CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide and Port Augusta in the State of South Australia, on the 5th, 6th and 8th days of July 2011, the 4th day of October 2011 and the 14th day of November 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Neil Wills Heyward.

The said Court finds that Neil Wills Heyward aged 53 years, late of Port Augusta Prison, Highway One, Stirling North, South Australia died at Port Augusta Prison, South Australia on the 6th day of June 2009 as a result of neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mr Neil Heyward was 53 years of age as at the date of his death at Port Augusta Prison on 6 June 2009. Mr Heyward hanged himself using a sheet and a piece of twine. He had managed to slide the sheet between a bench top in his cell and the shower wall which was adjacent to it. He tied a large knot at one end of the sheet which was caught underneath the bench top, and the remainder of the sheet was hung over the wall of the shower. He then attached a length of twine to the end of the sheet and fashioned that twine into a noose. An autopsy was conducted by Dr John Gilbert, forensic pathologist, at Forensic Science South Australia who gave the cause of death as neck compression due to hanging[1], and I so find.

[1] Exhibit C4a

2. The circumstances surrounding Mr Heyward's death

2.1. Mr Heyward was last seen alive by his cell mate at approximately 2300 hours on 5 June 2009. His cell mate awoke at 0300 hours on 6 June 2009 to use the toilet and it was at that time that he found Mr Heyward hanging in the shower cubicle. He immediately alerted prison staff and attempts were made at resuscitation but without success. Mr Heyward was on remand in the Port Augusta Prison on a charge of murder of Glenys Heyward. Glenys Heyward had been the defacto wife of Mr Heyward for more than 20 years. They had two sons, Matthew and Thomas Heyward.

2.2. Mr Heyward had been in custody since 3 December 2007 having been arrested the previous day after a six hour siege at Beachport in the South East of the State. At the time of his apprehension Mr Heyward was found to have stabbed himself in the left side of the neck and in the upper abdomen. The wound to the abdomen required surgery for a lacerated bowel. Mr Heyward was placed in the Yatala Labour Prison on 10 December 2007 and remained in the infirmary until 17 December 2007 when he was moved into E Division. Thereafter he was seen by a member of the medical staff each day until 27 February 2008. He had a number of ailments including hypertension, high cholesterol and gastroesophageal disease. He also used a CPAP machine for obstructive sleep apnoea.

2.3. Mr Heyward was transferred to Port Augusta Prison on 12 May 2008. In the three months leading up to his death Mr Heyward worked in the prison laundry. The Manager of the laundry, Mr Andrew Couzner who gave evidence at the Inquest, stated that Mr Heyward tended to keep out of the way of other prisoners as he was not getting along well with them. Mr Couzner did not notice any change in Mr Heyward's demeanour in the period leading up to his death. The twine used by Mr Heyward to commit suicide was obtained by him from the laundry.

2.4. I heard evidence from Ms Karen DaCosta who was an Intervention Manager at Port Augusta Prison. Her qualification was in social work. She said that she spoke to Mr Heyward on only one occasion, namely 4 May 2009. At that time Mr Heyward had requested that someone witness his will. Ms DaCosta said that when she was asked to witness Mr Heyward's will she saw that as an indication that he may possibly be planning self-harm. She raised that issue with Mr Heyward and asked him if he was

looking to harm himself. Mr Heyward assured her that he was just updating his paperwork and gave her reassurance that he was not at risk. Ms DaCosta said that she had been asked to witness wills three or four times in the course of her career. She was reassured by Mr Heyward but nevertheless she informed her supervisor and Mr Heyward's caseworker about the matter. She also raised the matter at the following high risk assessment team meeting[2].

2.5. Ms Mary O'Shea was another social worker employed at the Port Augusta Prison. She gave evidence that she first saw Mr Heyward on 19 May 2008. She spoke to him because he was on the high risk assessment team list and he presented as being very sad and lost. However, he denied intentions of self-harm. Ms O'Shea said that Mr Heyward was not a person who volunteered a lot about himself and she had to obtain information from him by asking questions. She assisted Mr Heyward with various matters of concern to him, for example, obtaining eye drops and fish oil. She made phone calls on his behalf. Over time she thought that Mr Heyward had settled. However, on 30 January 2009 he presented as fragile and scared. He reported having been 'stood over' by some prisoners. Ms O'Shea spoke to the prison management about removing Mr Heyward to another unit. When she saw him on 3 February 2009 he was better. She described Mr Heyward overall as being a very unhappy person. She said he would cry a lot. She said that he blamed his wife for what had happened and regarded her as the 'bad person' and himself as the 'good person'[3]. He never said anything to her about self-harm, although she raised the subject on a number of occasions. He always denied that he would do any such thing. Ms O'Shea gave evidence that she did not think Mr Heyward would commit suicide.

2.6. I also heard evidence from Mr Couzner, the correctional officer in charge of the laundry. Mr Couzner gave helpful evidence about the management of the laundry, including a number of suggestions as to improvements that could be made. I hope that the prison management will recognise these helpful suggestions and act on them in due course.

2.7. Finally, I heard from Ms Mann who was a Chaplain at Yatala Labour Prison. Ms Mann gave disturbing evidence of having seen Mr Heyward during a period when he was moved to Yatala Labour Prison in late 2008 and early 2009. At that time Mr

[2] Mr Heyward was on the high risk assessment team list. This meant that his circumstances were considered at meetings of the team on a weekly basis.

Heyward had told her that he was in a relationship with a lady for the first time since the events that led to his incarceration. When Ms Mann saw Mr Heyward on 23 December 2008 she described him as being extremely upset. He said that the woman with whom he had formed a relationship had been asked by her family to sever the connection. Mr Heyward was almost inconsolable as a result. Ms Mann was extremely concerned and, after meeting with Mr Heyward, she decided to raise the matter with some prison officers. It was her view that he was at risk of self-harm. She said that she raised the matter with two officers at the gate immediately after leaving Mr Heyward. She informed one of them that she considered that Mr Heyward needed extra monitoring. She said that another officer then came along and was abusive towards Ms Mann. Ms Mann left the prison. She gave evidence that she felt 'violated' following this episode[4]. She said that she conveyed this episode to the Department for Correctional Services (DCS) representative with the Chaplain service in late February of that year. She claimed also to have raised the matter with Mr Oxford who was the General Manager of Yatala Labour Prison at the time, some three days after Mr Heyward's death. Mr Oxford subsequently made an affidavit[5] in which he denied that any such encounter took place. Furthermore, the DCS representative for the Chaplin Service, Jane Farrin, also made an affidavit denying Ms Mann's allegations[6].

2.8. In the circumstances I am unable to draw any conclusions about this issue and I expressly refrain from doing so.

3. Conclusions

3.1. Having considered the whole of the evidence I am satisfied that there is no evidence to suggest that Mr Heyward's treatment while in Yatala Labour Prison or in Port Augusta Prison was anything other than appropriate, subject to the glaring exception of the physical layout of the cell in which he hanged himself. It is a matter of great concern that in the matter of the Inquest into the death of Brian Keith Dewson[7], State Coroner Chivell had cause to consider a death by hanging in the Port Augusta Prison in circumstances very similar to those that occurred in this case.

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[3] Transcript, page 51
[4] Transcript, page 89
[5] Exhibit C47
[6] Exhibit C48
[7] Inquest 1/2004

4. Recommendations

4.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

4.2. This Court has made a great many recommendations about the need to improve prison cell design by removing ligature points and rendering cells safe. By way of example, I have made recommendations in the matter of John Trenorden[8], in the matter of Arthur Charles Smith[9] and in the matter of the Inquest into the death of Daniel William Barry O'Keeffe[10] in which I reiterated previous recommendations made in Inquests in relation to safe cell practices. Once again, I take the opportunity to make a formal recommendation that safe cell practices be implemented in all prisons in South Australia as a matter of urgency.

Key Words: Death in Custody; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 14th day of November, 2012.

State Coroner

[8] Inquest 2/2007
[9] Inquest 18/2007
[10] Inquest 26/2008