Western Australia: an opportunity to take the lead on coronial law reform

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Introduction

The Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation. PIAC works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights; and
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from the Industry and Investment NSW for its work on energy and water, and from Allens Arthur Robinson for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

PIAC's work on inquests and coronial law reform

PIAC has an active interest in Coroners' Inquests both from a policy perspective and as a community legal centre that represents families of deceased persons in inquests in NSW.

In 1988, PIAC's 'Coronial Project' produced several papers advocating law and policy reform of the coronial system in NSW. In 1991, PIAC produced a guide setting out accessible information on the coronial system for families and friends of the deceased. In 1989, PIAC also published *Death in the Hands of the State*, which dealt with the issue of deaths in custody.

In 2006, PIAC represented the family of Scott Simpson at the Inquest into his death by suicide at Long Bay Correctional Facility. More recently, PIAC represented the family of Mark Holcroft, who died in custody in a prison van in 2009.

PIAC is an active member of the Australian Inquest Alliance, a national organisation formed in 2010 to advocate for reform of coronial law and practice.

1. Summary

PIAC welcomes the opportunity to comment on the Western Australian (WA) Law Reform Commission's Discussion Paper released as part of its Review of Coronial Practice in Western Australia (the Discussion Paper). PIAC commends this Discussion Paper for raising many important issues regarding coronial law and practice.

PIAC's direct experience with inquests has been almost exclusively before Coroners' Courts in NSW. However, as a member of the Australian Inquest Alliance, we have had the opportunity of communicating with other legal centres and organisations throughout Australia in relation to their experiences representing families in inquests. This has given us a strong sense of the reforms needed to improve coronial law and process in all jurisdictions in Australia.

In this submission, PIAC addresses only some of the many specific proposals and questions posed by the Discussion Paper. The submission firstly addresses five areas that PIAC considers are essential reforms for Australian coronial law and practice. The submission then deals with three specific proposals made in the Discussion Paper.

2. Essential reforms in Australian coronial practice

2.1 Clarifying and strengthening the coroner's role in prevention

PIAC recognises that Coroners have played and continue to play an essential role in preventing deaths in all Australian jurisdictions. PIAC notes that one of the objectives of the WA Government's reference to the WA Law Reform Commission is 'to strengthen and support the prevention role of the coroner'. PIAC strongly supports that objective.

There has undoubtedly been an increasing trend across all jurisdictions for Australian coroners to make findings and recommendations that are aimed directly at preventing future deaths. Sometimes the findings have gone far beyond responding to the immediate cause of death and they make comment about more systemic issues, such as the institutional and structural causes of the death in question. This has led to recommendations for law reform and systemic change in government authorities and government services as well as organisations and private bodies that are aimed at prevention.

Nevertheless, families and their legal representatives are sometimes prohibited by coroners from raising matters that are seen as too remote from the immediate 'manner and cause of death'. Similarly, coroners are often reluctant to make recommendations considered too remote from the immediate and direct cause of death. For example, in a death by suicide, coroners may be willing to examine events that occurred in the days or weeks before a person's death, but are reluctant to deal with systemic failures that may have occurred in the preceding months or even years, which can at least be argued are as much contributing factors towards the death as those occurring immediately before the death.

As the Supreme Court of Victoria affirmed in *Harmsworth v State Coroner of Victoria*[1] (*Harmsworth*), coroners' powers in Australia are limited. In this case, the Court held that the power to make recommendations arises as a consequence of the obligation to make findings. The Court, referring to statutory provisions about coroners' recommendations, held that

> [t]hey are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.[2]

PIAC submits that limiting the coroner's power to make recommendations limits the coroner's role in preventing deaths. Clear legislative mandates are needed to give coroners broader powers to make appropriate recommendations.

Section 25 of the *Coroners Act 1996* (WA) states:

> A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.

An identical provision is found in the current *Coroners Act 2009* (Vic) and in its predecessor, the *Coroners Act 1985* (Vic), which was the legislation that applied at the time of *Harmsworth*.

Similarly, in *X v Deputy State Coroner of NSW*,[3] O'Keefe J found that the making of recommendations was not one of the 'primary duties' of a coroner in NSW.

PIAC submits that it is important that coroners have broad powers to make recommendations in relation to the 'manner and cause of death', interpreted broadly to include all matters that could have prevented it.

PIAC refers the Law Reform Commission to s 4(2)(b) of the *Coroners Act 2006* (NZ), which specifically gives New Zealand coroners the power to:

> Make specified recommendations or comments that, in the coroner's opinion may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

Section 57 of the New Zealand Act sets out the 'purposes of inquiries' under that Act .The first purpose is the familiar 'causes' and 'circumstances' of the death.

The second purpose is:

> ... to make recommendations or comments that, in the coroner's opinion may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

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1 (1989) VR 989.

2 Ibid 996.

3 [2001] NSWSC 46.

The third purpose is to refer appropriate deaths to investigative agencies.

The *Coroners Act 2006 (*NZ) was enacted after recommendations in a report from the New Zealand Law Commission in 2000.

PIAC endorses the following comments of the New Zealand Law Commission, which relate to the way in which inquests are conducted in Australia today, and the possibilities for enhancing the role of Australian coroners, particularly in making recommendations to prevent future deaths:

> The inquiries of the Coroner should not be limited to matters of mere formality, but should be of social and statistical significance in a modern community.
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> Recent research into the investigation and analysis of accidents and death has revealed the crucial importance of not focusing exclusively on what seems to be the immediate cause of a fatality: the primary causes can and frequently do lie much deeper. In this context it has progressively become evident that the fundamental causes of fatalities, and therefore the measures needed to avoid recurrence, can require a much broader perspective than the one currently adopted by Coroners.
>
> With certain notable exceptions ... deaths tend to be considered in isolation. There is no system for appraisal of the background factors contributing to the death to determine whether it is an isolated episode or an example of a deeper seated problem. The Commission considers it imperative that an investigation into the possibility of fundamental causes be a regular exercise of the Coroner's functions. A true appraisal of apparently insignificant incidents can reveal, and then remove or reduce, the risk of disaster.[4]

The reports of the Royal Commission into Aboriginal Deaths in Custody, released over 20 years ago, also recommended broader powers for coroners in order to prevent deaths, citing recommendations from PIAC at that time:

> A coroner inquiring into deaths in custody should be required by law to investigate not only the immediate cause and circumstance of death, but also the quality of the care, treatment and supervision of the deceased prior to death. A coroner inquiring into a death in custody should be required to make findings on those matters which are required to be investigated. The setting of precise statutory criteria is a matter for the government in each jurisdiction. I draw attention to a *'Preliminary Note to the Attorney-General of New South Wales: Review of the Coronial System in New South Wales'* prepared by the Public Interest Advocacy Centre. In that paper, it is suggested that coroners be obliged to report on the following matters:
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> - the cause or causes of such death and any incident resulting in the death; the reasonable precautions, if any, whereby the death and the incident resulting in the death might have been avoided;

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4 Law Commission of New Zealand, *Coroners, Report No 62,* cited in Ian Freckleton, 'Reforming Coronership: International Perspectives and Contemporary Developments' (2008) 16 *Journal of Law and Medicine* 379, 381.

- the defects, if any, in any system of working which contributed to the death or to such incident; and
- any other factors which are relevant to the circumstances of the death.[5]

PIAC again submits that these principles should be at the core of any reform of Australia's coronial system.

It is not enough to give coroners powers to make recommendations. That power is now established in all Australian jurisdictions. Legislation should not only give coroners the power to make recommendations, but also include clear provisions, similar to s 57 of the *Coroners Act 2006* (NZ), which state that making recommendations with the aim of preventing similar deaths occurring in future is one of the primary purposes of inquests.

2.2 Ensuring that governments listen to and respond to the recommendations of coroners

In Australia, there has been a lack of administrative and legal mechanisms to mandate responses to coroners' recommendations from governments and other bodies. The inadequacy of both policy and law in Australian jurisdictions in this regard was highlighted early in 2009 in a study by Watterson, Brown and McKenzie published in the *Australian Indigenous Law Review*.[6]

The study tracked the response of government agencies to 484 coroners' recommendations in 185 inquests around Australia, mostly in 2004, arising from both Indigenous and non-Indigenous deaths. The survey revealed that fewer than half of coroners' recommendations to prevent future deaths are being implemented by governments across Australia. Less than half had been implemented in NSW (48%), ahead of only Tasmania (41%) and Victoria (26%). The ACT (70%) and the Northern Territory (65%) had the best implementation record. The survey revealed what Watterson has called 'ad hoc implementation of coronial recommendations by State and Territory governments and agencies'.[7]

Watterson concluded that:

> The fate of coronial recommendations is often left to media pressure, advocacy group intervention, and family and community action. The upshot of these systemic failures is that governments, coroners, families and the community know very little about whether or not coronial recommendations are in fact implemented.[8]

The Royal Commission into Aboriginal Deaths in Custody made the following recommendations:

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5 Commonwealth, Royal Commission into Aboriginal Deaths in Custody*, National Report (*1991*)* vol 1 *[4.7.4].*

6 Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (Special Edition 2) *Australian Indigenous Law Review* 4.

7 Ray Watterson, 'Coroners and Indigenous Death' (Paper presented at the 4th National Indigenous Legal Conference, Adelaide, 24-25 September 2009) 7 < http://www.docstoc.com/docs/31894856/Coroners-and-Indigenous-Death > at 17 August 2011.

8 Ibid.

14. That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister for Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate. (1:172)

15. That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person. (1:172)

16. That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendation.

17. That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above.

18. That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody.[9]

Since the Watterson et al paper, the redrafted Victorian *Coroners Act 2008* now contains the following in s 72:

1) A coroner may report to the Attorney-General on a death or fire which the coroner has investigated.

(2) A coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.

[9] Cited in Watterson, Brown and McKenzie, above n 6, 6-7.

(3) If a public statutory authority or entity receives recommendations made by the coroner under subsection (2), the public statutory authority or entity must provide a written response, not later than 3 months after the date of receipt of the recommendations, in accordance with subsection (4).

(4) A written response to the coroner by a public statutory authority or entity must specify a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the coroner.

(5) The coroner must –
  (a) publish the response of a public authority or entity on the Internet; and
  (b) provide a copy of the response to any person-
    (i) who has advised the principal registrar that they have an interest in the subject of the recommendations; and
    (ii) who the principal registrar considers to have a sufficient interest in the subject of the recommendations.

This represents the most comprehensive provision of its nature in Australian jurisdictions, and PIAC recommends that all Australian jurisdictions, including WA, adopt a similar provision in their respective coronial legislation.

PIAC also considers that recommendations from inquests arising from certain categories of deaths should also be referred to the respective parliaments in the jurisdiction where the death occurred, with the government being required to table a response after a set time period.

Where a person dies in the care of the state, in particular where they are in custody, including police custody, there is a strong argument that the parliament as well as the executive should be part of the process that responds to coroners' recommendations. Having the parliament involved ensures an extra level of public scrutiny of responses to recommendations from coroners by governments and their agencies.

Section 25 of the *Coroners Act 2003* (SA) reflects this position, mandating the reporting to Parliament of recommendations and the tabling of timely responses by government in relation to inquests arising from deaths in custody.

PIAC submits that all deaths in custody and all deaths where the police are present or somehow involved should be subject to such a provision in all Australian jurisdictions.

2.3 Legal representation of families at inquests

PIAC strongly supports Proposal 70, which calls for government funding for representation of families at inquests. PIAC agrees with the comments, at pages 147 to 148 of the Discussion Paper, that legal representation of parties at an inquest does not necessarily lead to a more adversarial approach. PIAC notes that coroners have powers to ensure that witnesses are always treated with respect and in accordance with the principles of procedural fairness.

While it seems that Australian coroners do not usually create barriers to families of the deceased person being given leave to appear at inquests, the funding of legal representation of families is more problematic.

PIAC has experience representing families at inquests in NSW, including families of persons who have died in custody. Recently, PIAC acted in a matter where a person suicided during a period in which they were receiving treatment in the community from a public health provider. In all cases, the government bodies involved were fully represented by counsel at the inquest. In a recent death in custody matter where PIAC represented the family of the deceased, NSW Corrective Services, NSW Justice Health, two prison officers and two nurses all had separate representation. Only the nurses where not represented by counsel.[10] In the matter concerning the suicide, the Area Health Service providing the care, a nurse and a government psychiatrist all had separate legal representation, again all with counsel except the nurse.[11]

If families cannot find accessible legal representation at inquests, there is a power imbalance that cannot be easily remedied, even with the best efforts of a diligent counsel assisting the Coroner. Families are often at different stages of the grieving process at the time of the inquest, and if they come from a disadvantaged group or English is not their first language, the power imbalance is amplified.

Legal Aid NSW has in recent years established a Coronial Unit that provides representation, and some limited grants, at inquests, including for families, subject to their usual legal aid guidelines. Legal aid for the representation of families at inquests is less available in other states and territories.

Given that there is both a forensic and therapeutic purpose in families being represented at inquests, PIAC submits that more resources should be allocated to ensure that legal representation is provided to those who cannot afford it themselves.

PIAC supports the recommendations made by the former Australian Coronial Reform Working Group (ACRWG) (now called the Australian Inquest Alliance). They have stated:

> Unlike many other legal proceedings, costs are not usually awarded in inquests, because inquests are formally inquisitorial, and technically there are no parties. This is despite the fact that many families find inquest proceedings highly formal and intimidating, especially when there are issues involving government departments or corporations, whose interests are often advanced in an adversarial manner. The legal issues can also be very complex and the whole process may be the subject of intense media interest. Unrepresented families tend to rely on the coroner's assistant or police informant for legal advice, which raises conflicts of interest.[12]

PIAC supports the following recommendations suggested by ACRWG:

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10 *Inquest into the death of Mark Holcroft* (2011) DSC McMahon 12 August 2011

11 *Inquest into the death of Jason Szczepek* (2010) DSC Macpherson 3 June 2010.

12 Australian Coronial Reform Working Group, *Australian Coronial Reform- The Way Forward* (2009) 26.

- Legal aid must be sufficient to enable all families to obtain, without financial hardship, legal advice and representation for investigations and inquests, as a fundamental component of Australia's international human rights obligations under the right to life.

- Legal aid must be sufficient to enable all advocacy organisations with a sufficient interest to intervene in inquests, as a fundamental component of Australia's international human rights obligations under the right to life.

- A specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.

- Aboriginal Legal Services [should] be funded to provide legal representation for Indigenous families at inquests.[13]

2.4 The need for support for and liaison with families

The therapeutic role that inquests can play is often acknowledged but has not, until recently, been formally recognised in Australian law. This has lead to an uneven approach by different coroners to the needs of families and their communities outside the narrow focus of their role in declaring the 'manner and cause' of a death.

PIAC submits that this role of the coroner should be at least acknowledged in the purpose/objects clause of coronial legislation and/or national uniform coronial legislation.

In his article 'Death investigation: the coroner and therapeutic jurisprudence', Ian Freckelton cites a recommendation of the Victorian Parliament Law Reform Committee in 2006 that one of the purposes of coronial legislation should be 'to accommodate the needs and provide support for families, friends and others associated with a death which is the subject of a coronial investigation'.[14]

The article cites a study undertaken in Victoria for the Committee, which suggested there was

> a problematic incidence of families being unclear about the roles, functions and processes of the coroner, as well about those of the police. Too many were also unaware of their ability to engage in the coronial process, and their ability to touch or view the body of the deceased, to be consulted about or give permission for an autopsy, and to view documentation considered by the coroner, including police briefs. The report emphasised the need for improvements in the frequency of communication between the coroner's office and family members, as well as the provision of information about matters such as counselling and support services.[15]

PIAC, both from its experience representing families in inquests in NSW and from anecdotal evidence received from the families of deceased persons, submits that the same is true of families in NSW and throughout Australia.

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13 Ibid.

14 Ian Freckelton, 'Death investigation, the coroner and therapeutic jurisprudence' (2007) 15 *Journal of Law and Medicine* 1, 9.

15 Ibid 9.

PIAC recommends that all Australian coroners Acts should have a provision similar to 8 of the *Coroners Act 2009* (Vic), which states:

> Factors to consider for the purposes of this Act
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> When exercising a function under this Act, a person should have regard, as far as possible in the circumstances, to the following-
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> (a) that the death of a family member, friend or community member is distressing and distressed persons may require referral for professional support or other support;
> (b) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death;
> (c) that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected;
> (d) that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation;
> (e) that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information;
> (f) the desirability of promoting public health and safety and the administration of justice.

2.5 The investigation of deaths in custody or deaths where there is a police presence

PIAC welcomes the focus of the Discussion Paper on this issue. Investigations of deaths should be independent and free from apparent or actual bias. Deaths where police are present attract a lot of public and media attention. Often, police spokespeople provide their own perspective on the events in question, while noting that there will be a full investigation by the coroner at a subsequent inquest.

This situation creates a clear conflict of interest. The police or individual police officers involved are, in a democracy, entitled to give their versions of events when something is in the public arena. However, the public and families of deceased persons in particular are understandably concerned when investigations are carried out by police officers, even if they come from different units or different geographic locations to those involved with the death. There is a perception that police will be more sympathetic to other police, rather than the deceased. Similarly, in cases involving a death in corrective services custody, there is a perception that police officers will be more sympathetic to prison officers, rather than prisoners whom they would have helped to incarcerate in the first place.

In both cases, it is important that the public's perception of neutrality in the investigation is maintained, even if we accept that in the majority of inquests that involve deaths in custody or deaths where police are present, there is no evidence of actual bias.

PIAC notes the range of options suggested to address this problem, particularly in relation to police related deaths at pages 93 to 96 of the Discussion Paper. PIAC notes the preference of the WA Law Reform Commission for a model where investigators from the WA Corruption and

Crime Commission are embedded with the police in investigations where there might be a suggestion of bias and/or conflict of interest.

PIAC supports this approach in preference to the status quo, but would urge the Commission to recommend that there should be independent bodies established and funded to carry out the particular task of investigating deaths in custody and police-related deaths.

PIAC believes this is an issue that should be dealt with on a national basis, with a core national team of experienced investigators able to co-opt investigators from the various Australian police forces and anti-corruption bodies, such as the WA Corruption and Crime Commission and the NSW Police Integrity Commission, as well as the various state, territory and Commonwealth Ombudsman. This team could report directly to the various state coroners. Given the persistence of deaths in custody and deaths involving the police Australia-wide, there would be an ample number of investigations for such a unit to undertake. The funding for such a unit should be shared by all Australian governments on a permanent basis.

3. Responses to particular proposals and questions in the Discussion Paper

3.1 Proposal 1 – Objects of the Coroners Act

PIAC supports the proposal and recognises the importance of comprehensive objects in coronial legislation.

PIAC is particularly supportive of the proposed object (e). Contributing to the reduction in the incidence of preventable deaths is a key function of all Australian coroners. Stating this as an objective of legislation has the effect of both educating the public about this important role and mitigating against any potential attempt by parties during an inquest to limit the role of the coroner in this regard.

3.2 Proposal 60 - guidance for coroners on when an inquest should be held

PIAC is supportive of this proposal.

PIAC submits that the proposed provision is preferable to the provisions of the *Coroners Act 2009* (NSW), which provides for a general jurisdiction to conduct inquests after reportable deaths, and then sets out provisions indicating when an inquest may be dispensed with. The proposed WA provision reinforces the importance of recommendations and the role of the coroner in the prevention of deaths.

This can be contrasted with the *Coroners Act 2009* (NSW*)* which, on recent construction by the NSW Supreme Court, provides that the desirability of recommendations and consequently the Coroner's role in preventing deaths, is not something that can be taken into account in a decision to proceed with or dispense with an inquest.

In *Josephine Conway v Mary Jerram, Magistrate and NSW State Coroner*,[16] the court considered an application to overturn the decision of the NSW State Coroner to dispense with an inquest. Barr J held that

> the phrase "manner of death" should be given a broad construction so as to enable the coroner to consider by what means and in what circumstances the death occurred.[17]

Barr J also stated:

> The power of a coroner to make recommendations about matters of public health and safety seems apt to enable the coroner to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death.[18]

His Honour went on to say:

> However, the power cannot arise until there is an inquest and there cannot be an inquest unless the evidence justifies it.[19]

This final statement diminishes the importance and relevance of the recommendation-making power of coroners. An inquest should be held if the likely outcome is a set of recommendations that have the potential to prevent death. This should be the case, even if the direct cause of the death is not in dispute. As stated in 2.1 above, coronial legislation should state that inquests should be held for the purpose, among others, of making recommendations, particularly recommendations that are aimed at preventing similar deaths occurring in the future.

3.3 Proposal 41 - Specialist health care-related death investigation team

PIAC strongly supports this proposal and believes it should be adopted in all coronial jurisdictions.

PIAC recently acted for the family of the late Mark Holcroft in the July 2011 inquest into his death. The Coroner delivered his findings on 12 August 2011. Mark Holcroft died in 2009 of a heart attack in a prison van travelling from Bathurst Correctional Centre to Manus Correctional Centre. NSW police conducted the investigation into his death for the Coroner. The police brief to the Coroner contained his medical records from NSW Justice Health, but the police investigation was centred totally on events in the prison van on the day Mark Holcroft died.

The medical notes revealed that Mr Holcroft had complained of chest pains a week before he died. He was given one dose of medication and tests (several electrocardiograms) but no other treatment. PIAC raised with the Coroner the need for the issue of the adequacy of Mr Holcroft's health care before his death to be dealt with at the inquest. The Coroner agreed and requested an expert report.

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16 [2010] NSWSC 371.

17 Ibid [52].

18 Ibid [63].

19 Ibid [63].

That report changed the focus of the inquest entirely because it found that Mr Holcroft's death would probably have been prevented if the second electrocardiogram he was given had been correctly interpreted and he had been transferred to hospital for successful management of his acute coronary syndrome.

The inquest examined the events of the day Mr Holcroft died and the conditions the prisoners in the van suffered, with no food, water or comfort stops on a four hour plus journey. However, extensive evidence was also given about the care and treatment that Mr Holcroft received from the time he entered the prison system until his death.

The Coroner, Mr McMahon, made the following finding:

> Mark's death is therefore primarily the result of the failure of Justice Health to provide him with proper care.[20]

The Holcroft family did have legal representation and PIAC was able to raise the health care related issues, and have them included in the issues dealt with by the Coroner. Whether they would have been issues before the Coroner had the family not been legally represented is unclear. They had not been contemplated for examination by the police in their investigation for the Coroner.

The police are not experts in health care matters. Had there been a specialist health care related investigation team in NSW, they would have at least been able to advise the police and the Coroner that there were questions to ask about Mark Holcroft's health care.

These questions could have been raised and dealt with earlier, compared to when they were finally raised by PIAC, and an appropriate investigation could have been commenced at the same time as the police investigated the immediate events leading to Mr Holcroft's death. In some matters, it may be too late to properly investigate these matters when an inquest finally becomes listed at the Coroner's Court. This delay was not crucial in the Holcroft inquest, but in other matters, because of faded memories and lost evidence, time could be crucial in ensuring the effectiveness and accuracy of the investigation.

PIAC notes that in New Zealand, there is a memorandum of understanding between the New Zealand Health and Disability Commissioner and the Coroner. Cooperation takes place between the two in health care related deaths. In Australia, although the NSW Coroner has the power to refer matters to the NSW Health Care Complaints Commission (HCCC) following an inquest, there is certainly no active cooperation between the Coroner and the HCCC like that which occurs in New Zealand.

PIAC submits that there should be similar memoranda of understanding between all Australian coroners and their respective state and territory health care complaints bodies. Such formal co-operation could greatly augment the role of a specialist health care-related death investigation team, attached to coroner's offices.

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20 *Inquest into the death of Mark Holcroft* (2011) DSC McMahon 12 August 2011, 11.