THE HOLCROFT INQUEST:

PRISONERS DESERVE MORE HUMANE PRISON TRANSPORTATION

by Peter Dodd

The recent Inquest into the death of Mark Holcroft resulted in significant recommendations from the Coroner about the transportation of prisoners and how prisoners are treated when in transit, particularly on long journeys. This follows the Inquest in Western Australia into the death of the late Mr Ward, which also made findings and recommendations regarding the transport of prisoners, particularly in remote locations.

Deputy State Coroner McMahon handed down his decision in the Holcroft Inquest on 12 August, 2011.[1] The Public Interest Advocacy Centre ('PIAC') represented two sisters and one brother of the late Mr Holcroft at the Inquest.

Mr Holcroft suffered a heart attack in a prison van travelling from Bathurst to Mannus Correctional Centre on 27 August, 2009. Despite the other prisoners in the van banging on the inside of the van in an attempt to get the attention of the prison officers in the front of the van, for a period estimated to be from 20 to 45 minutes, the van did not stop until it reached Mannus. Sadly, Mr Holroft was then already dead.

The Inquest highlighted that:

- there was no two-way communication in the van so that prisoners could alert the drivers to emergencies;
- there was only one observation camera working in each of the van's compartments;
- there is no alert button for prisoners in New South Wales ('NSW') prison transport vehicles; and,
- the prisoners had no food, no water and no toilet stops on a journey that lasted for well over four hours.

Mr Holcroft reported to Justice Health nurses that he had chest pains a week before he went on his fatal journey from Bathurst to Mannus. Tests were performed, but a Justice Health employed doctor misread the results. Expert evidence given at the Inquest indicated that his death was preventable because if the tests were properly interpreted, he should have been immediately hospitalised, and would have been treated successfully in hospital. As such, the Coroner found that Mr Holcroft's death was primarily the result of the failure of Justice Health to provide him with proper care.[2]

It is significant that the original police investigation for the Coroner did not identify the standard of the health care received by Mr Holcroft as an issue for the Coroner. It was only when PIAC raised the issue that the Coroner requested the expert report that lead to his findings about Mr Holcroft's care and treatment.

The Coroner made eight recommendations to the NSW Commissioner of Corrective Services. The most significant of which was:

> That the Standard Operating Procedures and Departmental practices for inmate transfers be reviewed so as to ensure that:
>
> - Adequate drinking water is always available to inmates during transfers
> - If the proposed journey is anticipated to be longer than three hours a toilet stop be included during the course of the journey, and
> - If the proposed journey is anticipated to be longer than four hours a meal is to be provided to each inmate prior to the commencement of the journey as well as during the course of the journey.[3]

The Coroner recommended that the upgrade of prison transport (in particular, by providing two-way communication between inmates and corrections officers), which has occurred as a consequence of Mr Holcroft's death, 'be reviewed with a view to ensuring that such communication capacity is available on all inmate transport vehicles at the earliest possible date'.[4]

The Coroner also recommended that disciplinary action be considered in respect of the performance of Corrective Services Officer Peter Sheppard with particular regard to his actions as observer of the inmate transport vehicle on 27 August, 2009. He found that had Mr Sheppard undertaken his duties in a proper fashion, he would have been aware that there was a welfare concern in the middle compartment of the van.[5]

The Coroner's findings raise significant issues regarding NSW Corrective Services' commitment to the welfare and human rights of prisoners. At no stage during the Inquest did NSW Corrective Services concede that what happened in the van on 27 August, 2009, was in any way inappropriate or of concern. In contrast, NSW Justice Health apologised to the Holcroft family at the Inquest and acknowledged its failure to provide Mr Holcroft with proper care and the consequences of that failure. When given an opportunity, NSW Corrective Services failed to do the same.

PIAC believes that NSW Corrective Services should encourage a culture in which their employees respect the human rights of prisoners and are acutely conscious of their basic human needs. This should be reflected in open and accessible policies and protocols that reflect international and national standards of care for prisoners.

PIAC has requested the responsible NSW Minister, Justice Minister, Mr Greg Smith MP, to take the lead in the implementation of the Coroner's findings in the Holcroft Inquest.

The NSW Government has recently responded to the Coroner's recommendations.

Corrective Services NSW has responded to the key recommendations of the Coroner as follows:

- A 'Commissioner's Instruction' has been issued which ensures the provision of water, food, toilet and exercise stops to inmates during designated journeys;
- Inmates who are being transported for two hours or more are given food at the beginning of a journey. If a trip is more than three hours, inmates are given food again, and at each subsequent three-hour interval;
- Transport officers on journeys of more than three hours are required to provide inmates with toilet and exercise breaks at designated secure locations at correctional centres or police stations; and,
- 39 transport vehicles (not the entire NSW fleet) have been fitted with two-way intercom systems. The remainder of the transport vehicle fleet is to be fitted out according to a 'prioritised installation program'.[6]

These responses represent a work in progress. PIAC will continue to press for a full and timely implementation of the Coroner's recommendations.

The Conference of State and Federal Corrections Ministers has agreed in principle to finalise national standards for prison transport in the near future. This process was initiated by Western Australia, and was driven largely as a result of the findings into Mr Ward's death. PIAC has called for all state, territory and Commonwealth Ministers to take full account of the Coroner's findings and recommendations in the Holcroft Inquest when finalising these standards.

The tragic deaths of Mr Ward and Mr Holcroft have already led to some significant changes to the way prisoners are treated in Australia. If the NSW Government finally implements all the recommendations of Deputy State Coroner McMahon in the Holcroft Inquest, then this will represent some progress towards a proper recognition of the rights of prisoners in Australia.

Mr Ward, a Western Australian Aboriginal elder, died in Kalgoorlie Hospital in 2008 after being transported in the back of a prison van from Laverton. He was driven 570 kilometres to a courthouse, remanded in custody, and driven a further 352 kilometres to a prison. The second journey lasted for four hours. Temperatures were recorded at mid-40 degrees Celsius. The air-conditioning in the back of the van was not working and Mr Ward died of heatstroke.

Seven out of the fourteen recommendations by the Coroner in the Ward Inquest[7] are about the transportation of prisoners in Western Australia where a private company undertakes prisoner transport (in NSW, prison transport is operated by NSW Corrective Services). These recommendations are mainly about proper maintenance of transport vehicles and oversight and training by the company carrying out transportation of prisoners.

The detailed recommendations of Mr McMahon represent a significant step towards more specific codification of the standards that should apply to prison transportation and the consequent rights of prisoners who have to undertake lengthy journeys between correctional centres, police custody and courts.

In 2001, the Western Australian Office of the Inspector of Custodial Services released a report highlighting the inadequacies of the privately provided prison transport services in that state; including serious concerns about the care and wellbeing of prisoners in Western Australian prison transport. Issues such as lack of adequate provision of food, water, toilet breaks, air conditioning and provisions for emergencies were all raised in the report.[8] The Australian Human Rights Commission ('AHRC') (formerly the Human Rights and Equal Opportunity

Commission ('HREOC')) has also commented and made specific findings about the maintenance of standards in relation to the transportation of people in detention based on Australia's international human rights obligations.

In 2007, AHRC investigated complaints by Mr Huong Hai Nguyen, Mr Austin Okoye and other detainees, against the Commonwealth of Australia and GSL (Australia) Pty Ltd, pursuant to section 11(1)(f)(ii) of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth).[9]

The President of the Commission found that the human rights of Mr Nguyen, Mr Okoye and three other immigration detainees were breached in the course of their immigration detention. This finding related to the transportation of the detainees from Maribyrnong Immigration Detention Centre to Baxter Immigration Detention Facility on 17 September, 2004. The Commission found that the conduct and conditions of that journey were in breach of the detainees' human rights pursuant to articles 7 and 10(1) of the International Covenant on Civil and Political Rights ('ICCPR').[10]

There are similarities in the conditions experienced by immigration detainees in 2004 and the conditions experience by Mr Holcroft and other prisoners in their journey between Bathurst Correctional Centre and Mannus Correctional Centre in 2009 and the conditions that led to the death of Mr Ward in 2008.

The HREOC finding was based on the cumulative effect of the following circumstances:

- The steel compartments in the van where the detainees were separately held were:
  - claustrophobic and cramped, and
  - dark, with only a small amount of natural light.
- Due to the configuration of the van and the lack of facilities on board the van, the detainees were unable to:
  - access toilet facilities

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- communicate with those in charge of their situation
- see into each other's compartments or see outside the van
- sleep or 'cat nap'
- stand upright or move about to any extent, or
- read or participate in any other comparable form of time passing distraction.

- The air-conditioning system in the van was poorly configured and was not operated properly during the journey, resulting in the compartments becoming uncomfortably overheated.
- The van did not stop for any breaks for the detainees during the 6-7 hour journey from Maribyrnong IDC to Mildura. This lack of break:
  - exacerbated the discomfort and harshness of the conditions
  - created a safety risk, given that the same officer drove the van for such a long period without a break, and
  - resulted in the detainees being forced to suffer the indignity and discomfort of having to urinate in their own compartments. This indignity was further compounded by being:
    - recorded on CCTV tape, as well as being in view of the female driver and male co-driver of the van via the CCTV monitor, and
    - in Mr Nguyen and Mr A's case, in immediate view of a fellow detainee.
- None of the detainees were provided with any food during the journey from Maribyrnong IDC to Mildura.
- With the exception of Mr Nguyen and Mr A, the detainees were not provided with any fluids during the Maribyrnong IDC – Mildura leg of the journey. . .
- The driver and co-driver of the van failed to adequately monitor the CCTV feed and also disregarded obvious:
  - appeals for assistance by the detainees, such as banging on the walls and calling out
  - signs that the detainees required toilet breaks, particularly the driver seeing, via the CCTV monitor, Mr Nguyen urinating in his compartment
  - signs that the detainees were overheating in their compartments, such as seeing on the CCTV monitor detainees removing clothing, and
  - general signs of distress of the detainees.[11]

The Commissioner stated that the findings in his report reflect poorly on the human rights culture that existed within the former Department of Immigration and Multicultural and Indigenous Affairs and GSL at the time of these incidents. He noted in particular the following:

- The occurrence of the breaches of human rights identified [in the report].
- The failure of the GSL officers involved in the transfer to recognise that breaches of human rights were occurring (despite obvious indications) or to report those breaches to their superior officers.[12]

There have been suggestions that the Coroner's recommendations in the Holcroft Inquest did not go far enough.[13] Certainly, the Coroner did not adopt all of the suggested recommendations for policy change by NSW Corrective Services that were put to the Coroner on behalf of the Holcroft family.

For example, it was submitted on behalf of the Holcroft family that there be mandatory installation of a duress alarm in all prison transportation vehicles that is clearly visible, marked accordingly and accessible to all passengers/inmates. It was also suggested that the Coroner recommend that all escort vehicles include a defibrillator. Neither of these propositions were included in the Coroner's recommendations. It was also submitted on behalf of the family that:

> NSW Corrective Services policies and procedures governing the duty of care to all inmates should be publicly available, in accordance with the *Government Information (Public Access) Act 2009* (NSW) with the exception of information where an overriding public interest against disclosure exists because of security reasons.

The Coroner did not adopt this recommendation either, and many of the significant policies and procedures that affect the rights of prisoners in NSW remain publically unavailable, despite a general government commitment to open access to such information.

However, the specificity of the recommendations made by the Coroner is very welcome, given that the recommendations of earlier inquests and reports regarding prison transport have been far more general, concentrating mainly on areas such as training and oversight of employees.

One hope for further prevention of abuse of prisoners' rights and basic needs is found in the Optional Protocol to the Convention against Torture ('OPCAT').[14] The Australian Government is committed to the ratification of OPCAT. Once ratified, the Commonwealth, state and territory governments will be required to set up 'preventative mechanisms' in the form of independent inspectorates with strong investigative powers, to 'shine a light' on all places of detention. There are also provisions in OPCAT for international scrutiny of Australian places of detention. PIAC will be vigorously campaigning for the ratification of OPCAT in 2012.

Finally, it is worth noting that at both Mr Ward's Inquest and Mr Holcroft's Inquest, the families had legal representation. NSW is the only state or territory in Australia that has a coronial unit operating in its Legal Aid Commission that provides representation for families in some Inquests.

Funding for legal aid, Aboriginal legal services and community legal centres for legal representation for families in inquests needs to be increased. This will enable families' interests to be better represented and protected in the very stressful atmosphere of an inquest. It may also ensure that there are lawyers representing families who are able to advocate for law reform and systemic change so that the circumstances that lead to preventable deaths (well illustrated in the deaths of Mr Holcroft and Mr Ward), are not repeated.

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1 A copy of the decision is found at Public Interest Advocacy Centre <http://www.piac.asn.au/new-south-wales-state-coroner%E2%80%99s-court-holcroft-inquest-finding>.

2 Ibid, 10.

3 Ibid, 2.

4 Ibid.

5 Ibid, 19.

6 A full copy of the NSW Government response can be found at <http://www.lsb.lawlink.nsw.gov.au/lsb/coronialrecommendations.html>.

7 Copy of decision can be found at <http://www.safetyandquality.health.wa.gov.au/mortality/inquest_finding.cfm>.

8 Office of the Inspector of Custodial Services, Western Australia, *Report of Announced Inspection Of Adult Prisoner Transport Services*, Report No 3 (2001) <http://www.custodialinspector.wa.gov.au/go/reports-and-reviews/inspection-reports>.

9 Human Rights and Equal Opportunity Commission, *Complaint by Mr Huong Nguyen and Mr Austin Okoye against the Commonwealth of Australia (Department of Immigration and Citizenship, formerly the Department of Immigration and Multicultural and Indigenous Affairs) and GSL (Australia) Pty Ltd*, Report No 39 (2007) <http://www.humanrights.gov.au/legal/humanrightsreports/hrc_report_39.html>.

10 Ibid, Executive Summary, 7.

11 Ibid, 7-8.

12 Ibid, Recommendations.

13 Lucy Swinnen, 'The Death in Custody of Mark Holcroft: Coroners Report Doesn't Go Far Enough', *Right Now* (online) (October 2011) < http://rightnow.org.au/writing-cat/article/the-death-in-custody-of-mark-holcroft-why-the-coroner%E2%80%99s-recommendations-don%E2%80%99t-go-far-enough/>.

14 *Optional Protocol to the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment*, opened for signature 18 December 2002, A/RES/57/199 (entered into force 22 June 2006).

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