Human Rights in Coronial Inquests

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Introduction

I would like to start by acknowledging the traditional Aboriginal owners of Brisbane.

I would also like to acknowledge the people of Palm Island and particularly the family of Mulrunji Doomadgee and their courage and determination to seek justice.

In this presentation I will discuss the role of coroners and coronial inquests in the protection of human rights.

I will argue that the modern coronial inquest is an important forum for protecting and promoting human rights. In particular I will consider:

- The development of the modern coronial process and the power of a coroner to comment;
- What human rights arise in the context of the coronial process;
- How human rights can be protected through the coronial process; and
- How human rights principles were applied in the Inquest into the Death of Mulrunji on Palm Island.

I should note that I am speaking tonight in my personal capacity and these are my personal views and not those of HREOC.

The development of the modern coronial process

The coronial inquest has traditionally been a fairly narrowly-focused inquiry that has sought to determine the facts surrounding the 'who, what, when, where and why of unexpected deaths'.[2] Until relatively recently in some jurisdictions, a coroner was either not given any power to make comment or recommendations,[3] or their ability to

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[2] Boronia Halstead, *Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study*, (1995, Australian Institute of Criminology) http://www.aic.gov.au/publications/dic/dic10.pdf at 3.

[3] As was the case, for example, under the *Coroners Act 1956* (ACT) (now replaced with the *Coroners Act 2003* (ACT) which contains the power to make recommendations: see s 25).

comment on broader issues related to the death was limited to the making of 'riders' that were not considered part of the coroner's findings.[4]

The reluctance to go beyond factual findings into comment and recommendation was based on the view that such matters are best left to the expert authorities concerned and that a coroner may not be aware of the ramifications of their recommendations or competing priorities in the allocation of public resources. Some commentators taking these views have described riders as 'mere surplusage' or even an 'irritation'.[5]

Halstead has commented that a potentially preventive role

> has been marginalised in some coronial practice through the emphasis on unpacking the facts of individual cases, rather than the systematic identification of patterns of death and injury. This emphasis reflects the over-riding modus operandi of the legal profession as a whole, which has concerned itself solely with dealing with events on a case by case basis, closing the file at the conclusion of each.[6]

Modern coronial law and practice has, however, increasingly freed itself from the narrow confines of this earlier approach and recognised the potential for a coroner to have a role in preventing potential deaths, rather than simply reporting on past ones. To paraphrase the motto of the Canadian Ontario and Victorian Coroners Court, the modern coroner 'speaks for the dead in order to protect the living'.

The Queensland *Coroners Act 2003*

Looking specifically to Queensland, we can note that one of the explicit objects of the 2003 *Coroners Act*, set out in section 3(d), is to 'help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to… public health or safety… or the administration of justice.'

Further, one of factors that the coroner may consider under s 28 of the Act in deciding whether to hold an inquest is 'the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future.'

Section 46 contains the coroner's power to comment. It states:

(1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to –
  (a) public health or safety; or
  (b) the administration of justice; or
  (c) ways to prevent deaths from happening in similar circumstances in the future.

[4] For example, the *Coroners Act 1958* (Qld) provided for the making of riders 'to prevent the recurrence of similar occurrences' (s 43(5)), but went on to state that 'a rider shall not be or be deemed to be part of a coroner's findings but it may be recorded if the coroner sees fit' (s 43(5A)). The position in NSW was similar prior to the insertion of s 22A of the *Coroners Act 1980* (NSW) in 1994 which provides a statutory basis for making recommendations.
[5] Halstead, above n 2, 3.
[6] Ibid.

We can see that this power to comment is in broad terms and it was held in *Doomadgee v Deputy State Coroner Clements*,[7] Supreme Court review proceedings arising out of the Mulrunji inquest, that as a remedial provision it should be liberally construed. [8]

Muir J noted that the terms 'connected with' and 'relates to' appearing in s 46 are 'of wide import' and are 'capable of including matters occurring prior to as well as subsequent to or consequent upon' the death as long as the relevant relationship exists.[9]

Muir J went on to note that 'public health or safety' and 'the administration of justice' are also 'broad subject matters with indefinite boundaries' and his Honour had

> difficulty in seeing why they are not sufficiently broad to permit comment on matters such as the handling by police officers of drunken and abusive prisoners in an about police stations or watch houses, appropriateness of training or lack thereof of police officers in the handling of such persons, including the control of emotional responses and procedures which could be adopted for investigation of incidents in such circumstances. Appropriate investigative processes are capable of playing a role in allaying suspicions of the deceased's family and maintaining public confidence in State institutions. Any such investigative process may relate to the administration of justice.

Is the power to comment a 'secondary' one?

One issue that arose in the Mulrunji inquest was the extent to which the modern coroner's function of comment under s 46 should still be considered a 'secondary' function to that of the 'findings' function.

More particularly, the question was whether a coroner could inquire into an issue or seek evidence on a point for the dominant purpose of making comment. For example, when looking at the decision to arrest Mulrunji, it was relevant to ask what alternatives were available. From this arose the question of why a diversionary centre was not available on Palm Island. That was not necessarily relevant to the 'who, how, when…' questions, but was clearly relevant to what comment it might be appropriate to make about the absence of a diversionary facility which might have meant that Mulrunji was not arrested.

Both the Palm Island Community Council and HREOC submitted that the Deputy State Coroner was entitled to, and indeed should, receive evidence on this and other broad social issues affecting the people of Palm Island to enable her to make informed comment directed at the administration of justice and prevention of future deaths.

Other parties, and indeed counsel assisting the Deputy State Coroner, were resistant to that idea, arguing that the comment function was a 'secondary' one and that the court

[7] Ibid.
[8] Ibid [31].
[9] Ibid [30], citations omitted.

could not inquire on matters in relation to which it was not required to make findings under s 45. In the end, without making a clear determination on the issue, the Deputy State Coroner did not inquire into these broader issues, although she did receive a range of written material from the Palm Island Council and HREOC dealing with them.

The issue arose in the context of argument about other evidence in the review proceedings and, in my view, Muir J's reasons in the review proceedings support the view that a coroner *can* gather evidence for the purposes of making appropriate comments – provided that such comments are within the broad scope of s 46.

This is, in my view, the appropriate approach: if a coroner is entitled to comment on a matter, he or she should be entitled to inform him or herself appropriately to do so, not simply from the matters that have been adduced to make the required factual findings. The idea that the comment function is subordinate to the function of making findings is, in my view, a hangover from the old days of riders and such an approach is not required by the Act.

The development of the power of a coroner to comment is a significant and welcome one from a human rights perspective. The broadened role of the modern coroner provides a vital opportunity for the protection of human rights.

And, as I will argue, the protection of human rights is a basis upon which coroners should be encouraged to continue to take an expansive approach to their role.

Why are human rights relevant to the conduct of an inquest?

For many, it may seem self-evident that human rights should be promoted where possible in the administration of our laws. Australia has agreed to comply with a range of human rights treaties, including, most relevant to this topic, the *International Covenant on Civil and Political Rights*[10] ('the ICCPR').

However, as you would be aware, these international obligations do not give rise to enforceable rights domestically unless they are implemented by domestic laws.[11]

Why human rights are legally relevant to the conduct of an inquest is the well-accepted principle of the common law that Commonwealth and State laws are to be interpreted and applied, as far as their language permits, so as to be in conformity and not in conflict with the established rules of international law.[12] Part of those established rules are those set out in the human rights treaties to which Australia is a party.

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[10] Opened for signature 16 December 1966, 999 UNTS 171 (generally entered into force 23 March 1976, article 4 entered into force 28 March 1978).

[11] *Minister for Immigration and Ethnic Affairs v Ah Hin Teoh* (1995) 183 CLR 273, 287 (Mason CJ and Deane J).

[12] *Kartinyeri v Commonwealth* (1998) 195 CLR 337, 384 (Gummow and Hayne JJ); *Jumbunna Coal Mine N/L v Victorian Coalminers' Association* (1908) 6 CLR 309, 363 (O'Connor J); *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287 (Mason CJ and Deane J); Pearce and Geddes, *Statutory Interpretation in Australia* (5th ed, 2001), [5.14].

So what are the international legal obligations that are relevant to the interpretation and application of legislation such as the Queensland Coroners Act?

What human rights arise in the context of the coronial process?

The Right to Life

Perhaps the most obvious human right relevant in the context of a coronial inquest is the right to life.

Article 6(1) of the ICCPR provides that

> Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

This is more than an obligation upon a State not to take life. It is also imposes a positive duty to protect life and prevent death.[13] The Human Rights Committee, in *General Comment 6* has noted (at para 5) that

> the right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures…

<u>Positive measures required to protect life</u>

The range of positive measures that might be required to protect the right to life is potentially very broad.

Most obviously, there is an obligation on States to carefully regulate and properly train personnel, such as police officers and prison guards, to minimize the chance of violation of the right to life.[14] An obvious area for such regulation and training is in the use of force and forms of restraint

There is also a particular duty to protect people held in any form of detention by the State. [15] This duty extends to ensuring appropriate monitoring and supervision of people in detention and providing appropriate medical care.

The requirement in Article 6(1) that the right to life 'shall be protected by the law' also imposes a duty to prevent and punish killings and deaths caused by negligence or recklessness in both the public and private sectors.[16]

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[13] See generally Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), Chapter 8, especially [8.01], [8.39]-[8.64].
[14] See Joseph et al, above n 13, [8.39] 181.
[15] See *Lantsov v Russian Federation* UNHRC Communication No 763/1997, UN Doc CCPR/C/74/D/763/1997 (2002); *Fabrikant v Canada* UNHRC Communication No 970/2001, UN Doc CCPR/C/79/D/970/2001 (2003); *Dermit Barbato v Uruguay* UNHRC Communication No 84/1981, UN Doc CCPR/C/17/D/84/1981 (1982).
[16] See Joseph et al, above n 13[8.42]-[8.43], 183-4.

More contentious is the extent to which Article 6(1) includes broader socio-economic aspects, imposing an obligation to protect against such threats to life as malnutrition and epidemics.[17]

In my view, the positive measures required to protect life should include a thorough investigation of deaths.

It is now well-established in jurisprudence concerning the right to life in Article 2 of the European Convention on Human Rights, that protection of that right requires an effective official investigation into deaths that may have been caused by agents of the state as well as other deaths in custody where the state is responsible for an individual's wellbeing.[18]

I would argue, however, that an effective investigation is required not just in cases in which the state has, or may have, such direct involvement in the death: the positive steps that a State is required to take to properly protect the right to life must include adequately investigating all deaths. Such an obligation may frequently be satisfied by a police investigation. However, where a case raises systemic issues, a more comprehensive investigation, such as can be performed by a coroner, may be required to ensure that the lessons are learnt that may prevent future deaths.

Obligation to provide an 'effective remedy'

The obligation to comprehensively investigate a death also arises out of a State's obligations to provide an 'effective remedy' for violations of human rights. Article 2(3) of the ICCPR provides that:

> Each State Party to the present Covenant undertakes:
>
> (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity.

[17] Ramcharan has argued that the right to life includes a 'satisfaction of survival requirements' component, imposing an obligation on States to protect against death from causes such as hunger and disease: B G Ramcharan, 'The Concept and Dimensions of the Right to Life' in B G Ramcharan (ed) *The Right to Life in International Law* (1985). Other commentators have suggested that there may be no more than a 'moral "soft law" obligation, rather than a legal "hard law" duty, to tackle problems such as infant mortality and low life expectancy': Joseph et al, above n 13, [8.45], 185; see also Manfred Nowak, *UN Covenant on Civil and Political Rights, CPPR Commentary* (2nd ed, 2005), 124, n 17.

[18] See, for example, the discussion in *R v Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51, [18]-[23] (Lord Bingham).

Other relevant human rights

A comprehensive inquest into a death may also provide an effective remedy for potential breaches of a range of other human rights. [19]

For example, where a death has taken place in custody as was the case for Mulrunji, the following rights may be relevant:

- the right of detained persons to be treated with humanity and dignity;[20]
- the prohibition on torture or cruel, inhuman or degrading treatment or punishment;[21] and
- the prohibition on arbitrary arrest or detention and related rights upon arrest;[22]

Where a person's rights have been breached in the context of their death, the coronial inquest may be the most appropriate, or indeed the only, forum in which such breaches can be investigated and some form of remedy provided.

Implications for coronial practice

So what does this mean for the conduct of a coronial inquest in practice?

In general it is likely mean taking a broad approach to the scope of the inquest and to the coroner's power of comment.

I should note that I am not arguing that we can or should ignore the proper limits of the powers of the coroner to inquire and to comment. Rather, that human rights principles can inform how we understand and apply those limits.

The scope of the inquest

It is relevant to note that the coronial process is itself a flexible one. It is an inquisitorial, rather than an adversarial, process.

The coroners court is not bound by the rules of evidence and may inform itself in any way it considers appropriate (s 37) and the coroner enjoys comprehensive powers to compel the production of evidence and the attendance of witnesses for questioning (see s 37).

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[19] A prompt and impartial investigation of allegations of breaches of human rights by a competent authority is vital to providing an 'effective remedy'. *Herrera Rubio v Colombia* UNHRC Communication No 161/1983, UN Doc CCPR/C/OP/2 at 192 (1990), [10.5]; *Dermit Barbato v Uruguay* UNHRC Communication No 84/1981, UN Doc CCPR/C/17/D/84/1981 (1982); *Aktas v Turkey* ECHR 24351/94, 23 April 2003, [331]-[333]. See also UN Human Rights Committee *General Comment 20*, [14].

[20] See Article 10 of the ICCPR: 'All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person'.

[21] See Article 7 of the ICCPR.

[22] See Article 9 of the ICCPR.

The fundamental anchor of the coroners investigation is that it must be into a particular death or deaths (or suspected death(s)).

From there, the scope and boundaries of an inquest are defined by the coroner's obligation to make findings on the 'who, how, when, where and what' (in Queensland, under section 45) and the discretion to make comment (in section 46).

As Muir J noted in the *Doomadgee* review proceedings, this still gives a coroner a very broad scope within which to investigate, although he emphasised that a coroner is not a 'roving Royal Commissioner'.[23]

Human rights as a factor in the exercise of discretion

My argument is that given the wide discretion of a coroner, human rights principles provide a legitimate reference point for the exercise of that discretion.

One particular way in which human rights principles may be relevant is in determining when it is 'appropriate' to comment. In exercising the coroner's discretion, a coroner should, in my view, consider whether doing so will protect or promote human rights.

This may, in turn, influence what evidence a coroner thinks is necessary to receive to enable him or her to make meaningful comment.[24]

When it comes to formulating an appropriate comment, again the discretion of a coroner is very broad and human rights considerations may influence the scope and nature of such comments.

Human rights in the Mulrunji inquest

Turning now to the Mulrunji inquest, HREOC was, as you know, granted leave to appear. There are no 'parties' to an inquest as such. Persons may appear, examine witnesses and make submissions if the coroner considers they have a 'sufficient interest' in the inquest. HREOC sought leave to appear as a body with a 'sufficient interest' in the proceedings by virtue of its statutory functions relating to human rights.

In addition to making written and oral submission, HREOC put a range of material before the Coroner and cross-examined witnesses.

The focus of our involvement was systemic issues that impacted upon the human rights of Indigenous people. We sought to ensure, as far as possible, that the coronial

[23] *Doomadgee v Deputy State Coroner Clements* [2005] QSC 392, [29].
[24] *Doomadgee v Deputy State Coroner Clements* [2005] QSC 392, [36] and [39]. Previous Victorian authority, *Harmsworth v State Coroner* [1989] VR 989, had suggested that a coroner was not able to 'enquire for the sole or dominant reason of making comment or recommendation' and that inquiry had to be linked to the power to make findings on the 'how, who, when…' questions. Such an approach does not appear to have been followed by Muir J.

process provided an effective remedy for what HREOC viewed as breaches of Mulrunji's human rights and provide a basis for comment that would potentially prevent deaths or other breaches of human rights.

HREOC's final submissions sought to do this by setting out 40 comments that, in HREOC's view, would contribute to the protection of human rights.

Arrest and Policing

The first area covered by HREOC's submissions was the arrest of Mulrunji and related policing issues.

In HREOC's view, Mulrunji's arrest, for swearing at police, was an arbitrary arrest. Even if lawful, something not conceded by HREOC, it was an inappropriate exercise of discretion, demonstrating a lack of awareness of alternatives to arrest and a lack of awareness of the recommendations of the Royal Commission into Aboriginal Deaths in Custody.

HREOC suggested a range of comments concerning the exercise of police discretion, alternatives to arrest, police training, operational procedures and the funding and support of the Community Justice Group on Palm Island.

Diversionary centres and community patrols

The second area covered by HREOC's submissions concerned the availability of diversionary centres and community patrols as a means of diversion from custody.

The evidence in the inquest was that there were no options for diversion from custody such as a diversionary centre for people arrested while drunk. Further, there was no community patrol operating on Palm Island, despite support for such an idea from police and the well-recognised success of community patrols in other Aboriginal communities.

Again, coming from a human rights perspective that sees arrest as a last resort, HREOC suggested comments concerning the establishment of a diversionary centre and community patrol on Palm Island.

HREOC also argued that providing diversionary centres was consistent with the right to 'the enjoyment of the highest attainable standard of physical and mental health', recognised by Article 12 of the *International Covenant on Economic, Social and Cultural Rights*,[25] because of the role of such centres in improving the health and wellbeing of intoxicated people coming into contact with police.

[25] Opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

Assessment and monitoring of health

The evidence in the inquest also displayed a complete failure to adequately assess Mulrunji's health upon admission to the police watchhouse.

HREOC argued that Senior Sergeant Hurley's failures to adequately assess and monitor Mulrunji's health were inconsistent with Mulrunji's right to life and also inconsistent with Mulrunji's right to be treated with humanity and respect for his inherent human dignity.

HREOC also identified deficiencies in the police operating procedures regarding assessment and monitoring of health and potential inadequacies in police training.

Accordingly, HREOC sought comments by the coroner to acknowledge these failures and recommend improvements in police procedures and training.

Investigation of Mulrunji's death

Finally, HREOC's submissions considered the investigation of Mulrunji's death.

The evidence here revealed a range of shortcomings and inappropriate conduct by police officers in the course of the investigation which had the potential to undermine the integrity of the investigation and the appearance of integrity. This included difficulties in cross-cultural communication between police and Aboriginal witnesses.

HREOC's submissions were based on the importance of a thorough and effective investigation of deaths in police custody in protecting the right to life and ensuring the right to an effective remedy. HREOC argued for the making of 14 comments concerning police practice, procedures and training to avoid similar failures in future.

Conclusion – Lessons learnt?

The Coroner adopted HREOC's proposed recommendations and made all of the 40 comments suggested. The comments were sent to the Attorney-General, the Director General and Minister of government with responsibility for police and the Commissioner for police.

The Queensland government issued a reply to the comments of the coroner in November 2006, indicating support for the majority of the comments and listing action that was to be taken in relation to many of them. While not going as far as many might have hoped, it included changes to police policies and commitment of funds for a community justice programme.

Of course, Indigenous people in Palm Island and beyond have heard many promises before and have had countless recommendations made and reports written about the injustices suffered by them. I won't suggest that the outcome of this process is a brand new day.

But the inquest did provide an opportunity to shine a light on policing in remote Indigenous communities, highlight inadequacies in the investigation of custodial deaths and expose some of the wrongs done to Mulrunji Doomadgee. And human rights principles played a significant role in that process.

Human rights were an effective basis for encouraging the Deputy State Coroner to take a broad view of the issues about which it was appropriate to comment and to go on to make extensive comments aimed at improving systemic practices.

In this way, the inquest demonstrated the potential to protect and promote human rights through the modern coronial process.