QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Russell James Williams**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Rockhampton
FILE NO(s):	2018/2160
DELIVERED ON:	30 April 2024
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 August 2022, 20-21 April 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, remand prisoner, Safety Order, revocation of Safety Order, prison issued razor, suicide risk assessment.

REPRESENTATION:

Counsel Assisting:	Mr J Crawfoot
Queensland Corrective Services:	Ms A Bain, instructed by QCS Legal Strategy and Services
Central Queensland Hospital and Health Service:	Ms J Marsden, instructed by CQHHS

Contents

Introduction

1. Russell Williams was aged 51 years when he died at Capricornia Correctional Centre (CCC) in Central Queensland on 15 May 2018. The cause of death was determined to be an incised wound to the right arm.

The investigation

2. Detective Senior Sergeant Carr from the Queensland Police Service Corrective Services Investigation Unit (CSIU) completed a Coronial Report, dated 5 March 2020, outlining the circumstances of Mr Williams' death. This report was prefaced with a letter from Detective Senior Sergeant Anthony Buxton referring to previous inquest findings relating to the death of prisoners Garry Appleton and Terence Malone.

3. DSS Carr concluded that "all policy and procedures relating to the deceaseds custody and supervision had been complied with".[1] He stated that Mr Williams "appears to have been supervised by Correctional Officers as per normal procedures"[2], although no reference was made to any particular CCC policies or procedures.

4. DSS Buxton confirmed the investigation found no suspicious circumstances surrounding Mr Williams' death, and identified that he had "received the appropriate care and supervision and there was no identified negligence by any person".[3] The six recommendations made following the 2019 findings on the deaths of Mr Appleton and Mr Malone were attached and referenced. Consequentially, no recommendations were made by the QPS in relation to the circumstances of Mr Williams' death or the access to a razor in his cell.

5. A parallel investigation was conducted by the Office of the Chief Inspector in QCS. Those investigators also prepared a report which was tendered at the inquest.

The inquest

6. As Mr Williams died in custody an inquest was required by the *Coroners Act 2003*. The inquest was held at Brisbane on 20-21 April 2023. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

7. Leave to appear was granted to Queensland Corrective Services (QCS) and the Central Queensland Hospital and Health Service. QCS staff members who had interviewed Mr Williams on reception to prison and other custodial staff who interacted with him in the lead up to his death gave evidence.

8. In addition to the findings required by s 45 of the *Coroners Act 2003* the following issues were examined at the inquest:

[1] A4.1 – Final report, page 14.
[2] Ibid.
[3] A4 – – Cover Report, page 1.

a) Whether Mr Williams' intake assessment was reasonable and appropriate in all the circumstances.

b) Whether the making and cancellation of Mr Williams' Temporary Safety Order and full Safety Order were reasonable and appropriate in the circumstances.

c) Whether the supervision of Mr Williams, upon his return to Secure Unit, was reasonable and appropriate in the circumstances.

9. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

10. Mr Williams was born in Gladstone on 8 December 1966. He had five brothers, a sister and a foster brother. He recalled having a "happy family life"[4], that his parents never drank and there was no domestic violence. At age 13, Mr Williams left school to work at a local smelter. He continued working in labouring and driving jobs in the mines, and owned his own business cultivating lavender.[5]

11. On 9 April 1996, Mr Williams entered the public bar of a hotel at Calliope, near Gladstone, where he aimed a shotgun at his former partner. After the gun misfired Mr Williams reloaded before shooting his former partner in the back, killing her. On 5 August 1997, Mr Williams was convicted of murder and sentenced to life imprisonment. While serving that sentence, he engaged in hunger-strikes.

12. During this period of incarceration, Mr Williams married Tara King. On 9 January 2012, after serving nearly fifteen years imprisonment, Mr Williams was released on Board Ordered Parole with no full-time discharge date. He was released to a halfway house and placed in the "maintenance"[6] phase of supervision in Rockhampton.

13. In 2014, Mr Williams was involved in a traffic crash where an unlicensed driver crashed into Mr Williams, who was riding his motorbike. The accident fractured Mr Williams' neck and tore his right anterior cruciate ligament.

14. By 2018, Mr Williams and Ms King owned houses in Rosedale and Moura, Central Queensland, and Mr Williams lived between these houses.

15. On 29 January 2018, Mr Williams was arrested and charged with a further two murders from 1993. While he was remanded in watch-house custody, he commenced a hunger-strike. After being remanded, Mr Williams was asked a series of questions about his health. He denied having been treated for depression, receiving any current treatment for a metal health problem or having ever attempted suicide or self-harm. He also denied any thoughts of suicide or self-harm in the previous three months.[7]

[4] F1 – Medical File, page 28.
[5] Ibid.
[6] QCS Memorandum – 29.01.2018, page 2.
[7] Exhibit C24.1 – Custody Report at p. 12/13

16. On 30 January 2018, Mr Williams appeared before the Magistrates Court at Gladstone on the new charges. Bail was refused and he was remanded in custody.[8]

17. At about 8:00am on 31 January 2018, Mr Williams was transported from the Gladstone Watch House to CCC and officially released from police custody at 11:10am.[9] He was still engaged in a hunger- strike. He said he would continue until he was granted a telephone call to his wife.[10]

18. On the same date, Mr Williams was assessed by a Provisional Psychologist as Medium Risk of self-harm because of his hunger-strike behaviour (historical and active).[11] That risk level would have placed him on an 'At-Risk' observation regime to be monitored by Correctional Supervisors. However, the risk level was downgraded soon after, when the Provisional Psychologist consulted with custodial correctional staff.

19. It was accepted that the nature of the fresh charges Mr Williams was facing placed him at risk of suicide, regardless of the other factors.[12]

20. Mr Williams was accommodated in Secure Unit 7 (S7), a two-level unit. On 6 May 2018, Mr Williams was placed under a temporary 'Safety Order' and moved from S7 to the Detention Unit (DU). That order was to be in effect for five days. The basis of that Safety Order was that Mr Williams had disclosed he was thinking about becoming a "*crown witness*", and held concerns for his safety.[13]

21. However, it is apparent Mr Williams also requested the Safety Order to allow time out from the Secure Unit to consider legal documents he had received in relation to his fresh charges. The temporary order was due to expire on 10 May 2018.

22. On 8 May 2018, Mr Williams appeared in the Magistrates Court at Gladstone. He was further remanded in custody to appear at the Gladstone Magistrates Court on 19 June 2018 for committal mention.[14]

23. On 8 May 2018, the temporary order was cancelled, and a full Safety Order was made, which was to be in effect for 27 days, due to expire on 3 June 2018.[15] The reason for the cancellation and fresh order was administrative as correct protocols had not been followed in the first instance. There had been no change to the information that had informed the making of the temporary order.

[8] Exhibit C24.5 – VJR
[9] Exhibit C24.1 – Custody Report at p. 13/13
[10] Exhibit D5 (03357-2019 - Endorsed Attachment 11 and 12)
[11] Exhibit D5 (03357-2019 - Endorsed Attachment 11 and 12)
[12] Exhibit F2 - CIMHA Records at p. 6/11
[13] Exhibit D5 (03357-2019 - Endorsed Attachment 13)
[14] Exhibit A4.1 at p. 4/15
[15] Exhibit D5 (03357-2019 - Endorsed Attachment 14)

24. On 14 May 2018, at or about 2:40pm, Mr Williams' full Safety Order was cancelled.[16] That cancellation was recorded by Correctional Supervisor Keith Johnson. An electronic note associated with that cancellation documented: "*Prisoner has returned to a unit at his own request*". There was no apparent consideration of the issues that had initially informed the making of the order or any consideration of risk levels upon cancellation.

25. After cancellation of the order, Mr Williams was transferred from the DU back to S7. A copy of the DU logbook confirmed that Mr Williams presented for muster at 7:30am, 9:45am and 2:15pm on 14 May 2018. Mr Williams was not present at the 6:15pm muster, and presumably had returned to S7 sometime after 2:15pm.[17]

26. A corresponding logbook for Unit S7 documented Mr Williams returned at 3:00pm.[18] It failed to document him as being returned to Cell 28. A review of the logbook identified the cell occupant as another prisoner.

27. The same logbook documented the last muster for S7 had occurred at 2:15pm. Mr Williams was not documented as a prisoner at that muster, although the progress note in the same logbook had still documented his return. Sometime after 4:57pm there was a "*lock away*" muster (likely at 6:15pm[19]) where all S7 prisoners were required to stand beside their cell door. Because cell details were not updated there is no positive documentation Mr Williams presented then.

28. Similarly, during a head count at about 8:00pm, after prisoners had been locked in their cells, there is nothing to confirm Mr Williams was sighted at that time.

29. There is no definitive evidence of when Mr Williams was last seen alive. Although a prisoner in a neighbouring cell heard a 'thud' shortly after the 8:00pm head count.

30. At 5:05am on 15 May 2018, Mr Williams was located deceased inside cell 28.

31. CSO Wilson found Mr Williams lying face down on the ground in the shower area of his cell. Mr Williams was unresponsive to verbal communication. CSO Wilson was the last person to see Mr Williams alive on the night of 14 May 2018 during the head count.

32. A Code Blue[20] call was made by CSO Wilson at 5:08:59am.[21]

33. CSO Wilson then notified fellow CSO, Kerrod Lehmann of the situation, who in turn radioed for additional staff so they could get authority to enter the cell. A minimum of four prisoner officers was required to enter.

[16] Exhibit D5 (03357-2019 - Endorsed Attachment 16)
[17] Exhibit D5 (03357-2019 - Endorsed Attachment 17)
[18] Exhibit D5 (03357-2019 - Endorsed Attachment 18)
[19] Folder D – Further Material - 2021.04.08 Statement of Richard Butcher at Paragraph 17
[20] Exhibit D5 (03357-2019 - Endorsed Attachment 3)
[21] Exhibit D5 (CCC DVR GB-Video_31-05-2018 13-53-53_13)

34. Shortly after 5:08am, CSO Richard Hamilton and CSO Darren Bartlem arrived at the cell which was then unlocked. Upon turning on the cell light and moving Mr Williams body, they observed a quantity of blood on the floor. There were biological markers of Mr Williams having been deceased for a period of time. CSO Hamilton commenced chest compressions, while CSO Lehmann used a resuscitation bag. CSO Wilson counted the compressions to assist CSO Hamilton.[22]

35. No other person was present in the cell with Mr Williams.

36. While there are cameras in each cell, these are only activated when specifically done so from the master control centre. The camera to Mr Williams cell was activated shortly after he was located deceased.[23]

37. At about 5:14am, Prison Nurse Pink arrived at the cell in response to the Code Blue call.[24] She observed officers still performing CPR, but Mr Williams' body was cold with no signs of life. She observed rigor mortis was present to the upper half of his body. Using a stethoscope, she was unable to detect a heartbeat. Nurse Pink instructed prison officers to cease to CPR. She confirmed no circulatory return was present.[25]

38. Nurse Pink declared Mr Williams deceased at 5:11am.[26]

39. Examination of the cell by officers with the Queensland Police Service (QPS) located the head of a disposable razor. One of the blades had been dislodged so that it protruded from the plastic frame and was secured in place with sticky tape.[27]

40. A quantity of unused disposable razors was also located in Mr Williams cell [28] along with a letter to his wife. Mr Williams informed her that he had put "*months of thought*" into ending his life and "*I just don't have any prison time left in me*".[29] In that letter he also told his wife that he did not commit the offences of murder.

41. Mr Williams had also prepared a letter to the investigating officer who had charged him with historical murder offences.[30] In that letter, Mr Williams denied any involvement in the murder charges brought against him. He nominated another person as a person of interest. In this letter Mr Williams also described having knowledge of locations relevant to the police investigation.

Office of the Chief Inspector Investigation

42. The Office of the Chief Inspector (OCI) investigation concluded Mr Williams' death was due to suicide.

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[22] Exhibit B12 – Statement of CSO Wilson at paragraph 13
[23] Exhibit A4.1 at p. 6/15 and Exhibit D5 (CCC DVR GB-Video_31-05-2018 13-53-53_13)
[24] Exhibit D5 (CCC DVR GB-Video_31-05-2018 13-53-53_13)
[25] Exhibit F1 p. 53/95
[26] Exhibit F1 – Medical File at p. 53/95
[27] Exhibit E1.1 at pp. 65-71 / 127
[28] Exhibit E1.1 at pp. 75-77/127
[29] Exhibit C2
[30] Exhibit C3

43. Prior to completing the report, OCI investigators interviewed the General Manager (GM) of CCC, Paula May.[31] Prior to that interview she was emailed a copy of the OCI preliminary findings.[32]

44. She informed interviewers she had not participated in the debrief after Mr Williams death as she had been in Brisbane at the time, although she did have conversations with his family.[33] She was aware of "*problems*" with the Safety Order on the Monday prior to his death.[34] She said a full Safety Order should have been made in first instance but this had been rectified.[35]

45. GM May accepted each the points raised by the investigators in their email, although with respect of the initial Temporary Safety Order, she gave weight to operational needs when making an order on a weekend and considered the alterative was an order that may not have been made until a weekday.[36]

46. As to the cancellation of Mr Williams' Safety Order, it is apparent that it was viewed through the lens of an administrative process i.e. whether the person cancelling the order had the correct delegation, as opposed to considerations of prisoner welfare.[37] When questioned about the conflicting reasons attributed to Mr Williams for being in the DU, and the extent to which that should have been reflected in the decision-making when his Safety Order was cancelled, GM May gave the following response:

> "*I think in a perfect world that's fine but we'd need to address some of those issues of exactly why somebody is being placed on a Safety Order prior to which may actually put people at risk further if we detail that sometimes in a Safety Order rather than detailing that elsewhere*"[38]

47. She went on:

> "*so then that creates another problem later on when you're trying to take somebody out of the detention unit as well, so ... I acknowledge there are issues with case notes because a case note reviewer will be any staff member that has the authority to access IOMS then get into the case notes and, and there are sensitive issues that we can't put into case notes...* "[39]

48. Ms May made the point and concession that the Intelligence Unit should have been informed Mr Williams' was thinking about becoming a Crown witness, and would ultimately become the repository of sensitive information. That information would not be shared with Managers, therefore a CSO cancelling the order, who did not make the order at first instance would not, and could not, be fully seized of all the information needed to make the decision.[40]

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[31] Exhibit D5 – ROI – Paula May
[32] Exhibit D5 – 03357-2019 - Endorsed Attachment 9
[33] Exhibit D5 – ROI – Paula May at p. 4/35 at [17]
[34] Exhibit D5 – ROI – Paula May at p. 4/35 at [21]
[35] Exhibit D5 – ROI – Paula May at p. 6/35 at [45]
[36] Exhibit D5 – ROI – Paula May at p. 7/35 at [59]
[37] Exhibit D5 – ROI – Paula May at p. 9/35 at [75]
[38] Exhibit D5 – ROI – Paula May at p. 14/35 at [102]
[39] Exhibit D5 – ROI – Paula May at p. 14/35 at [104] and [107]
[40] Exhibit D5 – ROI – Paula May at p. 14/35 at [110]

49. In relation to making an 'Intel note' GM May confirmed there had been some training around that issue in the past but was unable to give specifics and confirmed the training that had been provided was done "*a while ago*".[41]

50. A prisoner who was in the neighbouring cell to Mr Williams (Mr Tiaaleagia), was interviewed by investigators from the Office of the Chief Inspector.

51. Mr Tiaaleagia informed investigators he was in the cell next to Mr Williams. He knocked on his cell wall sometime between 6:00pm and 7:00pm and got a response. He recalled the head count that was performed at "20:05 at which time Mr Williams seemed fine", although it is not apparent how Mr Tiaaleagia was able to establish that. Mr Tiaaleagia said that about 30 minutes after the head count, he heard a "thud" from Mr Williams' cell.

52. Mr Tiaaleagia also informed investigators he had conversations with Mr Williams in which they discussed suicidal ideation, although Mr Tiaaleagia also informed investigators that he did not raise those conversations with any QCS Officers. Those conversations were consistent with the disclosure Mr Williams made in the letter to his wife.

Medical records

53. Mr Williams medical records following his move to the Detention Unit (DU) at CCC did not document the circumstances of his move. He remained in the DU until 13 May 2018 and was subject to daily medical observations. Other than documenting the date and time of observations, and that "*nil*" treatment was required, the progress notes do not disclose any other observations, such as the nature and extent of any conversations with Mr Williams.

54. The reason for his being placed in the DU was because he became subject to a 'Safety Order'.[42] The IOMS report also documents that he was eating all meals while in the DU. There is no indication of any self-harm or suicidal ideation.

Autopsy results

55. On 21 May 2018, Dr Andrew Reid conducted an autopsy consisting of an external and full internal examination of the body to the extent necessary to establish a cause of death, toxicology and a full body CT scan.

56. The CT scan found no fractures or displacements in the head, chest or abdomen/pelvis areas. There were no intracranial, thoracic or abdominal injuries.

57. The external examination showed a complicated, irregular shaped incised wound on the right antecubital fossa and a number of minor bruises and abrasions of the right arm and shoulder with no other significant injuries.

58. The internal examination showed an incised wound of the right antecubital fossa extending into the subcutaneous tissue and involving the medium sized antecubital vein with surrounding haemorrhage into the soft tissues. The heart

[41] Exhibit D5 – ROI – Paula May at p. 28/35 at [232]
[42] Exhibit D5 (03357-2019 - Endorsed Attachment 11 and 12)

was enlarged, however there was no arterial injury. There were no other significant injuries.[43]

59. Histology showed damage to the wall of the medium-sized vein, perivascular birefringent foreign material and non-specific mild myocyte hypertrophy and fibrotic changes to the myocardium. Hepatic stenosis (fatty liver) was observed and corpora amylacea (small hyaline masses) was seen in the lung.

60. Toxicology showed no alcohol or drugs detected in the post-mortem blood.

61. Dr Reid concluded that the cause of death was Incised wound to right arm

62. It was noted that bleeding from an arterial injury would have occurred in a pulsatile fashion under arterial pressure, and would have caused death more rapidly than a venous injury if untreated.[44] Dr Reid noted the bloody footsteps and considerable amount of blood smeared on the floor of the cell was evidence of Mr Williams walking around the cell after cutting himself.

Conclusions on Inquest Issues

Findings required by s. 45

Identity of the deceased – Russell James Williams

How he died – In January 2018, Mr Williams was remanded in custody to the Capricornia Correctional Centre on two charges of murder dating from 1993. He was placed in Secure Unit 7. He had already served a life sentence from 1996 to 2012 for another murder. He was facing a lengthy term in custody on remand on the new charges. He was placed on a Safety Order in the Detention Unit from 6 - 14 May 2018.

On 14 May 2018 he was returned to Secure Unit 7. He was locked in his cell at around 8:00pm on 14 May 2018. Sometime after, he intentionally cut the inner elbow of his right arm with a QCS issued razor blade. He was found on his cell floor by Corrections Officers at 5:05am on 15 May 2018, and declared deceased by a registered nurse at the scene.

Place of death – Cell 28, Secure Unit 7, Capricornia Correctional Centre, Etna Creek, Queensland 4702

Date of death– 14-15 May 2018

Cause of death – Incised wound to the right arm

[43] A3 – Autopsy Report, page 7.
[44] A3 – Autopsy Report, page 12.

Whether Mr Williams' intake assessment was reasonable and appropriate in all the circumstances

31 January 2018

63. At 10:10am on 31 January 2018, an Immediate Risk/Needs Assessment (IRNA) was performed by Provisional Psychologist, Ms Close. A copy of Mr Williams' Case File in the Integrated Offender Management System (IOMS) referred to this consultation.

64. During that assessment Mr Williams stated, "*he would go on hunger-strike*" unless he was allowed a phone call with his wife.[45] At 11:10am on 31 January 2018, Mr Williams disclosed he was "*currently on a hunger-strike as police would not allow phone call to wife*".

65. However, the Watch House Custody Report and Checklist did not identify Mr Williams requesting or being refused telephone contact with his wife. Mr Williams had 30 minutes in-person contact with his wife between 10:00am and 10:30am on 30 January 2018.[46]

66. Ms Close had knowledge of Mr Williams previous hunger-strike in 2010.[47] Based on that information, and that disclosed by Mr Williams during the IRNA, she assessed that Mr Williams was at medium risk for continued self-harm behaviour.[48] This would have resulted in 60-minute observations of Mr Williams, until his risk was reassessed.[49]

67. The watchhouse records for the period between 29 January 2018 and 31 January 2018 do not disclose any incident of Mr Williams commencing a hunger-strike while on remand. The same records indicate all meals were delivered to him. Daily checklists also make no mention of a hunger-strike.[50]

68. It appears that Mr Williams may have declared his hunger-strike status during the IRNA process for the purpose of securing telephone contact with his wife. If he had not made such a disclosure, he would not have been identified as 'medium risk'.

69. At about 10:00am on 31 January 2018, Correctional Services Officer (CSO) Story received notification that Mr Williams was being placed on hourly observations.[51] CSO Story was informed the basis of the risk assessment was Mr Williams' hunger-strike. CSO Story was also familiar with Mr Williams previous hunger-strike in 2010.[52]

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[45] Exhibit D16 - 03357-2019 - Endorsed Attachment 11 and 12; Exhibit 39.1 - ROI - Michele Close T1.6/52
[46] Exhibit C24.1 – Custody Report at p. 7/13
[47] Exhibit 39.1 - ROI - Close T1.9/111-114
[48] Exhibit D5 (03357-2019 - Endorsed Attachment 11 and 12) at pp. 1-2/3
[49] Exhibit D5 (03357-2019 - Endorsed Attachment 4 - COPD App 5)
[50] Exhibit C24.1 - Custody Report, Exhibit C24.2 - Checklist 29-01-18, Exhibit C24.3 - Checklist 30-01-18
[51] Exhibit D45.1 – ROI –Story 26.10.18 at T1.3/17
[52] Exhibit D45.1 – ROI –Story 26.10.18 at T1.3/17

70. CSO Story met with Mr Williams. They discussed his concerns about gaining access to a telephone call to his wife. CSO Story also discussed the arrangements for Mr Williams placement in S7.[53] CSO Story arranged food for Mr Williams which he was seen to eat.[54]

71. After he had consumed food and was given the assurance of a telephone call, Mr Williams was regarded as having a change in his risk of self-harm behaviour. The following entry was documented in IOMS:

> "*Given the changes in the prisoner's self-harm behaviour and his current circumstances and consideration of At-Risk procedures, a decision was made in consultation with CSO Phil Story and MOD Nicole McCance NOT to place the prisoner on At-Risk observation regime and to be monitored and managed by the Correctional Supervisors"*

72. When interviewed, Ms Close disclosed that she had not had a chance to read and inspect Mr Williams' file prior to the IRNA.[55] She conceded not having access to any means of confirming a previous mental health diagnosis,[56] although she did have access to IOMS.[57]

73. Ms Close said that after Mr Williams was told he could make a telephone call to his wife he began eating. CSO Story then said words to the effect: '*he doesn't want to continue his hunger strike'*.[58] Ms Close formed the view that Mr Williams was then at "*reduced risk*" not medium risk.[59]

74. In formulating the risk assessment, Ms Close discussed the following methodology:

> "*If there's no, no sort of history, no suicidal thoughts or anything like that that indicates some risk factors then, then there's no risk…*"[60]

75. Other than the hunger-strike, she had not identified any other risk factors.[61]

76. Ms Close told the inquest that she had only been working for one month as a provisional psychologist when she assessed Mr Williams. She said she consulted with her colleagues as Mr Williams was talkative and she considered the hunger-strike was his way of gaining access to his wife. He was otherwise presenting well. Although there was no senior psychologist present at the time, her colleagues (Mr Story and Ms McCance) had a good understanding of Mr Williams. Ms Close said she was under no pressure to alter her assessment.

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[53] Exhibit D45.1 – ROI –Story 26.10.18 at T1.3/17
[54] Exhibit D45.1 – ROI –Story 26.10.18 at T1.4/17
[55] Exhibit D5 – ROI Close at p. 6/16 at 65-66
[56] Exhibit D5 – ROI Close at p. 9/16 at 111-112
[57] Exhibit D5 – ROI Close at p. 9/16 at 114-117
[58] Exhibit D5 – ROI Close at p. 7/16 at 83
[59] Exhibit D5 – ROI Close at p. 8/16 at 90-91 and 96-97
[60] Exhibit D5 – ROI Close at p. 10/16 at 121
[61] Exhibit D5 – ROI Close at p. 10/16 at 122-123

77. On 21 August 2018, Manager of Offender Development, Ms McCance, was interviewed in relation to her knowledge of these events.[62] She recalled receiving a telephone call from Ms Close and having being told of Mr Williams intention to go on a hunger-strike. Ms Close was wanting to place Mr Williams on hourly observations.

78. Ms McCance told investigators that by the time she was able to observe Mr Williams in person "*he was at least three quarters of the way through a sandwich, so no sign of a hunger strike and more than happy to go to a unit*".[63]

79. With reference to the IOMS notation that "*a decision was made in consultation with CSO Phil Story and MOD Nicole McCance NOT to place the prisoner on At-Risk observation regime and to be monitored and managed by the Correctional Supervisors*", Ms McCance confirmed that it was a combined decision between herself, CSO Story and Ms Close.[64] She later described it as a "*lengthy discussion*".[65]

80. Ms McCance confirmed she did not have a background in psychology.[66]Ms McCance was interviewed again on 26 October 2018, and gave a similar version of her observations of Mr Williams:

> "*the prisoner was actually eating his lunch when I walked in and a considerable amount of the sandwich had well and truly gone. I spoke to the prisoner also, he said no, he's not on a hunger strike but he did want to talk to his wife and that was it and so he, from there he went down to the unit"*

81. Ms McCance disclosed: *"part of Michele's phone call to me was seeking clarification, guidance, advice, whatever the word is that you want to use about that assessment cause she was new and wasn't sure.*"

82. Ms McCance informed investigators that Ms Close was rostered to work on reception on 31 January 2018. She was unable to say whether there were any other psychologists that may have been available to conduct the assessment.[67]

83. CSO Story expressed the view that Ms Close was "*a bit naïve*" in her risk assessment of Mr Williams and that in his view: "*he was not at risk, he was just doing, doing that to get his own way so to speak*".[68]

84. CSO Story advised that if Mr Williams had been on hourly observations or any other observations regime, he would not have had access to razor blades.[69]

85. Ms McCance told the inquest that by 2108 she had been working with QCS for 21 years, including 8 years in her current role. She was responsible for supervising psychologists, counsellors and program staff and had chaired many risk assessment team meetings. As Ms Close was recommending observations for Mr Williams it was routine practice for Ms McCance or the

[62] Exhibit D5 – ROI McCance 21-08-18 at p. 5/12 at 72
[63] Exhibit D5 – ROI McCance 21-08-18 at p. 5/12 at 72
[64] Exhibit D5 – ROI McCance 21-08-18 at p. 7/12 at 102-103
[65] Exhibit D5 – ROI McCance 26-10-18 at p. 3/10 at 32
[66] Exhibit D5 – ROI McCance 21-08-18 at p. 7/12 at 106-107
[67] Exhibit D5 – ROI McCance 26-10-18 at p. 3/10 at 90-93
[68] Exhibit D5 – ROI Story 26-10-18 at p. 3/10 at 21
[69] Exhibit D5 – ROI Story 20-08-18 at p. 7/10 at 60-61

senior psychologist to be consulted. However, the senior psychologist was not on duty the day Mr Williams was received at the prison.

1 February 2018

86. On 1 February 2018, at the CCC, a Forensic Intake Form was completed by Psychiatrist, Dr Duggan, in relation to Mr Williams.[70] The intake form identified that Mr Williams had engaged in a hunger-strike during his previous period of incarceration. It also identified that he previously had contact with a psychiatrist in the prison system, but not while in the community.

87. Mr Williams was not prescribed any medication for depression or anxiety. His Psychiatric History (as appearing on the Intake Form) disclosed:

> "No *episodes of self-harm. From CIMHA – reference made to anxiety symptoms and treatment with diazepam*"

88. His family history did not identify any instances of suicide. Consideration of static and dynamic factors when assessing risk of suicide identified '*stressful life events'* as a static factor. All other metrics were negative. His social history did not otherwise disclose any events that may have contributed to that factor.

89. In relation to his outlook concerning the historical charges that had seen Mr Williams returned to custody, Dr Duggan documented as follows:

> "*He appeared very matter-of-fact about his charges. He was polite throughout and nonthreatening. There were no abnormal movements. He engaged well in the discussion. His mood appeared neither pathologically elevated nor depressed. His affect was really active. His speech was normal. There was no formal thought disorder. The content of his thoughts was appropriate and denied any thoughts of wanting to harm himself or others*".[71]

90. In relation to his suicide risk screen, Dr Duggan recorded:

> "*No previous history although the charge (and previous murder conviction) increase his actuarial risk. He is future focussed and has a wife and child*."[72]

91. Mr Williams denied any history of mental illness or suicidal ideation however he did disclose having "*contemplated*" a hunger strike the previous day (31 January 2018) because he had been unable to make a telephone call to his wife.

92. Dr Duggan documented that the nature of the charges was such that Mr Williams was at increased risk of suicide.[73] The plan was for Mr Williams to be provided with contact details for the Prison Mental Health Service (PMHS). Otherwise, his case was closed.

[70] Exhibit F1 pp. 26-32, 73-76/95
[71] Exhibit F1 at p. 28/95
[72] Exhibit F1 at p. 29/95
[73] Exhibit F1 p. 76/95

93. The Office of the Chief Inspector found that the failure for an initial assessment of risk to be conducted by a psychologist (other than a provisional psychologist) was contrary to the Custodial Operations Practice Directive.[74] However, the investigation report did not refer to the assessment that was conducted by Dr Duggan on 1 February 2018.

94. Mr Williams completed suicide 3.5 months after these intake assessments. There is no evidence that any of the risk factors (such as food refusal) persisted in the intervening period, although the nature of the charges was an ongoing risk factor.

95. While the initial risk assessment was performed by a provisional psychologist, it cannot be said that this contributed to Mr Williams death. The assessment proceeded on a correct footing based on the information that was being disclosed and was re-evaluated after consultation with more senior correctional officers.

96. I am satisfied that Mr Williams' intake assessment was reasonable and appropriate in all the circumstances. As noted by Dr Duggan, the nature of the charges Mr Williams was facing placed him at risk of suicide regardless of any other factors. However, the immediate risk on 31 January 2018 with respect to the hunger-strike had resolved. It was appropriate that the decision was made that he would not be placed on an at risk management plan.

97. That was the full extent of any involvement Ms Close had in relation to Mr Williams. He was placed in a cell in secure unit 7 where he stayed until the time of his death, apart from the time he was placed on a Safety Order.

98. There was no evidence in the intervening period between 31 January 2018 and 6 May 2018 (when Mr Williams was placed on a Safety Order) of there being any notifications of concern in relation to Mr Williams, or any behaviours to suggest the risk of suicide might have heightened after the initial assessment on 31 January 2018.

Whether the making and cancellation of Mr Williams' Temporary Safety Order and full Safety Order were reasonable and appropriate in the circumstances.

99. At 6:38am on Sunday, 6 May 2018, Mr Williams made an intercom call from his cell to QCS Officers. He asked to be removed from the unit before 'unlock' as he believed he would be assaulted that morning.[75]

100. Based on that disclosure, Mr Williams met with A/Correctional Supervisor Finegan and discussed his concerns. CS Finegan was interviewed on 16 October 2018 and made the following comments in relation to that interaction:

    a. She knew of Mr Williams but had not previously had dealings with him;[76]
    b. Mr Williams told her that he had received a brief of evidence in relation to the fresh charges and was considering becoming a Crown witness.

[74] D5 – Incident Investigation Report - WILLIAMS Russell FINAL
[75] D5 – Incident Investigation Report - WILLIAMS Russell FINAL at p. 14/36
[76] Exhibit D5 – ROI Finegan 16-10-18 at p. 2/13 at 21

He had fears for his safety within the unit and wanted to be placed in the Detention Unit under a Safety Order;[77]

c. In relation to that request, CS Finegan was under the impression that: "*he was asking for time to consider what he was going to do and that the threat wasn't immediate but that's only supposition on my part*"
d. She created an initial Temporary Safety Order[78] but acknowledged it should not have been made on a temporary basis;[79]
e. She discussed this decision with Ms McCance. In their discussion, Ms McCance expressed surprise Mr Williams was considering becoming a Crown Witness;[80]
f. The information given by Mr Williams was not provided to QCS Intelligence;[81]
g. While Mr Williams requested a Safety Order, he did not request Protection Status;[82]
h. On 6 May 2018, after being placed in the Detention Unit, Mr Williams was permitted to have contact with another prisoner (H);[83]
i. She had a direct conversation with Mr Williams during which he discussed the '*real purpose'* for seeking placement in the Detention Unit was to have an opportunity to "*go over his brief*".[84]

101. CS Finegan did not physically observe Mr Williams' brief of evidence but understood it to be a "*large document*".[85]

102. The Final Report by the Office of the Chief Inspector identified that prisoner H was interviewed. A summary of his interview indicates that in his conversation with Mr Williams, he "*talked him out of going Crown*".[86]

103. While the Temporary Safety Order noted Mr McIndoe as having created the document, CS Finegan confirmed that she created the order, but Mr McIndoe assisted her in saving it to the system.[87]

104. CS Finegan's reason for creating a Temporary Safety Order was because she did not consider Mr Williams was at risk.[88] This was contrary to the Risk Management directive that requires a prisoner to be placed on a Safety Order if the Chief Executive or authorised delegate "*reasonably believes there is a risk of the prisoner harming themselves … or being harmed by someone else*".[89]

[77] Exhibit D5 – ROI Finegan 16-10-18 at p. 3/13 at 23
[78] Exhibit D5 (03357-2019 - Endorsed Attachment 13)
[79] Exhibit D5 – ROI Finegan 16-10-18 at p. 4/13 at 33
[80] Exhibit D5 – ROI Finegan 16-10-18 at p. 4/13 at 33 and p. 8/13 at 89
[81] Exhibit D5 – ROI Finegan 16-10-18 at p. 8/13 at 91
[82] Exhibit D5 – ROI Finegan 16-10-18 at p. 5/13 at 56
[83] Exhibit D5 – ROI Finegan 16-10-18 at p. 5/13 at 58-64
[84] Exhibit D5 – ROI Finegan 16-10-18 at p. 7/13 at 78
[85] Exhibit D5 – ROI Finegan 16-10-18 at p. 5/13 at 56
[86] D5 – Incident Investigation Report - WILLIAMS Russell FINAL at p. 14/36
[87] Exhibit D5 – ROI Finegan 16-10-18 at p. 9/13 at 100
[88] Exhibit D5 – ROI Finegan 16-10-18 at p. 10/13 at 107
[89] Exhibit D5 – RB-1 COPD Risk Management at p. 75/90

105. It was appropriate for a temporary order to have been made by CS Finegan in circumstances where it was outside of normal business hours. However, a doctor or psychologist was required to review the order before the temporary period ended (within five days).[90] This did not occur in Mr Williams case although a full Safety Order was made prior to the expiration of the five-day period.

106. CS Finegan had a conversation with Ms McCance sometime between 6:38am and 7:56am on 6 May 2018. During that conversation CS Finegan informed Ms McCance that Mr Williams was going to 'go Crown'.[91]

107. This conversation likely informed an SMS that Ms McCance sent to Deputy General Manager Livingstone at 7:56am on 6 May 2018, informing Ms Livingstone that Mr Williams had been placed on a Safety Order and intended to become a Crown witness.[92] The message read:

> "*Hi Lexi, this is for your info only as I thought you might be interested, Russell WILLIAMS has been placed on a Safety Order as he claims he is going crown on [X]*"[93]

108. In circumstances where CS Finegan was already aware that a purpose for his seeking placement in a Detention Unit was to go over his brief, it was unclear whether that information was shared with Ms McCance. On the face of her SMS, it was not.

109. Ms Livingstone confirmed that in circumstances where a prisoner was considering becoming a Crown witness, a full Safety Order would be made, not a temporary one.[94]

110. At 8:32am on Monday, 7 May 2018 (the Labour Day Public Holiday), Ms McCance sent another SMS to Ms Livingstone in which she informed her that CSO Story had made his own enquiries and identified Mr Williams' request for a Safety Order had "*nothing to do with [X]*" and that he only wanted time out to go through his brief of evidence.

111. When interviewed on 26 October 2018, CSO Story agreed on that 7 May 2018 he had a conversation with Mr Williams while he was placed in the DU:

> "*I said how long you staying down here for, well why are you down here, he said mate, I just come down here to read my brief, that's all I want to do, with that many people on the block it was way too noisy, I just want to come down here and chill*"[95]

112. Mr Williams also told CSO Story that the QPS had offered him witness protection and that they wanted him to "*roll*", but another prisoner (H) had cautioned him against becoming a Crown witness.[96]

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[90] Exhibit D5 – RB-1 COPD Risk Management at p. 80/90
[91] Exhibit D5 – ROI McCance #2 26-10-18 at p. 5/10 at 53
[92] Exhibit D5 – ROI Livingstone #1 16-10-18 at p. 3/13 at 29
[93] D5 – Incident Investigation Report - WILLIAMS Russell FINAL at p. 19/36
[94] Exhibit D5 – ROI Livingstone #1 16-10-18 at p. 4/13 at 40
[95] Exhibit D5 – ROI Story 26-10-18 at p. 6/10 at 40
[96] Exhibit D5 – ROI Story 26-10-18 at p. 7/10 at 40

113. Mr Williams also informed CSO Story that his wife had been placing pressure on him to become a Crown witness against an alleged co-offender. CSO Story gave the following account of this conversation:

> "*his big dilemma was his missus was putting pressure on him to go Crowny on his coey and the police were offering him witness protection or he shuts his mouth and never gets out, that was his, that's what he told me his dilemma was and I said mate, that's your call*"

114. It is clear from that exchange that while Mr Williams may have expressed a desire to read legal documents associated with his criminal proceedings, he was also experiencing a high level of distress in relation to a decision whether to become a Crown witness or face another lengthy period of incarceration.

115. While Ms Livingstone did not have any direct conversation with CSO Storey on that day, she did have a discussion with CSO Story sometime after 7 May 2018 and more likely than not, prior to 10 May 2018, when she had a one-on-one conversation with Mr Williams.[97]

116. The full Safety Order approved by Ms Livingstone was made pursuant to s53 of the *Corrective Services Act* at 6:10pm on 8 May 2018. There were a number of conditions attached to that Order. The conditions included Mr Williams being able to have non-contact visits and to be "*totally segregated*" from other prisoners.

117. Upon making the full Safety Order, a doctor or nurse was required to examine Mr Williams as soon as practicable afterward.[98] Reference to IOMS records identifies Mr Williams was seen by a nurse, doctor and CS Johnson on the morning of 8 May 2022.

118. A review of medical records confirms Mr Williams was seen by a nurse on 6, 7, 8, 9, 10, 11, 12 and 13 May 2018 in the Detention Unit.[99] Those records are simply a stamp with the date on it, apart from a notation at 4:00pm on 8 May 2018, that he was given "*Panadol for headache*". There are no other notes providing any details of his physical or psychological wellbeing during his time in the DU.

119. When interviewed by investigators, CS Johnson (who later cancelled the Safety Order) confirmed he had seen Mr Williams on the morning of 8 May 2018 and recalled the doctor who saw him was Dr Davies.

120. Ms Livingstone spoke with Mr Williams on 10 May 2018, three days before the order was cancelled. She informed investigators:

> "*that he'd requested time-out for his court case. I asked him if there were any risks from any other prisoners or if he had any concerns in regards to placement at Capricornia, going Crown, anything like that and he said absolutely not. He had a huge amount of paperwork in his cell in the detention unit and he said I just need to go through all this, he was very polite and respectful. I reminded him of the opportunity for support from psychologists or*

[97] Exhibit D5 – ROI Livingstone #1 16-10-18 at p. 7/13 at 56
[98] Exhibit D5 – RB-1 COPD Risk Management at p. 76/90
[99] Exhibit F1 – Medical File p. 54-55/95

counsellors in which he said he was well aware of the support available to him"[100]

121. Ms Livingstone confirmed it was this conversation that satisfied her there was "*no risk*" to Mr Williams and that he was placed there [in the Detention Unit] "*purely*" for time-out for his court matters.[101]

122. On about 12 May 2018, Mr Williams was spoken to by CS Johnson. CS Johnson was not aware why Mr Williams was in DU but had knowledge of the fresh charges he was facing. CS Johnson described Mr Williams as having in his cell, "*several large boxes of documents pertaining to his trial that he'd been given by his solicitors*". Mr Williams informed him that he needed "*quiet*" to "*get his head around*" the material. [102]

123. CS Johnson was not concerned about Mr Williams' presence in the DU or his self-disclosed reasons for being there. CSO Johnson had further conversations with Mr Williams in the following days in which he discussed how his preparation was going.[103]

124. On 14 May 2018, CSO Johnson had a conversation with Mr Williams in which he was told Mr Williams wanted to return to S7. Mr Williams said words to the effect that he was "*ready to go back*" and had "*sufficiently researched his material*".[104]

125. CS Johnson then 'signed off' the Safety Order at 2:49pm that day,[105] and moved Mr Williams back to S7.[106] This is the last known, direct conversation between any QCS Officer and Mr Williams.

126. When asked by investigators whether he had consulted with any other person about the decision to 'sign off' the Safety Order, CS Johnson agreed he did not. He described there being a "*consensus*" about Mr Williams' situation, implying he had discussions with other QCS Officers, although this was not documented.[107] CS Johnson nonetheless did not hold the appropriate delegation to cancel the Order.[108]

127. The Risk Management Practice Directive, while requiring a medical assessment after an order is made, is silent on whether any additional assessment should be conducted before an order is cancelled.

128. Ms Livingstone accepted she had a conversation with CS Johnson about the basis for Mr Williams being in the DU.[109] Noting she also discussed the situation with CSO Story, it is more likely than not that a consensus was formed before 14 May 2018.

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[100] Exhibit D5 – ROI Livingstone #1 16-10-18 at p. 6/13 at 52
[101] Exhibit D5 – ROI Livingstone #1 16-10-18 at p. 6/13 at 52
[102] Exhibit D5 – ROI Johnson 21-08-2018 at p.4/17 at 31 and 33
[103] Exhibit D5 – ROI Johnson 21-08-2018 at p.4/17 at 33
[104] Exhibit D5 – ROI Johnson 21-08-2018 at p.4/17 at 33
[105] Exhibit D5 – 03357-2019 - Endorsed Attachment 16
[106] Exhibit D5 – ROI Johnson 21-08-2018 at p.4/17 at 33
[107] Exhibit D5 – ROI Johnson 21-08-2018 at p.7/17 at 68
[108] Exhibit D5 – 03357-2019 – Endorsed Attachment 10
[109] Exhibit D5 – ROI Livingstone #1 16-10-18 at p. 7/13 at 56

129. CS Johnson considered Mr Williams' request to be placed in DU to review his brief of evidence was reasonable in the circumstances and that Mr Williams was in a "*unique situation*".[110] He accepted there was no legal or procedural basis for Mr Williams to be in the DU, other than for punishment or to be under a Safety Order.

130. IOMS provided some observations during Mr Williams' time in DU, although no observations were documented on 7, 12 or 13 May 2018,[111] a failure CS Johnson attributed to laziness by other CSO officers.[112] Relevantly, those observations do record whether or not Mr Williams ate his meals on those days, which suggests the issue of his previous hunger strikes and associated risk profile was still a relevant consideration.

131. Other than the electronic note recording the cancellation of the Safety Order and the reason why (Mr Williams wanting to return to his unit), there were no other documented details about the nature and extent of any communication that may have occurred between Mr Williams and Correctional Officers, or any risk analysis around the decision. The only evidence comes from the oral testimony of witnesses who were involved in the decision.

132. The Custodial Operations Practice Directive in relation to Risk Management,[113] identifies a "*prisoner who appears to be vulnerable or indicates a history of being victimised*" as being a potential risk to safety. Indicators of self-harm are also relevant consideration. The Practice Directive does not require a 'multiplier effect'. It is sufficient to identify at least one risk factor in order for an analysis to be completed.

133. The Practice Directive requires analysis of the risk to determine:

a) The consequences of the risk; and
b) The likelihood of the risk occurring.

134. Such analysis should consider historical and static information including a persons' self-harm episode history (SHEH).

135. The Practice Directive, sets out a comprehensive flow chart, commencing with one of two events, first the identification of an at-risk factor and secondly when a prisoner is admitted into custody.

136. There is no evidence of any such risk assessment being completed.

137. Investigators were unable to identify any other prisoner named '[X] as having any relevant connection to Mr Williams although it was accepted there was a prisoner by that name housed in S7.[114] They attributed the initial conversation (on 6 May 2018) in relation to Prisoner X as arising from some "*confusion*" although it is not apparent how. It seems more likely, given how close in time those events occurred, there was some discussion with Mr Williams about prisoner X.

[110] Exhibit D5 – ROI Johnson 21-08-2018 at p.6/17 at 54-62
[111] Exhibit D5 – 03357-2019 – Endorsed Attachments 11 and 12
[112] Exhibit D5 – ROI Johnson 21-08-2018 at p.10/17 at 104
[113] Exhibit D5 (03357-2019 - Endorsed Attachment 4 - COPD Risk Management)
[114] Exhibit D5 – Incident Investigation Report – WILLIAMS Russell FINAL

138. Investigators also identified that none of the information regarding Mr Williams becoming a Crown witness was ever communicated to the QCS Intelligence Unit.

139. As to whether the making and cancellation of Mr Williams' temporary Safety Order and full Safety Order were reasonable and appropriate, it was acknowledged that the initial making of the temporary Safety Order was not the correct decision.

140. That error was ultimately resolved by the making of the full Safety Order approximately two days later. As to the appropriateness of the cancellation of the full Safety Order, while there was no information to indicate that Mr Williams was at any risk of harm to himself, it was not appropriate for CS Johnson to have cancelled the order himself in the circumstances.

141. The placement of Mr Williams on the Safety Order and his removal from that order came about at his instigation. While he may have primarily wanted time out to consider the brief, it was clear that he was also giving consideration to becoming a Crown witness. He was obviously aware of the risks associated with that decision. The full Safety Order would have been the appropriate order if he was considered to have been at risk of harm from somebody else within the prison. However, he would not have been placed on observations in those circumstances.

142. I accept that CS Johnson could not have foreseen that there would have any risk to Mr Williams in taking him off the Safety Order. There were no indications of heightened risk during the time he was in custody, apart for the initial threat of a hunger-strike.

143. The evidence of Mr Butcher was that changes have been implemented such that the cancellation of those orders can only be made by way of the Chief Executive or a delegate. I am satisfied that appropriate steps have been taken to remedy that issue.

Whether the supervision of Mr Williams, upon his return to Secure Unit, was reasonable and appropriate in the circumstances.

144. Mr Williams' partner expressed concern that he was not checked every two hours on his return to the detention unit from the Safety Order. She considered that if this had occurred, he would have been found in time to resuscitate him.

145. Mr Williams' partner was also concerned that his unit was not searched for implements that permitted him to self-harm after he returned from the Safety Order, particularly as he had spent most of the time following his return to his unit on the telephone to her. She considered he was not receiving adequate care as he was "obviously not coping with being in prison again".

146. The person who completed the logbook for S7[115] was Unit Officer Burns. He recorded Mr Williams' return to the unit as 3:00pm, which is consistent with the time the full Safety Order was cancelled. IOMS was updated at 3:17pm to reflect his return.[116]

[115] Exhibit D5 – 03357-2019 – Endorsed Attachment 18 at p. 5/5
[116] Exhibit D5 – Incident Investigation Report – WILLIAMS Russell FINAL at p. 25/36

147. Mr Burns participated in an interview on 26 October 2018. He observed Mr Williams' demeanour when he returned to S7 which he described to investigators as:

> "*He just seemed happy to be back in the unit and, cause he had, did have a couple of friends there, you know that he, he must have had confided in*..."[117]

148. In relation to the lock-away muster that was that was conducted at 6:15pm, Mr Burns described how he and another CSO stood in the middle of the floor while each of the prisoners stood beside their cell, and they were checked off.

149. While investigators did not specifically ask the question, Mr Burns appeared to confirm that he sighted Mr Williams at the muster.[118] It is unclear why the logbook does not reflect an amendment to the occupant of the cell 28 (Mr Williams). While Mr Burns wrote a comment about the muster being conducted at 6:15pm, there is no corresponding entry under 'muster times' for any of the prisoners.

150. The next opportunity for Mr Williams to have been sighted by QCS Officers, was at about 8:10pm on 14 May 2018, when a head count was conducted in S7. The headcount is documented in the logbook and signed off by CCO Lehmann, who conducted the headcount with CCO Wilson.

151. When interviewed by investigators on 18 October 2018, CCO Lehmann said he conducted the head count on the lower level, whereas CCO Wilson conducted the head count on the upper level, where Mr Williams' cell was located.[119]

152. When interviewed by investigators on 22 August 2018, CCO Wilson informed them that while he participated in the 6:00pm lock-away muster,[120] he was unable to recall whether he conducted the muster on the top or bottom landing of S7.[121] Prior to that muster he was not familiar with Mr Williams and had not worked a day shift in Secure Unit before that time.[122]

153. In relation to the 8:00pm head count, CCO Wilson informed investigators he recalled conducting the head count with CCO Lehmann and that he was doing the upstairs observations.[123] He did not have any discussions with any of the prisoners and commented:

> "*Most, most people have got their lights on watching TV cause it's only still 8:00 o'clock and stuff and just look in there, yep and I had nothing to report, I'd seen everyone that I'd seen and everyone seemed to be fine. It's hard to recall what prisoner you've actually seen in there so just like yep, okay, he's fine*"[124]

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[117] Exhibit D5 – ROI –Burns at p. 3/8 at 32 and p. 6/8 at 76-78
[118] Exhibit D5 – ROI –Burns at p. 4/8 at 45-50
[119] Exhibit D5 – ROI –Lehmann at p. 6/10 at 39-44
[120] Exhibit D5 – ROI –Wilson at p.3/14 at 34
[121] Exhibit D5 – ROI –Wilson at p.4/14 at 41-42
[122] Exhibit D5 – ROI –Wilson at p.4/14 at 56-57
[123] Exhibit D5 – ROI –Wilson at p.5/14 at 65-69
[124] Exhibit D5 – ROI –Wilson at p.5-6/14 at 73

154. CCO Wilson said he did not see anything unusual during the head count or whether the light in Mr Williams' cell was on or off.

155. While the QPS Death in Custody report refers to CCO Wilson being the last to see Mr Williams alive at 8:00pm on the night of 14 May 2018, CSO Wilson's statement to Queensland Police was silent on any observations he made.[125] His Officer Report as part of COPD Incident Management also omitted those details.[126]

156. A police notebook entry by an unknown Queensland Police Officer documented:

"*Last to see 8:09pm*"
"*14-05-18*"
"*in his room 28*"

157. That entry was made on 15 May 2018, at or about 6:52am.[127] CSO Wilson was identified in the notebook as the "*last to see*". It is therefore understood there was a conversation between CSO Wilson and the unidentified QPS Officer at the Correctional Centre.

158. The failure to maintain the up-to-date muster book was contrary to the Custodial Operations Practice Directive for Headcount Unlock Muster Lock Away (HUML).[128]

159. The Custodial Operations Practice Directive (HUML) requires a corrective services officer to check the muster book prior to the commencement of each shift to ensure it accurately reflects the prisoners accommodated in the area.[129] A headcount must also be completed between the hours of 7:00pm and 9:00pm at secure facilities.

160. The muster and the headcount are not passive exercises. Officers must observe prisoner behaviour to establish "*if they are in good health including [during night shift]*:

a) *Officers must be vigilant for any unusual behaviours or occurrences that should be reported to the Night Shift Supervisor. This will be based on good sense and sound judgment, noting that during a night shift the limited activity of a prisoner makes it difficult for an officer to determine their apparent good health.*

b) *Where officers during a nightshift identify that apparent good health observations were conducted with nothing to report this identifies that there were no reasonable indicators that a prisoner was NOT in apparent good health*"[130]

[125] B12 – WILSON, Travis
[126] Exhibit D5 (2018-05-15 - Incident Report and attach 231289)
[127] Exhibit C1 at p. 2/10
[128] Folder D - RB-6 Daily Operations – HUML at 4/13
[129] Folder D - RB-6 Daily Operations – HUML at p. 4/13
[130] Folder D - RB-6 Daily Operations – HUML at pp. 5-6/13

161. Even when a QCS Officer, who is performing a night shift, identifies a prisoner is in apparent good health with nothing to report, and there were no reasonable indicators the prisoner was not in good health, this must still be documented in a logbook.[131]

162. There is insufficient evidence that the supervision of Mr Williams on his return to the secure unit was reasonable and appropriate. However, there was also no evidence to indicate that he presented with any behavioural changes. I accept that it was Mr Williams' decision to return from the Detention Unit.

163. While there are aspects of the documentation relating to his return to S7 that indicated that there was a failure to properly document his return, those cannot be said to have contributed in any way to the outcome.

164. The OCI Report also found no information known to QCS prior to 15 May 2018 which might have indicated that Mr Williams was likely to complete suicide. Inspectors found nothing, "*within the bounds of reasonable prison management that QCS staff could have done to prevent the death*". However, the OCI Report contained eight procedural findings and eight recommendations for the improvement of QCS processes.

165. The OCI Report noted that while it had identified various instances of non-compliance with applicable policy or procedure, many of which involved what is viewed as inadequate record-keeping, it was not considered that any of these instances of procedural non-compliance caused or materially contributed to Mr Williams' death.

Comments and recommendations

166. Section 46 of the *Coroners Act* 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.

167. The 8 May 2019 inquest findings into the deaths of Terrence Michael Malone and Garry Ronald Appleton examined the availability of razor blades in correctional centres. It was recommended that Queensland Corrective Services develop a policy in relation to the management of the risks associated with the provision of razor blades to prisoners within the first month of entry to prison, particularly where a prisoner has recently expressed suicidal ideation or has recently been discharged from a hospital emergency department following an emergency examination authority.

168. The Queensland Government response to that recommendation[132] notes:

> *Queensland Corrective Services already have a process of the removal of all property which may pose a risk inclusive of razor blades if a prisoner is under observation because of suicide ideation/self-harm.*
> *…*

[131] Folder D - RB-6 Daily Operations – HUML at p. 6/13
[132] https://www.coronerscourt.qld.gov.au/findings-upcoming-inquests

The emphasis is on assessment of individual risk, needs and circumstances rather than a blanket approach being routinely imposed. Restricting a prisoner from access to sharps whilst in his/her first month in custody as a general rule is contrary to section 30(1) of the Human Rights Act 2019 with specific reference to proportionality expressed within section 13(d). Prisoners are accommodated in general population units so as to not restrict their access and movement, and without unnecessarily restricting access to privileges. Queensland Corrective Services has balanced the prisoner's risk with proportionate access to basic rights.

169. The OCI investigation report into the death of Mr Williams made eight recommendations for remedial action flowing from the findings contained in the report. A statement was provided by Richard Butcher, Chief Superintendent, General Manager, Capricornia Correctional Centre in relation to the implementation of the OCI recommendations.[133]

170. The following sets out the OCI's recommendations together with the QCS response:

Recommendation 1: *CCC give consideration to how the centre will adequately meet the COPD requirement for a provisional psychologist to consult with a Senior Psychologist, in respect to the part-time employment conditions of the current CCC Senior Psychologist.*

To address Recommendation 1, CCC put processes in place to manage absences. Planned absences by the Senior Psychologist are managed by a Registered Psychologist acting in higher duties/relieving at level at the Senior Psychologist level. In the other instances where the Senior Psychologist is absent, a provisionally registered psychologist may consult the Manager, Offender Development to discuss the assessment and placement of a prisoner on at-risk observations.

A second Senior Psychologist has also been recruited to assist local processes and provide an alternative for expert psychological advice.

Recommendation 2: *QCS, in conjunction with Queensland Health should seek to establish a Master Sharing Agreement using the processes established by the Queensland Government Chief Information Office and this sharing agreement should include information related to the sharing of medical information for the purpose of at-risk assessments.*

This recommendation was addressed through the introduction of the Prisoner Health Service MOU which was executed on 27 May 2020. The Department of Health and QCS have continued to collaborate to improve the treatment and well-being of prisoners in both correctional facilities.

Recommendation 3: *QCS staff should be reminded of the requirement to capture the information contained in QCS mobile telephone text messages so that the information is available as part of the relevant prisoner's file.*

[133] Ex B8.

Recommendation 3 was addressed within the comprehensive coverage of case noting and case reporting in the COPD - Daily Operations: Case Management and was published as instruction for all relevant QCS staff to follow. The COPD Daily Operations: Case Management makes specific references to different forms of communications relating to the management of a prisoner. The COPD also provides information relating to the principles and guidelines to case noting/case reporting and staff responsibilities.

Recommendation 4: *Steps should be taken to ensure that delegates are adequately trained so that they understand the process of establishing a Safety Order and the documentation requirements. This could take the form of "tip sheets" or "sample orders" being made available for acting Correctional Supervisors and newly appointed delegates. The approach should be state-wide to ensure consistency.*

Recommendation 4 was addressed with guidance from the Operational Policy and Practice Team, Policy and Legal Command. As a result, enhanced training and additional guidance material was developed and forwarded to Centre Staff Training Officers (STOs) state-wide by the QCS Academy. The training is provided across the state in accordance with Recommendation 4 and as an additional measure, pending availability of funding, the QCS Academy will continue with work to upload Safety Order Module on the online learning platform.

Recommendation 5*: Consideration should be given to amending the relevant COPD to provide a procedure for when and how a Safety Order should be cancelled or amended, including clear instruction on whether this is a function of the legislative delegation and if not, whom has the power to cancel the order if it is determined that the order should not run for its entire period.*

Recommendation 5 was addressed through amendments made to the COPD Safety Orders and Intensive Management Plan which specifically outlines when Safety Orders should be amended or cancelled. The amended COPD also clarifies that the Safety Order should be amended or cancelled by the delegate.

Recommendation 6: *Steps should be taken to ensure that QCS staff are adequately trained and instructed in relation to the need to document important information or events in case notes within the prisoner files (including periodic refresher training and instruction).*

Recommendation 6 was addressed through enhanced training and the provision of additional guidance material that has been forwarded to the Centre Staff Training Coordinators across the State by the QCS Academy.

Recommendation 7: *Steps should be taken to ensure that QCS staff consider the appropriateness of information published in the wider domain, such as in Safety Orders and case notes. Where information could be* ***considered*** *sensitive it should be provided as intelligence notes to the QCS Intelligence Unit and a sanitised version of the information be reported in other documents such as Safety Orders and case notes.*

Recommendation 7 was addressed by updating Case Management COPD published on 10 December 2020 with the inclusion of a new section titled *'Intelligence led information notes*'. This new section directs staff to complete an information note on IOMS to capture sensitive information and complete a case note advising an information note has been created.

Recommendation 8: *Steps should be taken to upgrade QCS CCTV systems to ensure that video footage is automatically recorded and stored for a period of at least 48 hours so that it is available to assist with the investigation of incidents that might occur.*

On 29 October 2020 Recommendation 8 was closed by the Operational Oversight Committee as it was deemed to be fully implemented after receiving advise from the Assistant Commissioner, Infrastructure, Asset Services and Major Capital Works Commands. The advice stated that in all high security facilities CCTV footage is stored for a period of 30 days. Capricornia Correctional Centre has been updated to meet this standard.

171. After considering the response from CCC and QCS to the recommendations in the OCI report I am satisfied that no further recommendations should be made under s 46 in connection with Mr Williams' death.

172. I close the inquest.

Terry Ryan
State Coroner
BRISBANE