating officers (either through analysis or appropriate questioning); and
- a draft report written by the investigating officer to his commanders which was not impartial and only put forward the version of events by the lead officer (without indicating there were significant differences in evidence as between the other officers and lay witnesses). This was the report that informed the

1 *Inquest into the death of Mulrunji*, 27 September 2006, Christine Clements.(Deputy State Coroner)
2 *Inquest into the death of Michael Eddy*, 12 February 2007, Michael Barnes (State Coroner)

28 Heal St
New Farm Q 4005
t. 07 3254 1811
f. 07 3254 1356
e. caxton@caxton.org.au
abn 57 035 448 677

> authorities about what action should be taken with the officers and informed the Coroner and counsel assisting.

Further, Deputy Coroner Clements, in *Mulrunji*, documents a series of shortcomings which emerged in the initial investigation process, beginning with the appointment, as part of the original investigating team, of an officer serving on Palm Island who was known to be a friend of Snr Sgt Hurley. Subsequent decisions which flowed from this initial appointment, such as Snr Sgt Hurley dining with the investigating officers at his home, had the effect, in the Deputy Coroner's view, of compromising the investigation (p10, para 4). Many of these departures from what might be considered the most appropriate way to investigate deaths in custody only became evident at a later stage of the investigation – either when the Crime and Misconduct Commission took charge of the investigation, or in the subsequent coronial inquest.

With respect to the Deputy Coroner, we do not consider that the recommendations arising from the *Mulrunji* inquest are sufficiently robust, even if fully implemented, to produce the desired confidence that the investigations into deaths in custody have been carried out with a desirable level of impartiality. In particular, the degree of detachment arising from leaving the investigations of deaths in custody in the hands of police – even if from a different region – is unlikely to engender the confidence comprehended in the Royal Commission into Aboriginal Deaths in Custody, where Elliot Johnson QC considered that:

> [a] death in custody is a public matter. Police and prison officers perform their services on behalf of the community. They must be accountable for the proper performance of the duties. Justice requires that both the individual interest of the deceased's family and the general interest of the community be served by the conduct of thorough, competent and impartial investigations into all deaths in custody".[3]

To establish a protocol for ensuring not only that investigations are "thorough, competent and impartial", but also (and perhaps more importantly) that they are perceived by the public as having these qualities, we believe that where a death in custody occurs, the investigation be immediately removed from either police or correctional officers, and placed in the hands of an adequately funded independent civilian body. We say this without in any way impugning the conduct of the vast majority of investigations into deaths in custody, but as a mechanism for ensuring public confidence in the processes adopted.

As a model, one might readily look to the statutory requirements established in the *Police Service Act 1990* of Ontario (relevant sections attached). Primarily, the Ontario Act establishes an independent, civilian body, the Special Investigations Unit (SIU), with the specific function of investigating "the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by police

---

[3] E Johnson, *National Report*, AGPS, Canberra, 1991, vol.1, p.109, cited by Deputy Coroner Clements in *Inquest into the death of Mulrunji* at p9, fn13.

officers" – s113(5). The desirable degree of detachment and independence is ensured by provisions which prevent police and former police from being appointed to the position of director, and prevents serving police from acting as investigators within the unit – s113(3). Section 113(6) requires than an investigator shall not participate in an investigation that relates to members of a police force of which he or she was a member. Section 113(9) imposes an obligation on police to co-operate fully with members of the SIU in the conduct of any investigation.

In the Queensland legislative context, it is, of course, not necessary (although we believe that it would still be desirable) to establish a specific independent statutory body to carry out such investigations, as that function could be performed, with the necessary level of perceived independence, by the Crime and Misconduct Commission (CMC). However, if either course were pursued, it would be necessary to ensure that the independent civilian body took control of the investigation immediately, rather than at some later stage. As the Deputy State Coroner observed:

> [o]nce the CMC took charge of the investigation, I am confident that it proceeded thoroughly, competently and impartially (*Mulrunji*, p11).

Of particular concern is the further observation by the Deputy State Coroner that:

> [t]he response by senior police officers to this inquest should be cause for some reflection. There was little acknowledgement that the investigation by the police was deficient. Clear directives from the Police Commissioner and a commitment to ensure proper standards of investigation are required to restore public confidence (*Mulrunji*, p11).

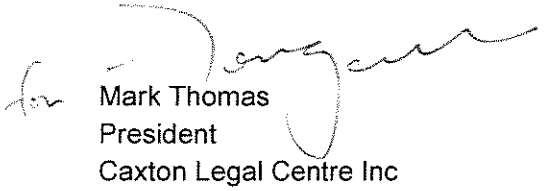
In addition to establishing an independent civilian investigation unit, either within the CMC or as a stand-alone body, the concerns which emerge from the two inquests would be addressed by the establishment and promulgation of clearly articulated standards and protocols under which investigations should proceed, with particular reference to the segregation of officers (where more than one officer is involved), and limitations on unofficial contact between investigators and officers the subject of an investigation. It is, perhaps more than anything else, the failures in these crucial aspects, together with the obvious and documented deficiencies in the investigations themselves, which attract attention to the systemic shortcomings in the *Eddy* and *Mulrunji* investigations.

Had the preliminary investigations into the deaths in custody of Michael Eddy and Mulrunji taken place in a statutory and administrative context as outlined, many of the criticisms raised in the respective coronial inquests would have been avoided. These measures alone would have obviated the need for the Coroners to comment respectively on the inadequacy of investigation procedures (*Mulrunji*, pp9-10; *Eddy*, p5).

We consider that the investigative function following a death in custody is not appropriately carried out by the police, and that its removal to an independent civilian body would be consistent with Recommendation B-1-1(b) of the Fitzgerald Inquiry, which envisaged such functions as being carried out by the (then) Criminal Justice Commission.

For public confidence in the police force to be sustained, all deaths in custody must be seen to be undertaken with absolute impartiality. The measures suggested are a way to avoid a repeat of the criticisms made by the Coroners, to avoid the exacerbation of the grief and understandable suspicion held by family members of the deceased and to avoid the erosion of public confidence in the police.

Yours sincerely



Mark Thomas
President
Caxton Legal Centre Inc

Police Services Act: R.S.O. 1990

Special investigations unit

113.(1) There shall be a special investigations unit of the Ministry of the Solicitor General.

Composition

(2) The unit shall consist of a director appointed by the Lieutenant Governor in Council on the recommendation of the Solicitor General and investigators appointed under the Public Service Act.

(3) A person who is a police officer or former police officer shall not be appointed as director, and persons who are police officers shall not be appointed as investigators.

Peace officers

(4) The director and investigators are peace officers.

Investigations

(5) The director may, on his or her own initiative, and shall, at the request of the Solicitor General or Attorney General, cause investigations to be conducted into the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by police officers.

Restriction

(6) An investigator shall not participate in an investigation that relates to members of a police force of which he or she was a member.

Charges

(7) If there are reasonable grounds to do so in his or her opinion, the director shall cause informations to be laid against police officers in connection with the matters investigated and shall refer them to the Crown Attorney for prosecution.

Report

(8) The director shall report the results of investigations to the Attorney General.

Co-operation of police forces

(9) Members of police forces shall co-operate fully with the members of the unit in the conduct of investigations. R.S.O. 1990, c. P.15, s. 113