HUMAN RIGHTS IN CORONIAL INQUESTS

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I Introduction

What is the relevance of human rights to the coronial process? And how might the coronial process be used to protect and promote human rights?

This article considers these questions using, as a case study, the *Inquest into the Death of Mulrunji*,[1] in which the Australian Human Rights Commission ('Human Rights Commission')[2] appeared as intervener.[3] I argue that the modern coronial inquest is an important forum for protecting and promoting human rights. In particular I consider:

- the development of the modern coronial process;
- human rights arising in coronial inquests;
- how human rights can be protected through the coronial process;
- the basis for the involvement of a 'human rights intervener' in coronial inquests; and
- how human rights principles were applied in the *Mulrunji* inquest.

II Background: The *Inquest into the Death of Mulrunji*[4]

On 19 November 2004, a 36 year-old Aboriginal man who came to be known by the tribal name Mulrunji was arrested on Palm Island by Senior Sergeant Christopher Hurley. The arrest followed an exchange of words between Mulrunji and a Police Liaison Officer Lloyd Bengaroo in which Mulrunji was said to have sworn. Mulrunji was drunk. Having said his piece, Mulrunji was walking away when he was arrested. It was the first time Mulrunji had ever been arrested on Palm Island.

Mulrunji was taken back to the police watch-house. While being removed from the police van, Mulrunji punched Hurley. A scuffle followed and the pair fell through the door of the watch-house onto the floor. At this point, the Deputy State Coroner found that Hurley hit Mulrunji to the body, causing a severe internal injury. Mulrunji ceased struggling and was placed in a police cell. He was dead within about 40 minutes, having bled to death from the injury which had cleaved his liver in two.

The inquest into Mulrunji's death took almost two years to complete. Mulrunji's family and de facto partner were represented at the hearing, as were Hurley, other police officers who were involved in or were witnesses to the events, the Commissioner of the Queensland Police Service, the Palm Island Aboriginal Council, the Australian Human Rights Commission and, by the conclusion of the inquest, the Aboriginal and Torres Strait Islander Legal Service (Qld).

Hurley denies having assaulted Mulrunji. Following the inquest he was prosecuted for manslaughter and was subsequently acquitted. The Coroner's findings are, at the time of writing, the subject of ongoing review proceedings in the Queensland District Court.[5]

III The Development of the Modern Coronial Process

The coronial inquest has traditionally been a narrowly-focused inquiry that has sought to determine the facts surrounding the 'who, what, when, where and why of unexpected deaths'.[6] Until relatively recently in some Australian jurisdictions, a coroner was either not given any power to make comment or recommendations,[7] or their ability to 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.[8]

The reluctance to extend the coronial role beyond factual findings so as to encompass comment and recommendations was based on the view that such matters are best left to the expert authorities concerned. The concern was that a coroner might not be aware of the ramifications of their recommendations or may fail to take into account competing priorities in the allocation of public resources. Some commentators who support these views have described riders as 'mere surplusage' or even an 'irritation'.[9]

Boronia 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.[10]

Modern coronial law and practice has, however, increasingly freed itself from the 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 incidents.[11] All Australian coroners now have a power to comment and/or make recommendations on matters connected with a death that relate to public health and safety.[12] In Queensland and Tasmania, the coroner's power to comment is explicitly directed to preventing future deaths, and in South Australia the coroner may make recommendations to 'prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest'.[13] Indeed, in Tasmania, a coroner '*must*, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate'.[14] To borrow the motto of the Ontario Office of the Chief Coroner, the modern coroner is empowered to 'speak for the dead to protect the living'.

IV How are Human Rights Relevant to the Modern Coronial Inquest?

For some, it may be 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 relevantly, the *International Covenant on Civil and Political Rights*[15] ('ICCPR'). These international obligations do not, however, give rise to enforceable rights domestically unless they are implemented by domestic laws.[16]

Human rights are nevertheless legally relevant to the conduct of an inquest because of the well-accepted common law principle that 'a statute of the Commonwealth or of a State is to be interpreted and applied, as far as its language permits, so that it is in conformity and not in conflict with the established rules of international law'.[17] These established rules include those contained in the human rights treaties to which Australia is a party.

A Human Rights Arising in Coronial Inquests

1 The Right to Life

The principal 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 also imposes a positive duty to protect life and prevent death.[18] The Human Rights Committee has noted 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 ...[19]

The range of positive measures that might be required to protect the right to life is potentially very broad. Importantly for present purposes, there is an obligation on states to carefully regulate and properly train personnel, such as police officers and prison guards, to minimise the chance of violation of the right to life.[20] 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.[21] This duty extends to ensuring appropriate monitoring and supervision of people in detention and providing appropriate medical care. The requirement in art 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.[22] However, the extent to which art 6(1) includes broader socio-economic aspects, such that it requires the state to protect against such threats to life as malnutrition and epidemics, remains contentious.[23]

Most directly relevant to the conduct of coronial inquests, the positive measures required to protect life include a thorough investigation of deaths. It is now well established in jurisprudence concerning the right to life in art 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.[24]

In *R (Middleton) v West Somerset Coroner*,[25] the House of Lords stated of the right to life under art 2 of the *European Convention on Human Rights*:

> The European Court has ... interpreted article 2 as imposing on member states a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances in which it appears that one or other of the foregoing substantive obligations has been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated.[26]

The House of Lords went on:

> In the absence of full criminal proceedings, and unless otherwise notified, a coroner should assume that his inquest is the means by which the state will discharge its procedural investigative obligation under article 2.[27]

Arguably, however, 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 may include adequately investigating all deaths.[28] Such an obligation may frequently be satisfied by a police investigation or by 'full criminal proceedings'. 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.

2 Other Relevant Human Rights

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 ...

A prompt and impartial investigation of allegations of breaches of human rights by a competent authority is vital to providing an 'effective remedy'.[29] 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. For example, where a death has taken place in custody, as was the case for Mulrunji, the following rights may be relevant to any subsequent coronial investigation:

- the right of detained persons to be treated with humanity and dignity;[30]
- the prohibition on torture or cruel, inhuman or degrading treatment or punishment;[31] and
- the prohibition on arbitrary arrest or detention and related rights upon arrest.[32]

V Implications for Coronial Practice

Human rights principles can influence the conduct of coronial inquests in a number of related ways and have the potential to form an important part of the modern coronial process. In particular, human rights principles may influence the scope of an inquest and provide a legitimate influence on the manner in which a coroner exercises their discretion. They may support taking a broad approach to the powers of the coroner to comment and provide a basis for intervention by parties with an interest in broader, systemic issues connected with a death.

A The Scope of the Inquest

The coronial process is a flexible one. It is an inquisitorial, rather than an adversarial, process. Coroners are not bound by the rules of evidence and may inform themselves in any way they consider appropriate.[33] Coroners enjoy comprehensive powers to compel the production of evidence and the attendance of witnesses for questioning.[34]

The anchor of the coronial 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' issues and the discretion to make comment.

Human rights principles provide a legitimate reference point for the exercise of the coroner's wide discretion. The need to conduct a comprehensive inquest into a death and both its immediate and systemic causes to adequately protect human rights provides a basis for arguing for a broader scope to an inquest, both in terms of the issues it seeks to traverse and the evidence it receives.

B The Discretion to Comment

From a human rights perspective, the development of the power of a coroner to comment is significant and welcome. This broadened role of the modern coroner provides a vital opportunity for the protection of human rights, and a coroner should, in my view, take into account the promotion and protection of human rights when deciding whether it is appropriate to comment on an issue. 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.

1 The Scope of the Power to Comment

As discussed above, the power of the coroner to comment is a feature of the modern coronial process and has, in more recent coronial legislation, been given increased prominence. Under the *Coroners Act 2003* (Qld), for example, one of the explicit objects of the Act 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.[35]

Further, one of the factors that the coroner may consider 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.'[36]

Section 46 of the Queensland Act contains the 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.

We can see that this power to comment is cast in broad terms. In Supreme Court review proceedings that arose in the course of the *Mulrunji* inquest, *Doomadgee v Clements*[37] ('*Doomadgee*'), it was further held that the power to comment, as it is a remedial provision, should be liberally construed.[38] While Muir J in *Doomadgee* noted that the power to comment 'does not make coroners roving Royal Commissioners',[39] his Honour 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.[40] 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 and 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.[41]

Muir J's comments demonstrate the substantial breath of the powers of a coroner to comment or make recommendations. While the precise terms of the provisions giving a coroner the power to comment vary across the Australian jurisdictions – and not all Coroners Acts have the same emphasis on prevention as does the Queensland Act[42] – the power is, in my view, appropriately approached in this same broad way in all cases to reflect its remedial character.

2 Is the Power to Comment a 'Secondary' One?

An issue that arose in the *Mulrunji* inquest was the extent to which the coroner's function of comment 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 arguably not directly relevant to the 'who, how, when' questions that are typically the focus of a coronial inquest, but was clearly relevant to what comment it might be appropriate to make about the lack of a diversionary facility, the presence of which might have meant that Mulrunji was not arrested and/or not taken into custody in the watch-house.

Both the Palm Island Community Council and the Human Rights Commission 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, including Counsel Assisting the Deputy State Coroner, argued against that approach. It was submitted that the comment function was a 'secondary' one and that the court could not inquire on matters in relation to which it was not required to make findings. Support for this narrower approach was drawn primarily from the decision of the Victorian Supreme Court in *Harmsworth v State Coroner*[43] ('*Harmsworth*'). There the Court held:

> Enquiries must be directed to specific ends. That is the making of findings as required …
>
> The power to comment, arises as a consequence of the obligation to make findings … It is not free ranging. It must be comment 'on any matter connected with the death'. The powers to comment and also to make recommendations … are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function, that is to make 'findings'.[44]

Similarly, in *R v Coroner Doogan; Ex parte Lucas-Smith*[45] the ACT Supreme Court held that 'the power to make comments does not enlarge the scope of the coroner's jurisdiction'.[46]

The Human Rights Commission, however, argued that, at least in the context of the Queensland legislation, the power in s 46 to make comment stands alone and should not be understood as subordinate to the obligations to make findings in s 45. The powers of comment arise whenever a coroner investigates a death, subject only to the requirements of s 46 itself: namely, that the matter must be 'connected with' the death and must relate to one of the matters such as public health or safety. This approach is supported by the recognition of the importance of the coroner's power to comment in the objects of the *Coroners Act 2003* (Qld), noted above. It is also the approach that best protects human rights and should therefore be preferred.

The Human Rights Commission submitted that *Harmsworth* should not be understood as limiting the ability of a coroner to receive evidence and inform him- or herself as he or she thinks fit in relation to matters 'connected with' a death. Rather, where a coroner is satisfied that an issue falls within s 46, they are entitled to seek and receive evidence going to such issues. Doing so simply ensures that a coroner has a sufficient evidentiary basis for making appropriate comments.

In *Chief Commissioner of Police v Hallenstien*,[47] Hedigan J, while citing *Harmsworth* with approval, stated:

> Doubtless it is correct to say that a coroner should not inquire into a death substantially to enable comments to be

> made. But once the inquest is held, the limits to the power to comment do not admit of easy definition.[48]

Support for a broader approach is also found in the decision of Muir J in *Doomadgee*. An issue in the review proceedings before Muir J was the reception of evidence relating to previous arrests by Hurley. Muir J's decision concerning that evidence supports 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. For example, Muir J stated:

> The scope and indefinite boundaries of a coroner's roles under ss 45 and 46, generally make it inappropriate to interfere with the gathering of evidence by a coroner, at least where the exercise on which the Coroner is engaged is within the ambit of *either of s 45 or s 46*.[49]

While his Honour elsewhere described the coroner's role in making comment under s 46 as being 'ancillary to the role under s 45', Muir J found that the Deputy State Coroner in the *Mulrunji* inquest was entitled to receive the evidence on the basis that it 'may be relevant to comments the Coroner may make under s 46'.[50]

This, in my view, is 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 in order to do so, not simply from the matters that have been adduced to make the required factual findings. The notion that the comment function is subordinate to the function of making findings is, in my view, a hangover from the days of 'riders' and, in the case of Queensland in particular, at odds with the objects of the Act. Indeed, if a coroner does not properly inform themselves on matters about which they believe it is appropriate to comment, they run the risk of their comments being 'mere surplusage'. A coroner should ensure that they have the information they need to make comments that are specific and, where necessary, detailed.

In the end, without making a clear determination on the issue, the Deputy State Coroner did not explicitly inquire into the broader social issues that were identified as arising in the inquest, although she did receive a range of written material from the Palm Island Council and the Human Rights Commission dealing with them. And, as we will see, she ultimately exercised her discretion to comment on a wide range of systemic issues.

C 'Human Rights Interveners'

While any party to an inquest can make submissions that rely upon or seek to promote human rights in an inquest, there is also a clear role for a 'human rights intervener' in cases that raise more complex systemic issues.

Persons with a 'sufficient interest' may appear in coronial proceedings to examine witnesses and make submissions.[51] In *Annetts v McCann*,[52] Brennan J noted that the class of persons with a 'sufficient interest' 'are, or may well be, larger than the class of persons against whom a coroner may contemplate making an unfavourable finding'.[53] There is, however, no clear test as to what will amount to a 'sufficient interest' such that a party without a direct interest in the proceedings (such as the direct interests of the family of the deceased or a person against whom an unfavourable finding may be made) will or should be granted leave.

Ian Freckelton and David Ranson comment that the 'evolving approach has been for this right [of appearance] to be reasonably liberally interpreted'.[54] They cite *People First of Ontario v Niagara*[55] where it was observed that '[i]t is increasingly common to grant standing to public interest advocacy groups who have no knowledge of or connection to the individual deceased'.[56] Freckelton and Ranson note that, in Victoria, the Council for Civil Liberties and the Flemington/Kensington Legal Service were granted leave to appear in a series of inquests into fatal shootings by police.[57] Similarly, the Villamanta Legal Service and the Public Advocate were given leave to appear in the inquest into deaths of intellectually disabled people in Kew Cottages. Notably, this latter grant of leave was said to be a provisional one, subject to review should the need arise.[58]

The Human Rights Commission has been granted leave to appear in a number of inquests in coronial courts in New South Wales,[59] Queensland,[60] Western Australia[61] and the Northern Territory.[62] In the case of the Northern Territory, leave was limited to making submissions and being present at the bar table to liaise with counsel assisting the coroner in relation to the asking of questions.[63] In the other cases, leave to appear was general in its terms, although the Human Rights Commission only sought to engage on issues in the proceedings that it saw as raising human rights issues.

The Human Rights Commission has based its claim to a sufficient interest on its statutory functions to protect and promote human rights, including its explicit function to intervene in court proceedings raising human rights issues.[64] In the United Kingdom, the Northern Ireland Human Rights Commission was accepted to be a 'properly interested person' in the inquest held into the 1998 bombings in Omagh, despite lacking a specific power or function relating to intervention in court proceedings.[65]

In the *Mulrunji* inquest, the Palm Island Aboriginal Council was also granted leave to appear because of its interest in matters affecting members of the community and falling within the ambit of the Council's governance responsibilities. Their submissions also drew on human rights principles.[66]

VI Human Rights in the *Mulrunji* Inquest

The Human Rights Commission played an active role throughout the proceedings in the *Mulrunji* inquest. It made written and oral submissions on both the substantive issues arising as well as on issues relating to the scope of the Coroner's powers, the appropriate scope of the inquest and communication with Aboriginal witnesses. The Human Rights Commission also put a range of evidentiary material before the Coroner and cross-examined witnesses.

The focus of the Human Rights Commission's involvement was on systemic issues that impacted upon the human rights of Indigenous people, rather than the immediate cause of death. The Human Rights Commission sought to ensure, as far as possible, that the coronial process provided an effective remedy for what it viewed as breaches of Mulrunji's human rights and to provide a basis for comment that would potentially prevent deaths or other breaches of human rights.

While the Human Rights Commission's submissions often explicitly referred to human rights principles and their relevance to the issues in inquest,[67] its involvement was aimed at engaging with the 'human rights issues' it identified on a practical level. The Human Rights Commission's final submissions therefore set out 40 detailed comments that, in its view, would contribute to the protection of human rights.[68] The submissions covered four main areas: arrest and policing; diversionary centres and community patrols; assessment and monitoring of health; and the investigation of Mulrunji's death.

A Arrest and Policing

The first area covered by the Human Rights Commission's submissions was the arrest of Mulrunji and related policing issues. In the Human Rights Commission's view, Mulrunji's arrest for swearing at police was an arbitrary arrest, contrary to art 9 of the ICCPR. Even if lawful – something not conceded – 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 that had highlighted the problem of over-representation of Indigenous people in custody and the need to divert Indigenous people from custody.[69]

The Human Rights Commission suggested a range of recommendations 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.

B Diversionary Centres and Community Patrols

The second area covered by the Human Rights Commission'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 Indigenous communities. Again, coming from a human rights perspective that sees arrest as a last resort, the Human Rights Commission suggested comments concerning the establishment of a diversionary centre and community patrol on Palm Island. The Human Rights Commission 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 art 12 of the *International Covenant on Economic, Social and Cultural Rights*,[70] because of the role of such centres in improving the health and wellbeing of intoxicated people coming into contact with police.

C Assessment and Monitoring of Health

The evidence in the inquest displayed a complete failure by police to adequately assess Mulrunji's health upon admission to the police watch-house. It also revealed a failure to properly monitor his health.

The Human Rights Commission argued that these failures 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 (art 10 of the ICCPR). In addition, the Human Rights Commission identified deficiencies in the police operating procedures regarding assessment and monitoring of health and potential inadequacies in police training. Accordingly, it sought comments by the Coroner to acknowledge these failures and recommend improvements in police procedures and training.

D Investigation of Mulrunji's Death

Finally, the Human Rights Commission'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, both in appearance and in fact. These included difficulties in cross-cultural communication between police and Aboriginal witnesses. The Human Rights Commission's submissions emphasised the importance of thorough and effective investigations of deaths in police custody in protecting the right to life and ensuring the right to an effective remedy. The Human Rights Commission argued that the Coroner should make a range of comments concerning police practice, procedures and training to avoid similar failures in the future.

VII Conclusion

The Deputy State Coroner adopted the Human Rights Commission's proposed recommendations and made all of the 40 comments suggested. The comments were sent to the Queensland Attorney-General, the Police Minister 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, the response included changes to police policies and commitment of funds for a community justice program.

Of course, the outcome of the inquest was not the dawn of a brand new day. Indigenous people in Palm Island and beyond have heard many promises and seen countless recommendations and reports about the injustices they experience. Nevertheless, 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 suffered by Mulrunji. Human rights principles played a significant role in that process.

By granting the Human Rights Commission leave, the Deputy State Coroner recognised that the protection of human rights gave the Human Rights Commission a 'sufficient interest' in the proceedings. Human rights then provided a legitimate and principled basis upon which the Human Rights Commission could urge the coroner to take a broad view of the issues about which it was appropriate to comment with the aim of improving systemic practices. In this way, the inquest demonstrated how human rights can be protected and promoted through the modern coronial process.

* Jonathon Hunyor is the Director of the Legal Section at the Australian Human Rights Commission. These are the author's personal views and not those of the Commission. The author thanks Mila Cerecina for her research and insightful comments, which have been of great assistance.

1 *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court, Acting State Coroner Clements, 27 September 2006) 27 <http://www.courts.qld.gov.au/mulrunji270906.pdf> at 21 November 2008.

2 The Australian Human Rights Commission was at that time known as the Human Rights and Equal Opportunity Commission and this remains its legal name under the *Human Rights and Equal Opportunity Commission Act 1986* (Cth).

3 The author appeared for the Human Rights Commission in the matter.

4 The facts are summarised in the inquest findings: *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court,

Acting State Coroner Clements, 27 September 2006). Further details of the case, the conduct of the inquest and subsequent criminal trial can be found in Chloe Hooper, *The Tall Man: Death and Life on Palm Island* (2008) and Jeff Waters, *Gone for a Song: A Death in Custody on Palm Island* (2008).

5 *Hurley v Clements* D352/07. The matter was heard on 9 September 2008 and judgment reserved.

6 Boronia Halstead, *Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study*, Australian Deaths in Custody No 10, Australian Institute of Criminology (1995) 3 <http://www.aic.gov.au/publications/dic/dic10.pdf> at 21 November 2008.

7 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).

8 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 New South Wales 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.

9 Sir John Jervis and HH Pilling respectively, quoted in Halstead, above n 6, 3.

10 Ibid.

11 Other features of the modern coronial process are discussed in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 59–66.

12 *Coroners Act 2003* (Qld), s 46(1); *Coroners Act 2003* (SA), s 25(2); *Coroners Act 1980* (NSW), s 22A; *Coroners Act 1995* (Tas), ss 28(2), 28(3); *Coroners Act 1985* (Vic), s 19(2); *Coroners Act 1997* (ACT), s 52(4); *Coroners Act* (NT), s 34(2); *Coroners Act 1996* (WA), s 25(2). See also Coroners Bill 2008 (Vic), s 67(3).

13 See *Coroners Act 2003* (Qld), s 46(1)(c); *Coroners Act 1995* (Tas), s 28(2); *Coroners Act 2003* (SA), s 25(2).

14 *Coroners Act 1995* (Tas), s 28(2) (emphasis added).

15 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) ('ICCPR') (note that art 4 did not enter into force until 28 March 1978).

16 *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 286–7 (Mason CJ and Deane J).

17 *Kartinyeri v Commonwealth* (1998) 195 CLR 337, 384 (Gummow and Hayne JJ); *Jumbunna Coal Mine N/L v Victorian Coal Miners' 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); D C Pearce and R S Geddes, *Statutory Interpretation in Australia* (6th ed, 2006) 176–7.

18 See generally Sarah Joseph, Jenny Schultz and Melissa Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004) ch 8, especially [8.01], [8.39]–[8.64].

19 Human Rights Committee, *General Comment 6, Article 6*, 16th sess (1982), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, 7, UN Doc HRI/GEN/1/Rev.1 (1994).

20 See Joseph, Schultz and Castan, above n 18, [8.39], 181.

21 See *Lantsov v Russian Federation*, Human Rights Committee, Communication No 763/1997, UN Doc CCPR/C/74/D/763/1997 (2002); *Fabrikant v Canada*, Human Rights Committee, Communication No 970/2001, UN Doc CCPR/C/79/D/970/2001 (2003); *Dermit Barbato v Uruguay*, Human Rights Committee, Communication No 84/1981, UN Doc CCPR/C/17/D/84/1981 (1982).

22 See Joseph, Schultz and Castan, above n 18, [8.42]–[8.43], 183–4.

23 B G 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 BG 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, Schultz and Castan, above n 18, [8.45], 185. See also Manfred Nowak, *UN Covenant on Civil and Political Rights, CPPR Commentary* (2nd ed, 2005) 124 (note 17).

24 See, eg, the discussion in *R v Secretary of State for the Home Department; Ex parte Amin* [2003] UKHL 51, [18]–[23] (Lord Bingham); Clare Ovey and C A Robin White, *Jacobs and White: The European Convention on Human Rights* (3rd ed, 2002), 48–51; John Leckey, *Inquests and Human Rights in Northern Ireland* (2005) Northern Ireland Human Rights Commission <http://www.nihrc.org/dms/data/NIHRC/attachments/dd/files/63/Coroners_INQUESTS_AND_HUMAN_RIGHTS_IN_NORTHERN_IRELAND.doc> at 21 November 2008.

25 [2004] AC 182.

26 Ibid [3].

27 Ibid [47].

28 See Ovey and White, above n 24, 51.

29 *Herrera Rubio v Colombia*, Human Rights Committee, Communication No 161/1983, [10.5], UN Doc CCPR/C/OP/2 at 192 (1990); *Dermit Barbato v Uruguay*, Human Rights Committee, Communication No 84/1981, UN Doc CCPR/C/17/D/84/1981

(1982); *Aktas v Turkey* (2004) 38 Eur Court HR 18, [331]–[333]. See also Human Rights Committee, *General Comment 20, Article 7*, 44th sess (1992), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, 30, [14], UN Doc HRI/GEN/1/Rev.1 (1994).

30 See art 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.'

31 See art 7 of the ICCPR.

32 See art 9 of the ICCPR.

33 *Coroners Act 2003* (Qld), s 37(1); *Coroners Act 2003* (SA), s 24; *Coroners Act 1980* (NSW), s 33; *Coroners Act 1995* (Tas), s 51; *Coroners Act 1985* (Vic), s 44; *Coroners Act 1997* (ACT), s 47; *Coroners Act* (NT), s 39; *Coroners Act 1996* (WA), s 41.

34 See *Coroners Act 2003* (Qld), s 37; *Coroners Act 2003* (SA), s 23; *Coroners Act 1980* (NSW), s 35; *Coroners Act 1995* (Tas), s 53; *Coroners Act 1985* (Vic), s 46; *Coroners Act 1997* (ACT), s 43; *Coroners Act* (NT), s 41; *Coroners Act 1996* (WA), s 46.

35 *Coroners Act 2003* (Qld), s 3(d).

36 *Coroners Act 2003* (Qld), s 28.

37 [2006] 2 Qd R 352.

38 Ibid [31] (Muir J).

39 Ibid [29].

40 Ibid [30] (citations omitted).

41 Ibid [32].

42 For example, the *Coroners Act 1980* (NSW), makes no explicit mention of prevention at all, although that would appear to be the purpose of the power to make recommendations on matters of public health and safety: see s 22A.

43 [1989] VR 989.

44 *Harmsworth* [1989] VR 989, 996 (Nathan J).

45 (2006) 158 ACTR 1.

46 Ibid [41] (Higgins CJ, Crispin and Bennett JJ).

47 [1996] 2 VR 1.

48 Ibid 7.

49 *Doomadgee* [2006] 2 Qd R 352, [36] (emphasis added).

50 Ibid [39].

51 *Coroners Act 2003* (Qld), s 36(1)(c); *Coroners Act 2003* (SA), s 20(1)(b); *Coroners Act 1980* (NSW), s 32(1); *Coroners Act 1995* (Tas), s 52(4) *Coroners Act 1985* (Vic), s 45(3); *Coroners Act 1997* (ACT), s 42(b); *Coroners Act* (NT), s 40(3); *Coroners Act 1996* (WA), s 44 ('interested person').

52 (1990) 170 CLR 596.

53 Ibid 609–10.

54 Freckelton and Ranson, above n 11, 566, citing New South Wales Law Reform Commission, *The Coroners Act 1960* (1975); *R v Coroner for the Southern District of Greater London; ex parte Driscoll* (1995) 159 JP, 45.

55 (1991) 85 DLR (4th) 174.

56 Ibid 184 (Hartt, Montgomery, Campbell JJ).

57 Freckelton and Ranson, above n 11, 566.

58 Ibid.

59 *Inquest into the Death of Scott Simpson* (Unreported, NSW Coroner's Court, 27 June 2006). The Human Rights Commission's submissions are available at Human Rights Commission *Inquest into the Death of Scott Simpson* <http://www.humanrights.gov.au/legal/submissions_court/intervention/simpson.html> at 21 November 2008.

60 *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court, Acting State Coroner Clements, 27 September 2006). The Human Rights Commission's submissions are available at Human Rights Commission, *Submission to Court as Intervener and Amicus Curiae* <http://www.humanrights.gov.au/legal/submissions_court/> at 21 November 2008.

61 *Inquest into the Deaths of Nurjan Husseini and Fatimeh Husseini* (Unreported, WA Coroner's Court, 16 December 2002). The Human Rights Commission's submissions are available at Human Rights Commission, *Inquest into the Deaths of Nurjan Husseini and Fatimeh Husseini* <http://www.humanrights.gov.au/legal/submissions_court/ashmore/leave_intervene.html> at 21 November 2008.

62 *Inquest into the Death of Andrew Ross* (Unreported, NT Coroner's Court, 9 February 1999).

63 See Freckelton and Ranson, above n 11, 566.

64 See *Human Rights and Equal Opportunity Commission Act 1986* (Cth), s 11(1) and particularly s 11(1)(o).

65 *R v Re Northern Ireland Human Rights Commission* [2002] UKHL 25, [4], [24], [28] (Lord Slynn, Lord Woolf and Lord Nolan); [61] (Lord Hutton).

66 The submissions made on behalf of the Palm Island Aboriginal Council are available at Boe Lawyers, *Current Focus* <http://www.boelawyers.com.au/current%20focus.html> at 21 November 2008.

67 I note that, although the Human Rights Commission's submissions on the relevance of human rights were supported by some parties, the Deputy State Coroner did not express any views on that issue.

68 See Human Rights Commission, *Inquest into the Death of Mulrunji on Palm Island: Submission of the Human Rights and Equal Opportunity Commission* <http://www.humanrights.gov.au/legal/submissions_court/intervention/mulrunji.html> at 21 November 2008.

69 See Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, pt B, and concerning diversion from custody and imprisonment as a last resort, vol 3, pt D.

70 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).