



International Covenant on Civil and Political Rights

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Human Rights Committee

Communication No. 1995/2010

Decision adopted by the Committee at its 111th session (7–25 July 2014)

<i>Submitted by:</i>	Elizabeth Gail Hickey (represented by Emrys Nekvapil, Flemington & Kensington Community Legal Centre)
<i>Alleged victim:</i>	Thomas James Hickey (deceased son of the author)
<i>State Party:</i>	Australia
<i>Date of communication:</i>	14 February 2010
<i>Document references:</i>	Special Rapporteur's rule 97 decision, transmitted to the State party on 25 October 2010 (not issued in document form)
<i>Date of adoption of decision:</i>	21 July 2014
<i>Subject matter:</i>	Lack of independence in investigation of the death of a person that involved the police
<i>Substantive issues:</i>	Right to effective remedy; right to life; prohibition of discrimination
<i>Procedural issues:</i>	Level of substantiation of claims; exhaustion of domestic remedies
<i>Articles of the Covenant:</i>	2, 6 and 26
<i>Articles of the Optional Protocol:</i>	2 and 5 (para. 2 (b))



Annex

Decision of the Human Rights Committee under the Optional Protocol to the International Covenant on Civil and Political Rights (111th session)

concerning

Communication No. 1995/2010*

Submitted by: Elizabeth Gail Hickey (represented by Emrys Nekvapil, Flemington & Kensington Community Legal Centre)

Alleged victim: Thomas James Hickey (deceased son of the author)

State Party: Australia

Date of communication: 14 February 2010

The Human Rights Committee, established under article 28 of the International Covenant on Civil and Political Rights,

Meeting on 21 July 2014,

Adopts the following:

Decision on admissibility

1. The author of the communication is Elizabeth Gail Hickey, an Australian national. She submits the present communication on behalf of her deceased son, Thomas James Hickey, an Australian national, born 9 March 1986. The author and her son are aboriginal Australians. She claims that her son was the victim of a violation by the State party of his rights under articles 2, 6 and 26 of the Covenant. She is represented by counsel.

Factual background

2.1 On 14 February 2004, members of the Police Force of New South Wales (NSW), in three vehicles, were searching for an indigenous male in Redfern, Sydney, NSW, who allegedly committed an aggravated robbery. Thomas Hickey, who was considered by the police as a “high-risk offender”, was in the vicinity of the police operation, riding his bicycle, while his girlfriend was timing his ride. According to witnesses, one police vehicle (Redfern 16) started following him. It seems that he was riding his bicycle at a high speed and, at some point, he fell and his neck and chest were impaled on the poles of a metal

* The following members of the Committee participated in the examination of the present communication: Yadh Ben Achour, Lazhari Bouzid, Christine Chanet, Ahmad Amin Fathalla, Cornelis Flinterman, Yuji Iwasawa, Walter Kälin, Zonke Zanele Majodina, Gerald L. Neuman, Sir Nigel Rodley, Victor Manuel Rodríguez-Rescia, Fabián Omar Salvioli, Dheerujall B. Seetulsingh, Anja Seibert-Fohr, Yuval Shany, Konstantine Vardzelashvili, Margo Waterval and Andrei Paul Zlătescu.

fence. The author alleges that the police officers did not provide her son with medical assistance and when a police rescue van arrived at the scene, it was turned away by the police. Mr. Hickey was taken to the Prince of Wales Hospital. Police Investigator R.E.E. from Redfern Police Station also arrived at the scene. However, it was decided that the event was not a “critical incident”, as the police denied any type of pursuit.

2.2 On 15 February 2004, Mr. Hickey died in hospital. Later, the author went to the Redfern Police Station and claimed that the police were responsible for her son’s death. She also told the police that her son had \$20 and a small quantity of marijuana in his possession, and that these had not been returned to her. She was allowed to see her son’s bicycle and noted that the back wheel was wobbly or loose and that the chain was hanging off it. Police Investigator R.E.E. informed the media that the police were not chasing Mr. Hickey and that the police had tried to give him first aid. On the same day, Redfern residents had attacked police vehicles, the police station and policemen. The riot lasted seven hours and about 40 policemen were injured. It attracted the interest of the international media. In that context, Police Commander B.W. declared that the riot was started because people believed that the police were actually involved in a pursuit when the Aboriginal youth was killed. However, he denied police involvement in the death.

2.3 On 16 February 2004, a decision was taken that the death should be considered a “critical incident”, and subjected to a coronial investigation. NSW Detective Senior Constable M.K. from the Leichhardt Area Command took over the investigation from Police Investigator R.E.E. The author claims that, although he had been informed that he was investigating a “critical incident”, Detective Senior Constable M.K. did not interview the four policemen involved in her son’s death until 21 February 2004. She stated that the delay was due to his superior’s concern about the well-being of the four officers.

2.4 On 25 March 2004, the police refused to allow the author and a forensic consultant retained on her behalf to photograph her son’s bicycle that was still in police custody. Nevertheless, the author claims that she could see from a distance that one wheel had been replaced.

2.5 From 5 to 16 July 2004, the coronial inquest was conducted by NSW State Coroner J.A. who was not a police officer. On 17 August 2004, State Coroner J.A. concluded that Mr. Hickey’s death occurred during a police operation, within the meaning of section 13A of the Coroners Act 1980; that the police vehicles were not pursuing him, within the meaning of the NSW Police Safe Driving Policy; that although police vehicle Redfern 16 was following Mr. Hickey and may have influenced the manner in which he was riding his bicycle, there was no evidence to conclude, as a probability, that the actions of the police vehicle contributed in any way to his death; and that although, neither the \$20 or the small quantity of marijuana were found in his possession, there was no evidence as to what happened to the property.

2.6 On 26 September 2004, NSW Assistant Commissioner of Police reported that the coronial inquest conducted at Glebe Coroner’s Court before State Coroner J.A. had been completed and that based on its outcome, no further action would be taken on the matter. He also indicated that a copy of the investigation had been referred to the Ombudsman, who had been represented at all the interviews conducted by the police investigating the incident.

2.7 After the inquest had been closed, the NSW Attorney General refused to carry out a new inquest, despite requests submitted in that regard by different persons in 2004 and 2005. According to the documentation provided by the author, on 25 March 2008 the NSW State Coroner dismissed a request to reopen the inquest, indicating that the coronial file relating to Mr. Hickey’s death had been reviewed by senior magistrates/coroners on several occasions since the matter had been closed; that there had been several separate requests to

reopen the inquest; and that all the requests had been denied because a fresh inquest could only be carried out if there were new evidence or facts that would render it necessary or desirable in the interests of justice. The State Coroner further noted that at the conclusion of the original inquest, the parents of Mr. Hickey, who were represented by an experienced counsel, were told that they could appeal the decision of State Coroner J.A. before the Supreme Court, but they failed to do so.

2.8 On 14 September 2009, NSW Ombudsman informed the author that it did not make a report in relation to the death of Mr. Hickey under section 26 of the Ombudsman Act 1974 (NSW). He indicated that he had overseen the investigation in accordance with section 146 of the Police Act and that he was satisfied that all reasonable and available avenues of investigation had been undertaken and that the complaint had been properly dealt with by the NSW Police Force.

2.9 The author claims that she was not satisfied with the manner in which the police conducted the initial investigation and that the shortcomings at that stage had contaminated all the proceedings which took place afterwards. According to section 85 of the Coroners Act 2009, the Supreme Court of New South Wales may quash a coronial inquest and order that a new inquest be held, if the Court is satisfied that it is necessary or desirable to do so in the interests of justice. However, such an order could not remedy the failure of the State party to undertake an independent investigation into Mr. Hickey's death. New South Wales does not have, and has never had, a body that can independently investigate deaths in which the police are implicated. Therefore, a Supreme Court order would be unlikely to bring effective relief and should be considered ineffective. An effective investigation entails the prompt collection of evidence by an independent body, to prevent contamination of evidence, and the gathering of testimonies from immediate witnesses. NSW Coroner's Office does not meet the requirements of an independent investigative body. The Coroner's Office is unable to conduct its own investigations and is compelled to rely on information obtained by the police, as happened in the present case. Against that background, any recourse to the Supreme Court would have no prospect of success, if success is understood to mean an order for a fresh coronial inquest that excluded evidence gathered by the police. There is no other effective remedy in the legal system of the State party. In addition, neither Australia nor the state of New South Wales has a charter of rights protecting the right to life.

2.10 As to the delay in submitting her communication to the Committee, the author holds that she was unaware of the relevant United Nations human rights mechanisms and of the Covenant until 2009. A determination by the Committee on her communication would be a matter of significant public interest, as her son's death remains a controversial issue for the Aboriginal community in Australia.

The complaint

3.1 The author claims that her son was a victim of a violation of his rights under articles 6 and 26, alone and in conjunction with article 2, of the Covenant.

3.2 The author submits that article 6, paragraph 1, set out positive and negative obligations for the State party. The negative obligation is violated in cases where the facts disclose a material possibility that the agents of the State party have deprived an individual of his or her life arbitrarily or unlawfully, and the State party has failed to investigate the death effectively. Thus, the State party is subject to a duty to take specific and effective steps to investigate the circumstances of the death of an alleged victim. Furthermore, in such circumstances, an effective investigation must be independent, adequate, prompt and transparent. It should be initiated by the State party ex officio and should enable the effective participation of the alleged victim's relatives.

3.3 In the case in hand, none of those features were present. The investigation was not conducted by a body independent of the police. In that respect, the author is not asking the Committee to make findings about the adequacy, promptness or transparency of the investigation carried out into her son's death. Rather, she is seeking to demonstrate that the body that carried out the investigation lacked independence. Regardless of the particular qualities of the investigation, owing to the procedures, policies and institutions surrounding the investigation of police-related deaths in NSW, the investigation was not capable of being independent. Independence should be understood as the institutional and functional separation between the investigative organ and the organ to which the alleged perpetrators belong.

3.4 In NSW, the effect of an inadequate police investigation cannot be later ameliorated by a coronial inquest which relies on evidence gathered by the NSW Police Force.

3.5 In the present case, there was information available to the authorities which potentially implicated the Police Force. This should have been sufficient to conclude that the death should be investigated by a body other than the same Police Force. Notably, the Redfern police station received telephone calls from third persons in the afternoon of 14 February 2004 implicating a police officer, D.P. Other witnesses also provided information on the behaviour of the police shortly after the event. Furthermore, the author's son was on the police list as a "high-risk offender". The author adds that studies have shown police propensity to arrest and harass Aboriginal young people. Notwithstanding that, there was no competent independent body to conduct the investigation against the police officers, since it is the Police Force itself that is in charge of investigations.

3.6 The persons who carried out the forensic investigation and sought evidence were also under authority of the NSW Police Commissioner, as was Assistant Commissioner B.W., who made public statements prejudging the outcome and circumstances of the death of the author's son. Being of lower rank to some of the officers at the scene and to his commander, who had prejudged the outcome, police investigator, Detective Senior Constable M.K., would have been in conflict with his superior if he had concluded that the author's son was, in fact, being pursued by the police. Given the importance of command and control structures within police agencies, rank is critical for an officer making potentially adverse findings against other officers.

3.7 The police investigation was not adequate and several precautionary measures were omitted during the first days of the investigation. Notably, police officers concerned were not interviewed until a week into the investigation; they were not separated; and they had ample time to discuss the matter among themselves. Key policemen potentially implicated were not interviewed within the State Coroner's inquest. One of them, Senior Constable D.P., was even permitted to have an active role in the investigation itself, as he interviewed a key civilian witness. Other relevant witnesses were not interviewed either. The author's son's bicycle was not impounded elsewhere than Redfern Police Station until several days after the incident.

3.8 The coronial inquest was based on the investigation by the Police Force and the evidence obtained by it. The Police Force interviewed witnesses and was charged with collecting forensic evidence; it decided the content of the coroner's brief and controlled the exhibits and the autopsy material; it also decided which evidence would be forensically assessed, who would be treated as a suspect, the questions that would be asked and the timing of those questions. Although the NSW Ombudsman oversaw the investigation, it had no power to direct the police in the conduct of the investigation and was forbidden to disclose any observations it may have had about it.

3.9 Even if the NSW Coroner was not a police officer, he did not have the power to conduct investigations independently and to remedy any shortcomings in the police

investigation. The author points out that Senior Constable H, the most senior officer involved in the incident, refused to give evidence on the basis that it may lead to disciplinary action against him, and the coroner agreed to that. In addition, the investigation was not sufficiently prompt, as the death was not treated as a critical incident until 16 February 2004. It was only on that date that a police officer from the Leichhardt Area Command took over the conduct of the investigation.

3.10 The investigation did not permit the adequate involvement of the family. For instance, the author was not informed of her right to have an independent post-mortem examination done; she was not allowed to photograph her son's bicycle when she presented herself to the police station with a forensic expert; nor was she permitted to pose questions to the investigators.

3.11 The author concludes that the lack of separation between the organ investigating her son's death and the organ implicated in the death constitutes a violation of article 6, paragraph 1, of the Covenant.

3.12 As to her claims under article 26, the author argues that in the light of the documented history of violence and neglect by police officers in relation to Aboriginal Australians, in particular in Redfern, the obligation to conduct an independent investigation into an incident in which the Police Force was potentially implicated also becomes an obligation under article 26 of the Covenant. Moreover, such investigation should have examined whether discrimination had played a role in the incidents that led to Mr. Hickey's death.

3.13 The author claims that the State party has also violated article 2, read in conjunction with article 6 and 26, of the Covenant by not making available to Mr. Hickey's family any effective remedies for the violation of his rights.

3.14 As for remedies, the author requests the Committee to: (a) rule that she be awarded compensation; (b) call upon the State party to enact legislation for the independent and effective investigation of all deaths occurring during police operations and in police custody and deaths in which information potentially implicating the police in the death in some way is or should be available to the State party; (c) call upon the State party to enact legislation that ensures that the deaths of indigenous persons during police operations and in police custody are thoroughly, independently and adequately investigated, including for any racially prejudicial or other discriminatory motivation and for any systemic or structural racism; and (d) call upon the State party to establish a Royal Commission into the death of the author's son.

State party's observations on admissibility and merits

4.1 In a note verbale dated 19 April 2012, the State party submitted its observations on the admissibility and merits of the communication. It acknowledges the tragic circumstances of the death of the author's son, but maintains that the communication is inadmissible on the grounds of failure to exhaust domestic remedies, failure to substantiate the claims and abuse of the right to submit a communication. Should the Committee be of the view that the communication is admissible, each of the claims should be dismissed as they do not disclose a breach of the obligations enshrined in the Covenant.

4.2 The State party provides clarifications concerning the author's accounts and a detailed timeline of facts. It points out that the author's son had a criminal record for stealing, assault, breach of bail and breaking and entering. A warrant of apprehension was in existence for his arrest and his bail conditions precluded him from going into the area known as "The Block" in the NSW suburb of Redfern. On 14 February 2004, he went to The Block, then rode his bicycle towards Waterloo. During the investigation, it was not

disputed that the brakes of Mr. Hickey's bicycle were defective, and that several witnesses who had seen him riding that morning stated that he was riding his bike very fast.

4.3 Around the time he left The Block, members of the NSW Police Force were conducting an operation in the area, searching for another person, C.C., who was a suspect in a serious assault and robbery of a woman in Redfern that morning. The author's son looked nothing like C.C., beyond the fact that they were both indigenous Australians. Two police vehicles, Redfern 16 and Redfern 17, were engaged in the police operation. NSW State Coroner found, on the balance of probabilities, that it was likely that Redfern 16 had followed the author's son for a while during the operation. However, when Mr. Hickey rode through a pedestrian gateway in a wire fence, the police vehicle was physically unable to follow him. This conclusion was consistent with the evidence submitted by Mr. Hickey's relative, R.H., who was in a car on a nearby street. Mr. Hickey rode 40 to 50 metres without any police vehicle in proximity before he had the accident. Police vehicle Redfern 17 found him shortly after the accident and requested an ambulance urgently. Police officers applied first aid until the ambulance arrived. The police officers in Redfern 16 went to the hospital. At the hospital, a counsellor told the officers that Mr. Hickey's family had made a very general allegation that they believed that the police were pursuing him prior to his death. Nevertheless, at the time, no one from the family made the allegation directly to the police.

4.4 On 14 February 2004, the Assistant Commissioner of the NSW Police Force, in consultation with the Superintendent, Mr. S, and following advice from Police Investigator R.E.E., determined that the event was not a "critical incident", as the death had not involved a police pursuit and witnesses spoken to at the scene had corroborated that. In NSW, identification of an incident as a "critical incident" activates an independent investigative process conducted by a specialist critical incident investigation team as well as a subsequent review of the investigation by an independent review officer. While not deemed a "critical incident", Detective Sergeant P.D. and Senior Constable D.P. of the Redfern Police Station commenced initial investigations into Mr. Hickey's accident, and each of them took statements from two witnesses. Later, the four officers who were in the two police vehicles returned to the police station and made their statements. Contrary to what the author held, Senior Constable D.P. was not even in the vicinity of the scene of the accident, but at the Redfern RSL, a local club, as provided in his statement of 15 February 2004 and corroborated by a closed circuit television.

4.5 At 1:20 a.m. on 15 February 2004, Mr. Hickey died in hospital. That night, serious civil unrest broke out between Aboriginal persons and the Redfern police. As a result of the civil unrest and the exceptional public scrutiny and interest regarding the case, the decision was made on 16 February 2004 to treat the Mr. Hickey's bicycle accident and death as a "critical incident". Investigations were handed over to officers at Leichhardt Police Station, Detective Senior Sergeant R.D. and Detective Senior Constable M.K. On 21 February 2004, they interviewed the four officers who were in the police vehicles on the date of the accident, in presence of a representative from NSW Ombudsman's Office. Detective Senior Constable M.K. detailed in a statement the other steps that were taken during the investigation, including interviews of numerous civilian witnesses, as well as a scientific analysis of the scene of the accident and the bicycle. Following the police investigation, in July 2004, NSW State Coroner held an inquest into Mr. Hickey's death. He stated that it was not possible to conclude on the balance of probabilities that the police contributed to the death of the author's son.

4.6 As regards the admissibility of the communication, the State party asserts that the author has not substantiated her claim that her son was a victim of a violation as defined under article 1 of the Optional Protocol to the International Covenant on Civil and Political Rights, as in her submission dated 6 August 2010, complementary to her original communication, she asks the Committee to make an abstract finding about the adequacy of

the system of investigation in NSW. Although the author claims that there is no need for the Committee to review the coroner's facts and findings, her claims can only be verified if the Committee reviews the coroner's findings and rejects his conclusion.

4.7 The author failed to sufficiently substantiate her claims for the purpose of admissibility. With regard to article 6, she has not substantiated that her son's accidental death resulted in a violation of his right to life. Likewise, she has not claimed nor sufficiently substantiated that the investigation of her son's death breached the obligations contained in article 6 of the Covenant. Regarding her claims under article 26, the author has not provided evidence that indicates that her son's death was discriminatory, either *de jure* or *de facto*. There is no evidence that the law in NSW, either on its face, or in its application, resulted in discrimination in Mr. Hickey's case.

4.8 The communication should be declared inadmissible as the author has failed to exhaust domestic remedies, as required by article 5, paragraph 2 (b), of the Optional Protocol. There are a number of remedies that the author has failed to exhaust. As the appeal instance, NSW Supreme Court has the power to quash the findings of a coronial inquest or to order a new inquest. It is uncontested that this remedy was available, and the author has not claimed that she would have been unsuccessful in filing a petition for a new inquest. The mandate of NSW Supreme Court to review coronial findings would apply to the situation alleged by the author, i.e. that the coronial inquest was an ineffective or insufficiently independent inquiry. The Court could quash the proceedings and order a new inquest for reasons that include any insufficiency of inquiry or any other reason "in the interest of justice". Therefore, the author could have applied to the Supreme Court on the basis of the lack of independence of the investigation. A fresh coronial inquest is an effective remedy, since it is not the police, but the coroner who has the power to control a coronial investigation, pursuant to the Coroner's Act 2009. Among other powers, the coroner may issue a "coronial investigation scene order" to a police officer or other person to establish a coronial investigation scene at a specified place (including vehicles), give directions as considered fit for the speedy determination of the real issues with which the proceedings are concerned, establish the witness list and the method(s) by which evidence should to be gathered, give directions to the police officers concerning the investigations to be carried out, order the exhumation of a body for the purpose of a post mortem examination, and subpoena individuals to appear before the Court and answer questions, including persons who did not give evidence at the original inquest.¹

4.9 The State party contests the author's allegation that the only way such proceedings would be a success is to conduct a fresh coronial investigation that excluded evidence gathered by the Police Force. The State party does not consider an inquest on those terms to be consistent with good investigative practice. Notwithstanding that, it points out that, under section 82 of the Coroner's Act 2009, the coroner may recommend that another body conduct an investigation. Pursuant to section 83 (4) of the Coroner's Act, the author could have submitted a request to the coroner for a new inquest, on grounds of the discovery of new evidence or facts that render it necessary or desirable in the interest of justice to hold a fresh inquest. In that regard, the requests for new inquiries to which the author refers were submitted by other persons to NSW Attorney General and were rejected because they did not provide sufficient evidence. However, those refusals did not preclude the author from filing her own request based on the alleged defects in the inquest.

4.10 The author did not submit a complaint to NSW Police Integrity Commission (PIC). The statutory objective of the PIC is to detect, investigate and prevent police corruption and serious misconduct, which may be of concern in the death of a person. Its investigation may

¹ The State party refers to sections 40, 43 (1), 49, 51, 66, 82 and 91 of the Coroner's Act 2009.

result in the dismissal and prosecution of the officers concerned. The author also failed to file a civil claim against the police or request a criminal prosecution. Although there is no statutory “right to life” at the Commonwealth or state level, the State party has a robust civil liability regime, under which individuals may, for instance, bring a civil action against members of the police for wrongful death or negligence or misfeasance in public office. In addition, NSW criminal justice system provides a mechanism to prosecute murder and manslaughter or perverting the course of justice. It includes the right to pursue a private prosecution under section 49 of the Criminal Procedure Act 1986. Finally, the author failed to submit a complaint concerning her claim of racial discrimination to either NSW Anti-Discrimination Board (ADB) or, alternatively, the Australian Human Rights Commission (AHRC). NSW Court of Appeal has confirmed that the ADB has jurisdiction in relation to racial discrimination in services provided by NSW police, under the Anti-Discrimination Act 1977. The ADB can refer a complaint to the Administrative Decision Tribunal, which can order binding remedies such as compensation or an apology. Similarly, the AHRC has the power to investigate and attempt to conciliate complaints of discrimination. That includes jurisdiction over acts of discrimination by public authorities such as NSW police. If the AHRC is unable to successfully conciliate a discrimination complaint, the author also has the option of having her case heard and determined by the Federal Court of Australia or the Federal Magistrates Court.

4.11 The author’s communication constitutes an abuse of the right of submission, pursuant to rule 96 (c) of the Committee’s Rules of Procedure² on the grounds of a delay of over five years. In that respect, the relevant date is 15 February 2004, the date on which Mr. Hickey died, if as the author claims, there was simply no mechanism in NSW to independently investigate this death, or 17 August 2004, the date on which the coroner’s report was handed down. The author’s allegation that she was unaware of the relevant United Nations mechanism and the Covenant until 2009 is insufficient justification for a delay of that length, especially when she had access to legal representation, including representation at the time of the inquest by pre-eminent lawyers and Legal Aid NSW. Furthermore, she has not attempted to obtain redress through any mechanism since 2004.

4.12 As to the author’s claims under article 6, read together with article 2, of the Covenant, the State party states that there is no breach of article 6 where the duty to investigate is not enlivened by the existence of credible evidence, as in the author’s case. Moreover, even if there was a duty to investigate Mr. Hickey’s death, the investigation of his death met the obligations established in the Covenant. There was no conclusive and sufficient evidence nor lethal force nor any other circumstance to establish a direct violation of the right to life. The author failed to provide credible evidence of an alternative version of the chain of events stated by the coroner, aside from the suggestion that her son may have been riding his bike faster because the police had been following him for a time. Accordingly, it is contested that there was, at time of Mr. Hickey’s impalement and death, and shortly afterwards, information and evidence indicating that NSW Police Force may have been implicated in some way in his death. On the contrary, the police knew that they were not pursuing Mr. Hickey at the time of his death, whereas the author’s allegation is based on a belief or rumours, rather than evidence.

4.13 Alleged violations of the right to life can occur in many different circumstances, and the adequacy of the investigation into any particular death should be judged on a case-by-case basis. In the case of NSW, there is a complex system of checks and balances in place

² CCPR/C/3/Rev.8, in force at the moment when the communication was submitted to the Committee. The State party, however, also notes that rule 96 (c) was amendment in CCPR/C/3/Rev.9.

to ensure the effectiveness of any investigation regarding government conduct, including the promulgation of guidelines and the use of various oversight bodies.

4.14 Independence does not always require an investigation conducted in its entirety by an entirely separate body. In the present case, the coroner's investigation fully met any obligation to conduct a functionally separate investigation. When the senior police officer decided that the incident should be treated as a "critical incident", the investigation was taken over by police from a different Local Area Command, namely Leichhardt, and two representatives from NSW Ombudsman oversaw the subsequent conduct of the investigation and were present when civilians and police officers gave statements or were interviewed. The evidence collected by the police was provided to NSW State Coroner, who received a detail investigation brief, comprising more than 80 witness statements from police, civilians, paramedics, treating doctors, crime scene examiners, a pathologist, clinical forensic pharmacologist and an expert collision investigator/re-constructionist. It also contained video walk-through re-enactments, police computer system events, police radio recordings, aerial photos, interview recordings and related exhibits. Twenty-three witnesses gave evidence over the two weeks of the coroner's public hearing, during which time the author was represented by pre-eminent lawyers. In carrying out its duties, NSW Ombudsman has a range of powers, including the power to request that the Police Commissioner undertake further investigation, if necessary, and to report to Parliament on any matter of concern. Those reports may include a recommendation that the report be made public as soon as practicable.

4.15 The NSW Coroner is an independent statutory office holder and has jurisdiction to investigate all deaths reported to the coroner. The coroner may make recommendations following a coronial inquest. He may also refer a coronial file to NSW Director of Public Prosecutions, if he has formed a view that there is sufficient evidence that a known person has committed an indictable offence in connection with a death. A particular high standard of investigation is required in coronial investigations and in many of those, the coroner will direct NSW Crown Solicitor's Office to instruct private Counsel — a barrister not employed by the State party — at an early stage. In the present case, the State Coroner was assisted by a very senior member of NSW Bar, who was, at the time, a Justice of NSW Supreme Court, and cross examined each of the witnesses.

4.16 The State Coroner's examination in the case of the author's son demonstrated that he took into account flaws in the evidence of the police, in particular concerning the officers who were in police vehicle Redfern 16, and was highly critical of them, concluding that the account of the events by one policeman was not correct in several aspects.

4.17 The investigation in the present case was sufficiently prompt. Based on all evidence available to the police initially, the incident was not treated as a "critical incident". However, within two days of the event, the situation was re-assessed and declared "critical". The delay of eight days before interviewing the four officers in police vehicles Redfern 16 and 17 is explained in the light of the degree of stress that they were under and because they were all off duty from 16 to 21 February 2004.

4.18 Mr. Hickey's family was involved in the investigation and was represented by a senior lawyer at the inquest, who was able to cross-examine all the witnesses and to call witnesses. The fact that the author was not allowed to photograph the bike cannot be interpreted as lack of involvement in the investigation.

4.19 Regarding articles 26 and 2 of the Covenant, the State party submits that Mr. Hickey's death was not a violent or deliberate death and cannot be considered a racially motivated killing. Furthermore, the author failed to provide any evidence of racial motivation in the particular circumstances of this case.

Author's comments on the State party's observations

5.1 On 8 August 2012, the author submitted her comments on the State party's observations and reiterated her allegations that the State party breached its obligations under articles 2, paragraph 3, and 6 of the Covenant.

5.2 The author submits that her complaint focuses on the lack of independence in the initial investigation itself which was carried out by officers of NSW Police Force which is not an independent body. She clarifies her submission of 6 August 2010 and holds that the purpose of her communication is not to pose a question in the abstract about the relevant legislation and practices in NSW, but to request the Committee to examine whether the investigation of her son's death was capable of being independent in the circumstances whereby it was conducted by officers of NSW Police Force and whether the investigation conducted by the State party, including the coronial inquest, constituted an independent investigation under the Covenant. In that regard, she points out that the State party relied extensively on the findings of the coroner, misconceiving the nature of her claim as the coroner's findings in turn relied on the investigation conducted by officers of the Police Force.

5.3 The coroner had the power to give police officers directions concerning the investigations to be carried out. However, he was, to a very significant degree, reliant on the investigation conducted by the Police Force. Although NSW Supreme Court could take into account a wide range of matters when examining an application against the findings of the coroner's inquest, it would not quash a coronial inquest on the basis that the inquest itself was incapable of providing an independent investigation. As the coroner could not remedy the failure of the State party to conduct an independent investigation in the initial period after the injury that led to Mr. Hickey's death, it would be futile for the Supreme Court to quash the order for that reason. Even if she would succeed in her allegation before the Supreme Court, a new inquest would not be a meaningful remedy.

5.4 The other venues mentioned by the State party, such as the proceedings before the Police Integrity Commission (PIC) and the possibility of civil action and private prosecution, do not constitute effective remedies. The PIC has discretion in deciding the cases it investigates and a review of previous reports to Parliament shows that none of its investigations involve cases where the police were implicated in the death of a person. It is doubtful whether the PIC has jurisdiction to investigate allegations concerning the death of a person during a police operation. But even if it were the case, the PIC cannot conduct an independent investigation. Moreover, due to its limited resources, the PIC would be unable to investigate Mr. Hickey's death in a reasonable amount of time and, therefore, unable to provide an effective remedy. A civil claim, and an award of compensation, by itself, would not be an effective remedy. A private prosecution in the circumstances of the present case would be very likely to be taken over or discontinued by the Director of Public Prosecutions and be dependent on the initial investigation.

5.5 When a person dies in circumstances that might involve a violation of the right to life, the State party is bound to conduct an investigation and to ensure that there is no impunity, without a need to show a strong presumption that a violation has occurred. Information about a potential violation will very often be almost exclusively within the knowledge of the authorities, as they have more power and access to information about the conduct of their own officers. On the other hand, if the obligation to conduct an independent and effective investigation only exists once an individual can demonstrate strong presumption of a violation, the protection under articles 6 and 2 of the Covenant would be eroded.

5.6 It is necessary for the persons responsible for and carrying out the investigation to be independent from those implicated in the events. This means not only the absence of hierarchical or institutional connection, but also practical independence.

Further submissions by the parties

6.1 By notes verbales dated 24 April 2013 and 27 November 2013, the State party reiterates that the communication should be declared inadmissible.

6.2 The State party acknowledges the author's concern about the potential for bias or inadequacy in internal police investigations and that this issue has generated public debate from time to time. Nevertheless, whether or not a particular investigation is independent ultimately can only be properly assessed on a case-by-case basis. There is no inherent reason to conclude that a properly conducted internal police investigation cannot be independent. The author failed to demonstrate that the current investigation system in NSW is defective, beyond her assertion that having the police investigate the police automatically equates to biased or inadequate investigation, and that independence must always entail an investigation conducted in its entirety by an entirely separate body. Likewise, she has failed to show that the investigation into her son's death lacked independence or in any other way violated the State party's obligation to investigate deaths under articles 2 and 6 of the Covenant.

6.3 The State party reiterates that the author did not exhaust domestic remedies. Regarding proceedings before the PIC, the functions of the PIC include detecting, investigating and preventing police corruption and police misconduct. section 5 of the Police Integrity Commission Act 1996 defines "police misconduct" and provides a non-exhaustive list of examples that include the commission of a criminal offence by a police officer. In practice, the PIC takes a broad interpretative view of the term "misconduct" when determining the scope of an investigation, including, for instance, the examination of a critical incident investigation conducted by NSW Police Force about suspected police involvement in civilian deaths, as in the case known as "Operation Calyx", that was pending at the time when the State party submitted its observations. The PIC therefore has jurisdiction to investigate deaths involving the police. Furthermore, the author limited herself to stating that an investigation by the PIC would involve a delay that would amount to ineffective remedy, without providing reasons. As regards civil action, the State party points out that, in her communication, the author requests to be granted compensation as the first listed remedy. Finally, her comments on the possibility of a private prosecution action are only speculative and mere doubts about the action that can be taken by the Director of Public Prosecutions.

6.4 There was no hierarchical link between the investigating unit and the unit implicated in the present case. The investigating unit was a completely separate local area command (Leichhardt) of NSW Police Force and the officers were not direct colleagues of any of the four police officers who were conducting operations in the area where the incident occurred.

7.1 On 13 August 2013, the author reiterated her claims and informed the Committee that in June 2013, the PIC had published its report about Operation Calyx. The report was highly critical of the conduct of the police in the investigation and stated that some members of the police had engaged in police misconduct, recommending that those police officers be prosecuted for a criminal offence under section 107 of the Police Integrity Act. The report further suggested that all critical incidents be investigated by a body independent of NSW Police Force. The author claims that those findings support her claim that police should not be involved in investigations into the conduct of other police officers.

7.2 The author rejects the State party's observation that there was no hierarchical link between the investigating unit and the unit implicated in her son's death and reiterates that the investigation was inadequate, belated and lacked public scrutiny. The Leichhardt Police Station is close to Redfern Police Station geographically and all police officers were members of the same organization and under the same command. The two-week public hearings of the coroner's inquest cannot satisfy the requirement of public scrutiny, nor can it ameliorate the lack of independence or inadequacy of the initial police investigation.

Issues and proceedings before the Committee

Consideration of admissibility

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

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

8.3 The Committee notes the author's main claim that the investigation of her son's death by the State party was not independent. Given that there was information available to the authorities, which potentially implicated NSW police in the incidents leading to his death, the investigation, especially at its initial stage, should have been conducted by a body independent of the police. However, no such body exists in NSW and any subsequent State Coroner's inquest cannot ameliorate the flaws resulting from the lack of independence of the initial police investigation. To illustrate her claim the author refers to a number of irregularities which, in her view, took place in the investigation of her son's death, while at the same time indicating that she is not asking the Committee to make findings about the adequacy, promptness or transparency of the investigation into her son's death.

8.4 The Committee notes in this respect that the author did not lodge an appeal against any aspect related to the police investigation or the coroner's inquest at the national level, nor does she claim before the Committee that the coroner was not independent. In the light of the foregoing, the Committee considers that the author's claim regarding the lack of independence of the police investigation is formulated in general terms and is not based on concrete facts and evidence challenged by the author before the domestic authorities in connection with the death of her son. While the Committee, through consideration of individual communications, can examine claims challenging the lack of independence of the institutions and proceedings surrounding a criminal investigation and identify legislation or practices which are inconsistent with the rights protected under the Covenant, the purpose of the procedure is to determine whether such type of deficiencies in the concrete circumstances of the case under examination constitutes a violation of the rights of the alleged victim. Accordingly, the Committee considers that the author has failed to sufficiently substantiate her claims of violation of articles 6 and 26, alone and in conjunction with article 2, of the Covenant, and that those allegations are therefore inadmissible under article 2 of the Optional Protocol.

9. The Human Rights Committee therefore decides that:

(a) The communication is inadmissible under article 2 of the Optional Protocol to the International Covenant on Civil and Political Rights;

(b) The decision shall be transmitted to the State party and the author.