



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 10th day of April 2019 and the 8th day of May 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Steven Malcolm Williams.

The said Court finds that Steven Malcolm Williams aged 31 years, late of Yatala Labour Prison, Peter Brown Drive, Northfield, South Australia died at Northfield, South Australia on the 1st day of January 2015 as a result of acute neck compression by ligature. The said Court finds that the circumstances of his death were as follows:

1. Introduction, reason for inquest and cause of death

- 1.1. Mr Steven Malcolm Williams died at Yatala Labour Prison on 1 January 2015. He was serving a term of imprisonment and accordingly his was a death in custody within the meaning of that expression in the Coroners Act 2003 and this inquest was held as required by section 21(1)(a) of that Act.
- 1.2. An autopsy was performed and the pathologist gave the cause of death as acute neck compression by ligature¹, and I so find.

2. Background and psychiatric history

- 2.1. Mr Williams had a lengthy criminal history and served prison sentences on numerous occasions. His offending dated from 2002. He also had an extensive juvenile conviction history.

¹ Exhibit C2a

- 2.2. Mr Williams was diagnosed with schizophrenic disorder at the age of 18 years and had multiple admissions to James Nash House. For about 12 years he was prescribed antipsychotic medication. He was then prescribed antidepressant medication. At the time of his death Mr Williams had been weaned off all antipsychotics and antidepressant medications for about two and a half months, at his own request.
- 2.3. Mr Luke Williams is employed by the Department for Correctional Services who had involvement with Mr Williams. He described the High Risk Assessment Team (HRAT) and how a referral can be made to that team.
- 2.4. On 3 June 2014 Mr Williams reported to a social worker that he had trauma symptoms flaring up again. The deceased saw Mr Luke Williams, the psychologist, who stated that at that time the deceased was more interested in going for a pharmacological approach by resuming taking antipsychotic medication as he had in the past. At that point Mr Williams referred the deceased to the HRAT meeting on 5 June 2014.
- 2.5. The deceased saw Mr Luke Williams again on 3 November 2014 following a self-harm attempt in his cell on 31 October 2014. Mr Williams was placed in a holding cell pending a transfer to Holden Hill Police Cells. He was found semiconscious on the floor with his prison issued pants tied around his neck. Staff untied the pants, sat Mr Williams up and he began breathing freely.
- 2.6. Mr Williams claimed it was not a serious self-harm attempt, but merely a ploy to avoid being transferred. Furthermore he said he had scared himself by passing out. Mr Williams provided the same explanation to the psychologist in relation to that incident. As a result of that incident, a suicide risk assessment was conducted. That assessment did flag some risk factors, but they were largely static factors such as the psychiatric history, his previous diagnosis of schizophrenia and potential bipolar, which were known risk factors.
- 2.7. Given Mr Williams had denied intending to harm himself, the psychologist formed the opinion that there was nothing to suggest he was at an acute risk of self-harm or risk of further attempts in the next 24 hours. A recommendation was made that Mr Williams was to remain in G Division and to receive ongoing monitoring and remain on the agenda of the HRAT committee.

- 2.8. On the next occasion the deceased saw Mr Luke Williams he again confirmed that the self-harm attempt was to avoid being transferred and he stated he would not try anything like it again because he was worried it might inadvertently lead to his death. He was absolute in his reporting to the psychologist that it was not his intention to die and Mr Luke Williams had no reason to doubt that. Again, following that meeting the recommendation was that Mr Williams continue on the agenda of the HRAT committee.
- 2.9. On 13 November 2014 the committee removed Mr Williams from HRAT monitoring. Mr Williams had also been under the care of psychiatrist, Dr Furst, whom he saw on a number of occasions. Dr Furst was not aware of the suicide attempt by Mr Williams on 31 October 2014. The explanation seems to be that the HRAT team would have called for psychiatric referral if they deemed it necessary, but there was no need as the suicide attempt was not genuine.

3. Mr Williams' death is discovered

- 3.1. At about 7:50am on 1 January 2015 Mr Williams' cellmate, having initially thought he was sleeping on his bunk, realised that he was not breathing. Mr Azaparti had only recently started sharing a cell with Mr Williams. He stated that on the night before his death he had been playing cards with him until about midnight. Mr Azaparti stated that he was perfectly fine when he went to bed. Mr Bugg was the third occupant of the cell. He also stated that the three of them were in the cell and two of them were playing cards. He noted no concerns in relation to Mr Williams.
- 3.2. In the morning Mr Bugg left the cell to obtain his methadone. When he returned to the cell he and Mr Azaparti noted Mr Williams was not responding. The alarm was raised. Correctional officers attended and cleared the cell. They removed Mr Williams from the top bunk and found him with blue prison clothing around his neck. He was non-responsive. CPR was administered until ambulance officers attended and pronounced him deceased.

4. Conclusion

- 4.1. An expert overview was obtained in this matter from psychiatrist, Dr Maria Naso. In her opinion the episodes Mr Williams was having were in keeping with drug induced psychosis. Dr Naso had no criticism of the medication which had been prescribed

throughout his care. She believed he was on appropriate antipsychotic doses. Dr Naso had no criticism of the HRAT team, saying that it reviewed him carefully. Dr Naso was of the opinion Mr Williams' death could not have been prevented, and I agree.

4.2. I have no recommendations to make in this case.

Key Words: Death in Custody; Prisoner; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 8th day of May, 2019.

State Coroner