QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Stuart Ronald WILLIAMS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1212/04(4)
DELIVERED ON:	27 June 2006
DELIVERED AT:	Brisbane
HEARING DATE(s):	18 May 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, correctional centre, natural causes

REPRESENTATION:

Counsel Assisting:	Detective Inspector Gil Aspinall
Department of Corrective Services:	Ms Kim Villis

Findings of the Inquest into the death of Stuart Ronald WILLIAMS

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The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system. These are my findings in relation to the death of Stuart Ronald Williams. They will be distributed in accordance with the requirements of the Act.

Introduction

Stuart Ronald Williams was an indigenous male, 45 years of age when he died on Monday, 17 May 2004, whilst in the custody of the Department of Corrective Services as an inmate at the Capricornia Correctional Centre at Rockhampton.

These findings seek to explain how the death occurred.

The Coroner's jurisdiction

The basis of the jurisdiction

Because when he died, Mr Williams was in the custody of the Department of Corrective Services under the *Corrective Services Act 2000*, his death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, the coroner is required to find:-

- whether the death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar

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[1] See s10

[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state corners or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future[4]. However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate".* That doesn't mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Brigenshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

As soon as Mr William's death became known to the prison authorities, the local police were contacted and Detective Sergeant John O'Shea of the Queensland Police Service's Corrective Services Investigation Unit was directed to conduct a "*death in custody*" coronial investigation.

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[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168

All relevant witnesses were interviewed and statements obtained and exhibits collected. On 17 May 2004, an autopsy was conducted at the Rockhampton Base Hospital by Dr Nigel Buxton, an experienced forensic pathologist.

I am satisfied that the investigation was competently undertaken and sufficiently thorough.

The inquest

An inquest was opened in Brisbane on Thursday, 18 May 2006. Detective Inspector Aspinall was appointed to assist me. Leave to appear was granted to the Department of Corrective Services. Mr Williams' sister, Julie Purcell advised that neither she nor any other family member wished to be represented at the inquest and had no matters they wished to raise during the inquest. A copy of the police investigation report was provided to Julie Purcell, prior to the inquest.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

I determined that the evidence contained in these materials was sufficient to enable me to make the findings required by the Act and that there was no other purpose, which would warrant any witnesses being called to give oral evidence. The family indicated that they did not wish to challenge or examine any of the witnesses' versions as contained in the documents, which had been tendered and I could find no inconsistencies or conflict in the evidence that required oral evidence to be given. Accordingly, I have made these findings based on the information contained in the exhibits

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Background

In 1996 Mr Williams murdered his female partner resulting in him being sentenced to life imprisonment.

They had a daughter who is now about twelve years of age. She is being cared for by her mother's family and understandably she had no contact with her father after his imprisonment.

Mr Williams' parents are both deceased. He has several brothers and sisters from two families. Julie Purcell is his half-sister and was nominated by Mr Williams as his "emergency contact" in his Department of Corrective Services records.

Mr Williams also has between ten to twelve children from different relationships. His oldest son is thirty odd years of age.

Custody

From the time of his sentence to the time of his death Mr Williams was incarcerated at the Capricornia Correctional Centre at Rockhampton.

At the time of his death, he was housed in cell 15, in Secure Block 7. No one else occupied the cell.

Medical issues

Medical records show that Mr Williams had an extensive history of cardiac disease with at least two confirmed myocardial infarcts; the first in September 1996 and the second in March 1999.

Since the first myocardial infarct, Mr Williams had been on medication to prevent narrowing and spasms of his coronary arteries. Although he was strongly advised to stop smoking, he continued to smoke until about three days prior to this death. Mr Williams had also been offered coronary angiography by the Department of Corrective Services, but he refused despite counselling of the associated benefits.

Mr Williams was 175 centimetres in height and weighed 105 kilograms, which is considered to be significantly overweight for his height.

Events leading up to the incident

On the afternoon of Sunday 16 May 2004, Mr Williams played squash with two other inmates namely Jason Ryan Flethouse and Kaz Van Der Hoek and complained to them of shortness of breath and pains in his chest. Mr Williams advised them that he put it down to the fact that he has just given up smoking. Both these prisoners saw Mr Williams later that evening and advise that he appeared normal to them. There is no evidence that Mr Williams complained to any correctional staff of any concerns about his health.

At approximately 6.20pm, Mr Williams was locked in his prison cell as this was the time the prison was 'locked down' for the evening. Once 'lock down' has occurred, inmates are not allowed out of their cell again until the next morning. His brother Wesley Williams, who was also an inmate at the Capricornia Correctional Centre, and other inmates who saw Mr Williams at about this time, all say he appeared to be in good health.

Corrective Services Officer Anthony Hickey states that he saw Mr Williams enter his cell on this evening. He said "Goodnight" to Mr Williams, who nodded in response. He then closed the door to Mr Williams' cell and it locked automatically. Correctional Services Officer Hickey confirms that Mr Williams was the sole occupant of the cell at this time. He considered that Mr Williams looked fine. He saw no indication that Mr Williams required any medical attention or other assistance.

Mr Williams was checked at various stages during the night by Corrective Services Officer Anne Keating. She conducted four head counts of the inmates in their cells throughout the evening and on each occasion she

viewed Mr Williams in his cell. She recalls that on the occasions she saw him, he was sleeping on a mattress on the floor of his cell and that his television was operating. She viewed the inside of Mr Williams' cell, through the glass window of his cell door and nothing appeared abnormal to her.

She advised that it is not unusual for inmates to sleep on their mattress on the floor and that inmates often leave the television set on and fall asleep watching it. She recalled nothing curious about Mr Williams' sleeping posture or position that made her suspect that he was unwell on any of the four occasions she undertook a head count throughout the evening.

At approximately 7.25am on 17 May 2004, Corrective Services Officers including Officer Henry Odgaard commenced their routine health checks and head count of the inmates in their cells. When Correctional Services Officer Odgaard looked through the window into the cell occupied by Mr Williams, he saw him lying across his mattress. He states that the mattress was on the floor of the cell at right angles to the bed approximately six feet from the door of the cell.

Correctional Services Officer Odgaard kicked at the cell door to make a noise to wake Mr Williams. When there was no response, he suspected that something was wrong with Mr Williams. He contacted Secure Control at the prison to get access to the cell. He also called for Corrective Services Officer Warren Nielsen to attend at Mr Williams' cell.

Once Officer Nielsen arrived, Officer Odgaard entered Mr Williams' cell. He placed his hands on Mr William's left shoulder and shook him in an attempt to elicit a response from him, but none was forthcoming.

Officer Odgaard found that Mr Williams' body felt stiff and he immediately called a 'code blue' over his prison two-way radio. A 'code blue' is a medical emergency notification that causes a response team and a nurse to immediately attend the scene.

In response to this notification, Supervisor Chris Anderson, Registered Nurse Jennifer Yeomans and Student Nurse Kellie Solito attended Mr Williams' cell.

Upon arrival at the cell, Nurse Yeomans observed Mr Williams lying on his back across his mattress, which was on the floor at right angles to the bed base facing the television set. She observed Mr Williams' arms were raised above his head and they were very stiff. She then conducted her clinical assessment of Mr Williams and found no signs of life.

Paramedics, who had been called to the scene, arrived at approximately 7.50am and also checked for signs of life and also established that Mr Williams was deceased.

Doctor Murray Cave issued a life extinct certificate at 8.32am on 17 May 2004.

Correctional Services officers declared the cell a crime scene and restricted entry to it. A crime scene log was also commenced.

Forensic Pathologist, Dr Nigel Buxton attended at the Capricornia Correctional Centre and examined Mr Williams *in situ*.

Rockhampton detectives and forensic officers also attended and conducted their respective investigations, including photographing the scene and Mr Williams. No evidence of any violence or third party involvement in the death was detected.

Mr Williams' brother, Wesley Williams, was advised of the death was allowed to view the cell and his brother. Other relatives including another brother Sean Williams and a nephew Cecil Kemp were also advised of Mr Williams' death.

As Mr Williams was indigenous, the Brisbane Aboriginal and Torres Strait Islanders Legal Service in Brisbane was contacted and informed of the death.

Autopsy results

Forensic Pathologist, Doctor Nigel Buxton conducted an autopsy on Mr Williams' body at the Rockhampton Mortuary on the afternoon of 17 May 2004. He advised that, in his opinion, Mr Williams died from natural causes namely "*coronary artery thrombosis due to or as a consequence of coronary artery atheroma*".

Conclusions

A comprehensive police investigation has been conducted into the circumstances of this death. The investigation, coupled with the autopsy, revealed that Mr Williams passed away peacefully from natural causes namely heart failure, whilst resting on his mattress watching television, in his cell.

I find that the Corrective Services authorities provided Mr Williams with an appropriate level of care and treatment whilst he was in their custody.

The investigation has revealed no suspicious circumstances concerning this death.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. I have already dealt with this last aspect of the matter, the manner of the death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Stuart Ronald Williams.

Place of death – He died whilst in the custody of the Department of Corrective Services at the Capricornia Correctional Centre at Rockhampton, Queensland.

Date of death – Mr Williams died on 17 May 2004

Cause of death – He died from natural causes namely coronary artery thrombosis due to or as a consequence of coronary artery atheroma.

Comments and recommendations

Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

I find that none of the Department of Corrective Services personnel or other inmates at the Capricornia Correctional Centre caused or contributed to Mr Williams' death and that, under the circumstances, nothing could have been done to save Mr Williams, who suddenly passed away from natural causes.

It is noted that his death was probably foreseeable, due to Mr Williams' long standing heart problems, coupled with his disregard of medical advice to lose weight, stop smoking and to get treatment for his known heart condition. Unfortunately, Mr Williams chose to disregard this medical advice.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
27 June 2006.