CORONERS COURT OF QUEENSLAND

Ruling in relation to the conduct of the Police Coronial Investigation

CITATION:	Inquest into the death of Selesa TAFAIFA
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2021/5437
DELIVERED ON:	20 June 2022
DELIVERED AT:	Brisbane
HEARING DATE:	13 June 2022
FINDINGS OF:	T Ryan, State Coroner

REPRESENTATION:

Counsel Assisting:	S Lio-Willie
Family:	D Kilroy, Kilroy & Callaghan Lawyers
Commissioner of Police:	M O'Brien, QPS Legal Unit
Queensland Human Rights Commission:	R Leong, Queensland Human Rights Commission
Queensland Corrective Services:	J Franco, instructed by Crown Law
Townsville Hospital and Health Service:	E Hall, Townsville Hospital and Health Service, Legal Services Unit
Nursing staff:	S Robb, instructed by QNMU Law

Introduction

1. Selesa Tafaifa was a Samoan woman who died in custody in the Detention Unit (DU) of the Townsville Women's Correctional Centre (TWCC) on 30 November 2021. As Selesa died in custody her death was reportable under the *Coroners Act 2003*. An inquest must be held into her death.

2. Selesa had been imprisoned for over 12 months. She had a range of significant health issues including diabetes, asthma, obesity and schizoaffective disorder. On 27 November 2021 Selesa was reported to have attempted suicide within the prison by means of an insulin overdose. She was transferred to the Townsville Hospital but was returned to the TWCC on the same day.

3. The immediate circumstances of Selesa's death were captured on body worn camera and CCTV footage. The footage has been obtained as part of the coronial investigation, together with a range of other materials including health records and statements from health staff. The coronial brief has not yet been finalised.

4. The CCTV footage indicates that Selesa died following a prolonged period of physical restraint after she was directed to return to her cell after she unsuccessfully tried to make a call from the prison using the Arunta call system. In addition to physical restraint the other use of force by QCS officers, including the TWCC's Correctional Emergency Response Team (CERT), included the application of handcuffs and the use of a spit hood to cover Selesa's head.

5. Following Selesa's death I gave a direction to the Queensland Police Service that there should be a full investigation into the circumstances of the death. Police officers have a duty under the *Police Powers and Responsibilities Act 2000* to help coroners in the performance of a function under the *Coroners Act 2003, including* the investigation of deaths. Police officers are to "comply with every reasonable and lawful request, or direction, of a coroner". [1]

6. In accordance with standing arrangements, most deaths of persons in the custody of Queensland Corrective Services (QCS) are investigated by the Queensland Police Service's Corrective Services' Investigation Unit (CSIU).[2] The MOU between QCS and QPS for operation of the CSIU envisages that the '*CSIU is <u>most likely</u>'* to conduct investigations related to deaths in custody.

7. The CSIU also has responsibility for investigating offences that occur within prisons, including offences committed by QCS employees.

8. Under the *Corrective Services Act 2006*, the QCS Commissioner will also appoint inspectors to conduct an investigation into this death. I understand that this will include the appointment of external inspectors, who are generally barristers. As the State Coroner's Guidelines note, those investigations are generally of a high quality and will examine systemic issues more thoroughly than investigating police.

9. A full internal and external autopsy examination was ordered following the death. However, the forensic pathologist is waiting on the results of neuropathology before finalising Selesa's autopsy report. This means that the cause of death is not yet determined.

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[1] *Police Powers and Responsibilities Act 2000*, s 794, Helping coroner investigate a death
[2] State Coroner's Guidelines, Chapter 7.3

10. A pre-inquest hearing was held on 13 June 2022 to specifically consider an application from Selesa's family in relation to the conduct of the police coronial investigation. This ruling relates only to that aspect of the family's application.

11. The family and the Queensland Human Rights Commission also made submissions on the scope of the coronial investigation into Selesa's death. Those submissions will need to be considered at a later pre-inquest hearing after Selesa's cause of death is established (if that is possible).

12. Those submissions require a consideration of the application of the *Human Rights Act 2019* (HR Act) to this investigation, and whether coroners are required to make findings in relation to breaches of human rights under that Act.

13. However, I accept that s 48 of the HR Act applies to s 45 of the *Coroners Act.* Section 48 requires all statutory provisions to be interpreted in a way that is compatible with human rights, to the extent possible that is consistent with their purpose.[3]

Submissions

Selesa's family

14. Selesa's family submitted that at the time of her death Selesa was facing charges in relation to her conduct within the DU.[4]

15. The charges were being investigated and prosecuted by the CSIU. The family submitted that the criminal charges brought by the CSIU arose from similar facts to the circumstances of Selesa's death on 30 November 2021. The charges related to the alleged serious assault of a corrective services officer, an offence punishable by 14 years imprisonment where the prisoner bites or spits on the corrective services officer, and otherwise by 7 years imprisonment. [5] The subject matter of the charges all related to alleged offences committed by Selesa in 2021 against QCS officers and health staff including a CERT leader, Detention Unit officers and nursing staff (either as victims and/or witnesses).

16. The family submitted that the conduct alleged in the charges was identical or similar in substance and pattern to the alleged circumstances surrounding the use of force, restraint and a spit hood that preceded Selesa's death. It was submitted that the alleged facts and circumstances for which the CSIU were prosecuting Selesa have a direct and relevant connection to the facts, circumstances and issues that will be considered as part of the investigation into her death.

17. Selesa's family submitted that the QPS Commissioner and the State Coroner have a duty to ensure that the investigation of Selesa's death is undertaken in a fair, impartial, independent and effective manner. The CSIU's criminal investigation and prosecution of Selesa places the CSIU in an "*invidious position*" and that there exists an institutional and operational conflict of interest (actual and perceived) if they have any substantive carriage of the QPS coronial investigation into Selesa's death in custody.

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[3] This is consistent with the approach taken by the Coroners Court in Victoria in the *Inquest into the death of Tanya Day – Ruling on Scope*, 25 June 2019.
[4] Submissions dated 21 March 2022 and 13 June 2022.
[5] s 340 of the Criminal Code, Serious assaults.

18. The family initially submitted that the Coroners Court should engage independent investigators directed by the Court to ensure that no continuing conflict of interest persists. It was ultimately submitted that the Homicide Squad should be appointed with carriage of the remainder of the coronial investigation and inquest.

Commissioner, Queensland Police Service

19. The Commissioner of the Queensland Police Service opposed the family's application.

20. The Commissioner did not accept that the CSIU had a conflict of interest because Selesa had been charged with offences alleged to have been committed in circumstances factually similar to those surrounding her death and involving the use of force, restraints and a spit hood.

21. It was submitted that the final arbiter in relation to the justification of the use of force is not the investigating officers. They will only be investigating the death. CSIU officers would also not be called upon to give an opinion about whether QCS officers were justified in the use of force. That was a matter for the Coroners Court, informed by expert opinion if necessary.

22. The Commissioner submitted that in order to uphold the family's application, I would need to decide that officers of the QPS would be unable to investigate Selesa's death impartially and independently in accordance with their sworn oath under the *Police Service Administration Act 1990*.

23. It was also submitted that, in any event, there was no longer any perceived conflict as Selesa is deceased and there is no longer a prosecution on foot.

24. The Commissioner's submission acknowledged that death in custody investigations should be independent and that previous coronial findings have found that the CSIU can thoroughly investigate deaths in prisons. It was submitted that a transfer of the investigation to another unit within the QPS would involve a concession by the Commissioner that there was a conflict of interest on the part of CSIU officers.

25. It was submitted that police who had previous dealings with Selesa in relation to criminal matters could independently execute their duties in accordance with their oath. The Commissioner referred to *Younan and Others v Callanan*[6], where it was held an officer of the Crime and Misconduct Commission (CMC) could act as both the delegate of the Commission and as a member of the Crime Reference Committee in relation to the same matter. However, that case was concerned with the investigation of the same criminal offences by the CMC, as opposed to separate criminal and coronial investigations.

26. It was also submitted on behalf of the Commissioner that I should find that "*real mischief and real prejudice will in all human probability result*" and that I should identify the mischief or prejudice in this matter before directing that a unit other than the CSIU have carriage of the coronial investigation.[7]

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[6] [2009] QSC 241

[7] Whiting, Re [1992] QSC 181

27. However, it was also accepted that a coroner might give a direction that another unit take carriage of the investigation on a basis other than a finding that there was a conflict of interest on the part of the CSIU.

Queensland Human Rights Commission

28. The QHRC has intervened in the coronial proceedings under s 51 of the HR Act. The QHRC sought to intervene and be joined as a party in this proceeding on the basis that:

    a) a question of law arises in the proceeding as to the basis and extent to which the HR Act applies to the conduct of this proceeding by the Court and to the findings and recommendation that, depending on the evidence, might be made by the Court; and

    b) a question arises as to the extent to which the provisions of the Coroners Act 2003 (Qld) (Coroners Act) under which this inquest is being held should be construed and applied in accordance with the HR Act.

29. The QHRC submitted that the HR Act applies to the Coroners Court when it is:

    a) Acting in an administrative capacity, as a public entity with obligations under section 58(1) of the HR Act; and

    b) Performing functions relevant to human rights, under section 5(2)(a) of the HR Act; and

    c) Interpreting statutory provisions, under section 48 of the HR Act.

30. The QHRC submitted that human rights will impact on the conduct of the inquest, as well as the exercise of powers to make findings and comments. The QHRC submitted that the HR Act, and in particular the right to life, "*requires the coroner to make findings on possible breaches of the HR Act by public entities that may have caused or contributed to the death*".

31. The QHRC submitted that s 16 of the HR Act provides that every person has the right to life and the right not to be arbitrarily deprived of life. However, the QHRC also acknowledged that the Explanatory Notes to s 16 of the HR Act emphasised that the right is limited to protection against *arbitrary* deprivation of life and that not every action that results in death will be arbitrary. The Explanatory Notes indicate:

    This right reflects the positive obligation on states in article 6(1) of the ICCPR to take positive steps to protect the lives of individuals through, for example, appropriate laws that prohibit arbitrary killing and positive measures to address other threats to life such as malnutrition and infant mortality.

32. The QHRC submission referred to the UN Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions and the Minnesota Protocol. Economic and Social Council resolution 1989/65 recommended the principles on 24 May 1989.

33. The Minnesota Protocol applies to deaths which occur 'when a person was detained by, or was in the custody of, the State'. The protocol relevantly provides that:

17. Where a State agent has caused the death of a detainee, or where a person has died in custody, this must be reported, without delay, to a judicial or other competent authority that is independent of the detaining authority and mandated to conduct prompt, impartial and effective investigations into the circumstances and causes of such a death. This responsibility extends to persons detained in prisons, in other places of detention.

28. Investigators and investigative mechanisms must be, and must be seen to be, independent of undue influence. They must be independent institutionally and formally, as well as in practice and perception, at all stages.

31. Investigators must be impartial and must act at all times without bias. They must analyse all evidence objectively. They must consider and appropriately pursue exculpatory as well as inculpatory evidence.

34. The European Court of Human Rights determined in *Hugh Jordan v United Kingdom*[8]*:*

The investigation must also be effective in the sense that it is capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances and to the identification and punishment of those responsible. This is not an obligation of result, but of means. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including inter alia eyewitness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard.

35. With respect to the independence of investigation, in the same decision the European Court further held that "*those responsible for and carrying out the investigation should be independent from those implicated in events*". This means not only a lack of hierarchical or institutional connection but also a "*practical independence".*

36. The QHRC noted that while an inquest presided over by a coroner will satisfy many of these principles, "*the preparation of the brief of evidence for the coroner will be critical to the effectiveness of that process*". The QHRC submitted that these principles should be applied in considering the level of independence and impartiality required for those investigating Selesa's death, particularly in light of the submissions made by her family.

37. The QHRC submitted that consideration should be given to whether another part of the Queensland Police Service can undertake the investigation, "*or if another independent option suggested by the family should be considered"*. The QHRC noted that the CSIU is part of the Homicide Group, Crime and Intelligence Command which is comprised of three other units including the Homicide Investigation Unit.

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[8] Application no. 24746/94, 4 August 2001

Consideration

38. The facts of this case are unusual in that persons who die in prison custody are generally not also the subject of serious criminal charges that have occurred in similar circumstances to the events leading up to their death. In Selesa's case her death is being investigated by the same QPS unit that was prosecuting her.

39. In most cases the investigation of a death in QCS custody will satisfy the principles set out in the Minnesota Protocol and by the European Court of Justice where the CSIU investigation is overseen by a Coroner, and is accompanied by other investigations, such as those carried by inspectors appointed under the *Corrective Services Act 2006,* the gathering of relevant expert evidence by the coroner and the holding of an inquest.

40. I do not accept the submission from the QPS that it is necessary for me to decide that the CSIU would be unable to investigate Selesa's death impartially and independently, or that they have an actual conflict of interest, in order to direct that the CSIU not have carriage of the investigation.

41. Section 58(1) of the HR Act provides that it is unlawful for a public entity:

    (a) to act or make a decision in a way that is not compatible with human rights; or

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

42. Section 9(4)(b) of the HR Act provides that a public entity does not include '*a court or tribunal, except when acting in an administrative capacity*.' Whether a coroner is acting in a judicial or administrative capacity in a particular instance requires a consideration of the legal character of the function in question.[9] I accept that a coroner is acting in an administrative capacity for the purpose of the HR Act when directing or requesting which unit within the QPS should be responsible for the investigation of a death in custody.

43. I also accept that the right to life under the HR Act requires an independent and impartial investigation into Selesa's death, and that this right extends to the investigation on behalf of the coroner and the preparation of relevant evidence for the coroner.

44. The principles relevant to the effective investigation of deaths of persons in state custody were set out in *R (Amin) v Secretary of State for the Home Department.*[10] It was held there that there must be "*proper procedures for ensuring the accountability of agents of the state so as to maintain public confidence and allay the legitimate concerns that arise from the use of lethal force*".

45. As GN Williams J (as he then was) noted when considering the integrity of an investigation under the *Criminal Justice Act 1989* in *Re Whiting*[11]*, "it must be remembered, as pointed out by Lockhart J. in* Bell*, that the interests of the community are involved, and that issues of public perception arise".*

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[9] *PJB v Melbourne Heath* (2011) 39 VR 373 at 404 per Bell J.
[10] 2004 1 AC 653 at 20 per Lord Bingham.
[11] At 13.

46. Section 8 of the HR Act requires in order for a decision about the coronial investigation to be compatible with human rights, any limitation of a human right needs to be justified under s 13 of that Act. In particular, s 13(2)(d) requires a consideration of "*whether there are any less restrictive and reasonably available ways to achieve the purpose".*

47. The QPS Operational Procedures Manual (the OPM) provides an alternative to the CSIU for investigations into deaths in custody that occur when a person is in the custody of an agency other than QCS. If a death in custody occurs in those circumstances first response police officers are required to treat the matter as a major investigation under s. 2.4.5 of the OPM.

48. The OPM provides at 8.5.19 that "*subject to the direction of the State Coroner, arrangements are to be made to ensure the death is investigated and a report prepared for the coroner by the Homicide Group, Crime and Intelligence Command. … Responsibility for the conduct of the investigation and report to the coroner will remain with the investigator from the Homicide Group*."

49. Faced with the competing options, and after balancing the relevant considerations, I consider that the investigation of Selesa's death should be finalised in accordance with OPM 8.5.19 by a unit within the QPS other than the CSIU, such as another unit within the Homicide Group. This is consistent with the current framework for the investigation of deaths in custody.

50. I give the following directions:

    1. That the coronial brief of evidence be finalised by a QPS unit other than the CSIU by 26 August 2022;

    2. A further pre-inquest is to be listed following receipt of the autopsy report and the brief of evidence to consider the scope of the inquest;

    3. The inquest is tentatively listed for 10 days from 6-17 February 2023.

Terry Ryan
State Coroner

20 June 2022