IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 1468

DECISION BY CORONER WHETHER OR NOT TO HOLD AN INQUEST INTO DEATH

Form 28 Rule 50(1)
Section 52(6) of the ***Coroners Act 2008***

I, Judge Ian L Gray, State Coroner investigating the death of:

Details of deceased:

Surname:	WILLIAMS
Given names:	Carl Anthony
Date of Birth	13 October 1970

have decided not to hold an inquest

for the following reasons:

1. Carl Anthony Williams was 39 years of age at the time of his death. He was the son of Mr George Williams and Mrs Barbara Williams (who died in 2008). Mr Williams married Roberta Williams in 2001 and they had one daughter, Dhakota Williams.

2. Mr Williams was murdered on 19 April 2010 in the Arcacia High Security Unit, HM Prison Barwon where he was serving a sentence of life imprisonment with a non parole period of 38 years for the murders of Jason and Lewis Moran, Mark Malia and Michael Marshall as well as conspiracy to murder Mario Condello. He had previously been sentenced for trafficking a drug of dependency.

3. A post mortem examination was undertaken by Dr Melissa Baker, Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Baker reported that a reasonable medical cause of death was 'Blunt Head Injury'. A toxicology analysis was conducted which was negative for substances.[1]

[1] Dr Linda Iles also prepared a Neuropathological Report

4. Mr Williams was killed by Matthew Johnson who was incarcerated with Mr Williams at the time of his death. Mr Johnson was convicted and sentenced to the murder of the deceased in the Supreme Court of Victoria on 8 December 2011.[2]

5. Following the finalisation of the criminal proceedings in the Supreme Court, the coronial investigation was able to be resumed pursuant to the *Coroners Act 2008* (the Act).[3]

6. The investigating member, Detective Senior Sergeant Stuart Bailey, prepared an extensive brief of evidence (16 volumes), comprising a range of evidentiary material with witness statements, visual material, various Government and agency reviews and reports as well as the criminal prosecution brief and prosecution material.

7. After considering the evidence, I convened a mention hearing on 18 September 2013 to assist me to decide whether I should conduct an inquest as part of my investigation. At this hearing, I invited submissions from any party (at their discretion) which addressed this issue. Submissions were expected to address the following:

   a. how the conduct of an inquest would assist me with the findings required pursuant to section 67 of the Act; and

   b. the possible scope and issues to be explored at an inquest, including any prevention issues.

8. I received two formal submissions. The first was prepared on behalf of the Chief Commissioner of Police (CCP), Corrections Victoria (CV) and Office of Correctional Services Review (OCSR)[4] and was received by the Court on 11 September 2013. The second was prepared on behalf of Mr George Williams and Mrs Roberta Williams[5] and was received by the Court on 18 September 2013.

9. I also received a letter on 12 December 2013 from Ms Bree Stevens, Mr Williams' step-daughter, which I will address as part of my determination.

10. In addition, I allowed the parties to make submissions in reply. Mr Williams' family submitted a reply on 12 February 2014[6] and the CCP, CV and OCSR submitted a reply on 28 February 2014.

[2] Reference: S CR 2010 195
[3] Section 7.
[4] Prepared by Mr Ben Ihle, Counsel for the Chief Commissioner of Police, Corrections Victoria, Office of Correctional Services Review, engaged by VGSO.
[5] Prepared by Spicer Lawyers.
[6] Prepared by Mr Dyson Hore-Lacy SC

Application of the Law

11. A coroner may hold an inquest into any death being investigated pursuant to section 52(1) of the Act (referred to as a discretionary inquest). The Act also outlines circumstances were an inquest must be conducted, such as where the coroner suspects the death was the result of homicide [section 52(2)(a)] or where the deceased was, immediately before death, a person placed in custody or care [section 52(2)(b))] (referred to as mandatory inquest).

12. If, however, a person has been charged with an indictable offence in respect of the death, section 52(3)(b) provides that it is no longer mandatory for a coroner to conduct an inquest as part of the investigation.

13. The death presently under investigation was clearly the result of a homicide and the deceased was in custody at the time of his death. However, as a person was charged with an indictable offence with respect to the death, an inquest is not mandatory in accordance with the Act.

14. I am therefore required to consider whether it is appropriate to conduct an inquest as part of my discretion. I note that there are no guidelines in the Act with respect to the exercise of this discretion. However, a coroner must exercise this discretion in a manner consistent with the preamble and purposes of the Act.

15. I note that the preamble of the Act states that the purposes of a coronial investigation are (as it relates to a death):

    (a) to find the causes of a death;

    (b) to contribute to the reduction of the number of preventable deaths; and

    (c) to promote public health and safety and the administration of justice.

16. I further note that Section 8 of the Act provides as follows:

    When exercising a function under this Act, a person should have regard, as far as possible in the circumstances, to the following—

    (a) that the death of a family member, friend or community member is distressing and distressed persons may require referral for professional support or other support;

(b) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death;

(c) that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected;

(d) that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation;

(e) that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information;

(f) *the desirability of promoting public health and safety and the administration of justice.*

17. In addition, section 9 of the Act provides:

The coronial system should operate in a fair and efficient manner.

18. Pursuant to section 7 of the Act, the Parliament has also directed that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. This section is particularly relevant to this investigation, as will be discussed below.

Findings and purpose of an inquest

19. Section 67(1) of the Act requires that, in relation to a reportable death, the coroner must find if possible, the identity of the deceased, the cause of death and '*the circumstances in which a death occurred*' (unless section 67(2) applies[7]).

20. The purpose of an inquest is to establish the findings required by sections 67 of the Act and to make such comments or recommendations as are appropriate in the circumstances of the case.

21. The precise scope of an investigation into the '*circumstances in which the death occurred*' depends on the facts of the case. In general, a coroner will **not** need to investigate events that did not cause or contribute to the death.

22. In deciding whether to conduct an inquest, a coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to

[7] This section is not relevant in this matter.

justify the use of the judicial forensic process; whether there is a likelihood that an inquest will uncover important systemic defects or risks not already known about and the likelihood that an inquest will assist to maintain public confidence in the administration of justice or services, or other public agencies.

Section 71 of the Act

23. Section 67 of the Act is subject to section 71 which provides that findings are not required if the decision to hold an inquest (or discontinue an inquest) is based on the fact that a person has been charged with an indictable office in respect of the death and, because of this, the making of findings would be considered inappropriate in the circumstances. There is no exception to this provision because a person dies in custody. This is clear from a plain reading of the provision.[8] In any event, section 71 would come into effect regarding the finding in relation to the death of Carl Williams, upon a decision not to hold an inquest and does not apply to my decision-making process at this time.

Submission and Reply from Mr George Williams and Mrs Roberta Williams

24. The Submission and Reply on behalf of Mr George Williams and Mrs Roberta Williams (referred to as the Family Submissions) contended that an inquest should take place as part of my investigation into Mr Williams' death.

25. With respect to the application of the law, the Family Submissions agreed that the determination of whether I should conduct an inquest was an exercise of my discretion and, with the matters I proposed as being appropriate to take into consideration when exercising that discretion, with one exception. An additional ground was proposed and expressed as either: *'The public interest and need for a public hearing'* or *'Has there been a sufficient, or any, public hearing in relation to the death of Mr Williams.'* I disagree with this part of the submission, as it is articulated. With respect to *the public interest and the need for a public hearing*, the public interest is clearly an integral aspect of many of the matters I have (and must) consider as part of my determination, such as maintaining public confidence in government institutions or drawing lessons from deaths to minimise the risk of recurrence. As to the sufficiency or absence of a public hearing as a discrete ground for consideration, the Act clearly states the circumstances when an inquest (or public hearing) is mandatory.

[8] This position was asserted in the Reply from the family. I agree with the submissions of the CCP, CV and OCSR regarding the law on this matter.

26. The Family Submissions state that whilst a criminal trial had taken place, an inquest was required to explore the following issues:

- *How it was that, although video monitored, and conducted in an environment in which a number of prison officers were present, the murder was not observed;*[9]
- *How it was that no one in authority was aware that Mr Williams had been attacked until an approximate period of 30 minutes after information was given to prison officers, and after Mr Williams' body had been dragged into a cell, again, apparently unobserved;*[10]
- *How it was that no precautions were set in place to protect Mr Williams after authorities received a number of warnings that Mr Williams' life was in danger;*[11]
- *How was it that no protection was given to Mr Williams after a Herald Sun front page article reporting that police were paying private schooling fees for Mr Williams' daughter, and the other matters which would cause members of the community to be aware that Mr Williams was cooperating with police in a significant matter or matters;*[12]
- *How was it that Mr Johnson had a copy of Mr Williams' statement implicating Paul Dale in the murder of Terrence Hodson, a police informant at the time, on his computer two days before the murder;*[13]
- *How was it that Mr Johnson had access to a lethal weapon in the form of part of an exercise bike, in particular within the circumstances where there were allegations that Mr Johnson had assaulted a prisoner in a similar way before;*[14]
- *The decision to place Mr Williams and Mr Johnson together in the circumstances;*[15]

[9] Expressed in question 1 in the Reply

[10] Also refer to question 2 and 3 in the Reply as well as question 2 of 'broader issues',
[11] Also refer to question 4a in the Reply
[12] Also refer to question 4b in the Reply
[13] Also refer to question 5 in the Reply

[14] Also refer to in question 6 in the Reply
[15] Also refer to questions 7, 8 and 9 in the Reply as well as questions 1 and 3 of 'broader issues' generally referred to as placement issues.

- *Whether there was a relevant connection between Mr Johnson and Mr Dale, especially in the circumstances where witnesses implicating Mr Dale, a police officer, had been murdered (Mr Williams had also implicated Mr Dale); and*
- *The source of the Herald Sun article and the circumstances leading to the relevant publication.*[16]
- *Should Mr Williams have been removed from prison to speak to Victoria Police?*
- *Was Mr Williams involved in a witness protection program, and it so, how did it operate?*
- *When Mr Williams was removed from prison to speak to Victoria Police, what mechanisms (if any) were in place to prevent other inmates from learing about the assistance?*

27. The above list was not expressed as being exhaustive.

28. I note that the Family Submissions do not acknowledge section 7 of the Act which says I should liaise with other agencies to avoid duplication of investigations. Rather, it says that other investigations should not be a 'substitute' for a coronial investigation, including an inquest. In my view, this analysis fails to consider the requirements of section 7, where they are properly applied by a coroner.

Submission and Reply on behalf of the Chief Commissioner of Police, Corrections Victoria and Office of Correctional Services Review

29. The Submission and Reply on behalf of the CCP, CV and OCSR (referred to as the CCP, CV and OCSR Submission) was that my investigation into Mr William's death should not include conducting an inquest.

30. The CCP, CV and OCSR Submission stated that:

The holding of an inquest in the present circumstances runs contrary to the Act and established principles which guide the exercise of the discretion and the limits of the Coroner's powers and functions. Accordingly, it is submitted that a decision to hold an inquest would:

a. Result in unnecessary duplication of inquiry and investigations:

b. Delay (as opposed to expedite) the investigation of the Death;

[16] Also refer to 'broader issues' question 4 in the Reply.

c. *Be inefficient with respect to the coronial process, especially when the relative costs and benefits of conducting an inquest are compared to those of not conducting an inquest;*

d. *Unnecessarily protract the investigation into the Death and potentially exacerbate the distress of those affected by the Death; and*

e. *Run contrary to the objective and express intention of the legislature evinced in the Act.*

31. The CCP, CV and OCSR submission further stated that:

'a vast amount of material already exists concerning investigations and inquiries into the specific and systemic issues concerning the Death which will be available to the Coroner. The investigations already conducted have been undertaken by appropriate and authorised authorities and the Act envisages that the Coroner liaise with such authorities so as to further the objectives of the Act. ...

All relevant findings with respect to the Act can, and should, be made on the material already available. The identity of the deceased, the cause of death and the circumstance surrounding the Death are all clear from the material available. It is difficult to envisage a case where such clarity would be greater, or where the holding of a prolonged inquest would be a more inefficient use of resources.'

32. In addition it was the position of the CCP, CV and OCSR that it is not the function of a Coroner to inquire into '*the underlying responsibility for each circumstance that may have contributed to a death...and that some of the issues identified in the Williams' submission...are impermissibly broad for the coronial jurisdiction.'*

Investigations into the death of Carl Williams

33. I note the following investigations have been undertaken regarding Mr Williams' death:

a. Supreme Court trial of Matthew Johnson following an extensive police investigation leading to the identification of only one suspect in the death;[17]

b. Victoria Police Driver Taskforce review charged with (amongst other matters) investigating the murder of Carl Williams, examining policing processes and systems employed in the management of human sources and witnesses in custody; examining processes and systems that existed within the prison system, particularly

[17] *Queen v M Johnson* [2011] VSC 633

in regards to the management of witnesses in custody; and examining media reports relevant to Carl Williams and other high risk and custodial witnesses, and the potential affect that these articles had on his death;[18]

c. The coronial investigation which produced a brief of evidence (as noted above), compiled by the investigating member, Detective Senior Sergeant Stuart Bailey. The investigating member was part of the Victoria Police Driver Taskforce and the investigation reports (including recommendations) of the Driver Taskforce have been provided as part of the inquest brief;

d. Reviews of the Office of Correctional Services Review (OCSR). These documents are not publically available but have been provided as part of the inquest brief and were made available to other investigative agencies including the Victorian Ombudsman;

e. Office of Corrections reviews. These are internal reviews (examining Major Offenders Unit, Correction Victoria Intelligence Function, Custodial Permits, Security Monitoring System Upgrades and High Security Accommodation – Infrastructure Options) are not publicly available but have been provided as part of the inquest brief;

f. Victorian Ombudsman – *the death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria* (April 2012);

g. Victorian Ombudsman, *Investigation into an alleged corrupt association* (October 2012). This investigation dealt with an email which was sent four days after the death of Carl Williams, setting out information apparently received by an interstate integrity body referring to an alleged corrupt association between unidentified officers of a Victorian public sector agency and a Victorian criminal identity, suggesting that the association may in some way be related to the death. The Ombudsman found that the email was not investigated by Victoria Police and three recommendations were made. The report is available on the Victorian Parliament website; and

h. The Office of Police Integrity[19] investigated matters relevant to the Victoria Police Processes, management and adequacy of its processes and practices as relevant to

[18] I was advised that the Driver Task Force conducted 34 investigations, 16 intelligence probes, a review of 40,000 prison ARUNTA telephone calls, a review of 3,000 prison letter, a review of 20,000 prison reports, processed 600 information reports and completed 1,217 intelligence tasks.

their management and handling of Carl Williams. This is a **restricted** report which was provided to me[20] and I considered in my determination. I make no further reference to this report in my determination.

34. I propose to refer, where appropriate, to details of some of these investigations. As noted above, section 7 of the Act provides that I should liaise with other investigative authorities, official bodies or statutory officers, in order to expedite the investigation and to avoid any unnecessary duplication.

Supreme Court trial of Matthew Johnson

35. On 29 September 2011, Matthew Johnson was convicted of murder following a plea of not guilty and a lengthy trial. Justice Lasry described the circumstances leading up to the murder as follows:

'Williams had made two statements to police about the murder of Mr and Mrs Hodson. The first was made in 2007. That statement was mainly to do with the corrupt relationship between Dale and Williams. In the second statement, made on 19 January 2009, Williams incriminated himself, Dale and Collins in the murder of the Hodsons. He made a third statement on that same date which reflected him having listened to some telephone intercept material.

The statements that Carl Williams made in January 2009 about the Hodson killings were based on discussions that he had with investigating police in late 2008. To facilitate those discussions, Carl Williams was taken away from the prison for some days. As a result of his statements, charges of murder were laid against Paul Dale and Rodney Collins.

He told his father, George Williams, that he had explained to [Johnson] *that he was talking to investigators about police corruption. Carl Williams clearly wanted* [Johnson] *to believe that he was not going to give evidence about other prisoners. He also told his father on a number of occasions prior to his death that he had been keeping*

[19] As of 11 February 2013, the Office of Police Integrity functions were transferred to the Independent Broad-based Anti-corruption Commission.

[20] As a result of a Supreme Court determination

[Johnson] *informed of what he was doing with police, and it is clear to me that he did that because he was concerned about how* [Johnson] *would respond.*

From then until his death in April 2010, Williams spent a lot of time in [Johnson's] *company. How the prison authorities permitted that to happen is beyond me. No matter what* [Johnson], *Ivanovic or Carl Williams said or thought about his prison circumstances, on any view* [Johnson was] *a threat to his welfare as long as he was on the record as a Crown witness against Dale and Collins.*

On 28 February 2010, Williams was again removed from Barwon Prison for a short time to meet the prosecutors for the criminal proceedings for the case against Dale and Collins. He was described in the evidence as being hesitant about doing this and was worried about how it would be perceived by other prisoners and, in particular [Johnson's] *response. George Williams gave evidence that Carl Williams had again explained to* [Johnson] *what he was doing, and that he continued to be concerned about leaving the prison.*

In March 2010, several phone conversations in which [Johnson] *participated recorded by prison authorities which demonstrate that* [Johnson] *had an interest in what was happening with the committal proceedings against Dale and Collins....*

On 5 March 2010, police provided Carl Williams with an electronic copy of the statements that he had made about the Hodson murders. On 6 March 2010, an electronic version of those statements was downloaded on to [Johnson's] *computer in* [his] *cell....*

The records from [Johnson's] *computer illustrate that the last time* [Johnson] *accessed the statements made by Carl Williams was on 17 April 2010, two days before* [Johnson] *murdered him. ..*

The evidence also demonstrates ...that [Johnson was] *either the leader, or a leader, of a group of prisoners known as the 'Prisoners of War'. One of the group's important principles is the hatred of anyone, particularly any prisoner, who co-operates with police and informs against any person charged with criminal offences. Carl Williams knew about* [Johnson's] *position in that group and his concern about* [Johnson] *knowing that he was assisting police is entirely understandable in that context.*

...I am satisfied that [Johnson] *believed there was a realistic chance that Williams would give evidence in accordance with his second and third statement against both Dale and Collins, and that* [Johnson] *could not be seen to sanction him doing so.*

The coronial investigation and the brief of evidence

36. The Coronial brief of evidence noted the following circumstances of the death on 19 April 2010, including the death as observed on CCTV.

On the 19th April 2010 the Herald Sun Newspaper published an article relating to the deceased and his former wife Roberta WILLIAMS. The article ran on the front page, and page four, and disclosed that taxpayers were to pay $8000 for the private school fees for the deceased's daughter, Dhakota; and $750,000.00 for a tax bill of his father George WILLIAMS.

At 8.30am the deceased, IVANOVIC and JOHNSON were all released from their cells into a communal exercise room called the Day Room in Acacia Unit One.

At 8.50am the deceased contacted Detective Inspector Steve SMITH from the Victoria Police Taskforce who, at the time, was attending a training course and unable to take the call. Detective Inspector Steve SMITH sent an SMS to George WILLLIAMS stating that he would attend at the HM Prison Barwon to see the deceased on the Wednesday 21st April 2010.

At 9.00am the deceased rang Roberta WILLIAMS, Roberta WILLIAMS states:

- *that they had a small disagreement on the phone about her going to an appointment with a magazine when the deceased wanted to keep talking;*
- *that the deceased seemed a bit agitated about something, but he did not mention any problems.*

At 9.20am the deceased rang his Barrister Shane TYRRELL in relation to the tax issue of his father George WILLIAMS. Shane TYRRELL states:

- *that the deceased expressed concern that part of the original benefits for him giving information to the police was that the police would settle the tax debt of his father George WILLIAMS. This arrangement had fallen through for legal reasons;*

- *that the deceased made no mention of any media articles, nor did he express any concerns about JOHNSON or IVANOVIC;*
- *that the deceased was concerned about information being leaked to the media even though it was suppressed.*

At 9.26am the deceased rang his Solicitor Robert STARY in relation to the news article that was in the Herald Sun that morning. Robert STARY states:

- *that the deceased sounded perfectly relaxed and did not seem terribly worried by the newspaper article, other than the impact it could have on his daughter and him;*
- *that a number of people were concerned about the deceased providing information to police, and that his movements outside the prison were seen as special treatment.*

At 9.40am the deceased rang a family friend...[She] *states the deceased did not mention that he was worried about anything.*

At 10.10 am George WILLIAMS visited the deceased at HM Prison Barwon and remained with him until 11.50am. George WILLIAMS states that they spoke about general things, but mostly about the Herald Sun Newspaper article.

At 11.40am, after the visit with George WILLIAMS, the deceased was escorted back to Acacia Unit One. Prison Officer Brendan BUTLER states that the deceased showed no apparent concerns at that time.

Acting General Manager of the HM Prison Barwon Nick Selisky states that he was aware of the article in the Herald Sun Newspaper...on 19th April 2010.

He asked the Operations Manger Gavin MARTIN to check with the deceased as to whether any concerns existed. No concerns were passed onto the Prison Staff by the deceased when approached and he is said to have appeared to be in good spirits.

The murder

The following events were captured on CCTV footage of the Day Room in Arcacia Unit One and clearly depict the events leading up to the deceased being murdered:

a. *JOHNSON removes the seat and stem of an exercise bike (hereafter referred to as the murder weapon) in the Day Room and secrets it in his individual cell;*

b. *JOHNSON then returns to the Day Room and sits down at a table with the deceased and IVANOVIC and has a conversation. There does not appear to be any animosity between the deceased, IVANOVIC and JOHNSON at this time;*

c. *the deceased, IVANOVIC and JOHNSON walk out to an external exercise yard of Acacia Unit One and return;*

d. *the deceased sits down at a table in the Day Room with his back to the cell block of the unit and continues to read a newspaper;*

e. *JOHNSON returns to his individual cell, covers the murder weapon with a white towel and carries it into the individual cell belonging to IVANOVIC;*

f. *JOHNSON removes the white towel used to cover the murder weapon and takes the towel to the laundry area;*

g. *JOHNSON returns to IVANOVIC'S individual cell;*

h. *JOHNSON exits IVANOVIC's individual cell armed with the murder weapon;*

i. *JOHNSON approaches the deceased from behind while he is still sitting at the table reading the newspaper;*

j. *at 12.48pm JOHNSON strikes the deceased to the right side of his head with the murder weapon, knocking the deceased off his chair onto the ground, face first;*

k. *JOHNSON then strikes the deceased with the murder weapon a further seven times to the head area;*

l. *the accused takes the murder weapon to the laundry area of the Acacia Unit One;*

m. *JOHNSON returns to the Day Room and places a white towel over the head of the deceased;*

n. *JOHNSON leaves the Day Room again;*

o. *JOHNSON returns to the Day Room, approaches the deceased and dragged him by his ankles into the deceased's individual cell and closes the door;*

p. *JOHNSON then places a white towel over the pool of blood left where the deceased had been lying.*

At about 12.54pm IVANOVIC uses the phone in Acacia Unit One to ring his sister...IVANOVIC informs her that he can't talk for too long as something has

happened, and that JOHNSON has just gone crazy … IVANOVIC says that he thinks it may be a murder, but he himself is safe.

At 12.58pm IVANOVIC uses the phone in Acacia Unit One to ring an associate...IVANOVIC informs him that the deceased is dead and that JOHNSON went crazy. [He] *tells IVANOVIC to tell the Prison Officers and to help the deceased ...*

JOHNSON and IVANOVIC then walk laps of the exercise yard and enter the Day Room several times until JOHNSON gains the attention of a Prison Officer.

At 1.15pm Prison Officer Suzette GAJIC states that whilst getting a trolley from the storage area adjoining the exercise yard of Acacia Unit One, JOHNSON and IVANOVIC approached her. JOHSNON tells her that she should press her button as the deceased had hit his head.

Prison Officer Suzette GAJIC raised the alarm and directed other Prison Staff to the area as she opened the gate. Several Prison Officers entered the Acacia Unit One and located the deceased in the individual cell, number 2, with extensive head injuries.

Both JOHNSON and IVANOVIC were calm at this time and advise the Prison Staff not to let any female officers in.

At 1.16pm a 'Code Black' was called and the Emergency Control Centre was opened within the HM Prison Barwon. Prison Officers and nursing staff rendered medical assistance to the deceased. Ambulance and police were notified.

JOHNSON and IVANOVIC were secured in separate cells and their clothing seized.

The deceased was unable to be revived and was pronounced dead shortly after the ambulance officers attended.

37. It is unusual for a death to be captured visually in such a comprehensive manner, as was in this case. This has allowed me to view and consider the images first-hand.

Victorian Ombudsman – *The death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria – April 2012*

38. The Victorian Ombudsman – *The death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria – April 2012* (refer to as the Ombudsman's Report) is publicly available. It is a comprehensive report which noted that the death: '*raises important questions as to how it is possible that a high profile prisoner in Victoria's highest security prison unit could be killed with an unsecured metal pipe from an exercise bike, and that prison staff did not find out about the incident for some 27 minutes. This raises*

important concerns about the monitoring systems in place at Barwon Prison.' The Ombudsman examined Mr Williams' management, including the decision to place Mr Williams with Mr Johnson, as well as the OCSR's investigation into his death.

39. I will not repeat or attempt to summarise the entire investigation, because it is publicly available, but I note the following:

- With respect to the placement of Mr Williams with Mr Johnson:

  'As Acting Commissioner [Mr Rod Wise] *should have exercised caution and not recommended that Mr Johnson could be placed with Mr Williams. In my view, the placement decision relied too much on: police advice; Mr Williams' perception of his own safety; and his wish to be accommodated with Mr Johnson. It gave too little weight to knowledge Corrections Victoria had about Mr Johnson that mitigated against the co-placement request...The statutory duty of Corrections Victoria was to protect Mr Williams. I consider that Corrections Victoria failed in its objectives to protect Mr Williams from real and appreciable danger both in January 2009 and subsequently.'*

- With respect to the monitoring of the placement:

  '...Corrections Victoria's monitoring of the placement either failed to identify the warning signals or, where alerts were raised, responded in a way that demonstrates a failure to apprehend the significance of these events and the danger Mr Williams faced from Mr Johnson.'

- With respect to access to the murder weapon:

  'The metal bar used by Mr Johnson to kill Mr Williams was removed from the set section of the exercise bike. It was unsecured. This was despite a similar piece of equipment having been used in a violent assault in Barwon Prison in the past, in which Mr Johnson was involved.'

- With respect to the failure to observe the killing via the CCTV system and the failure to discover the incident until 27 minutes later:

  'The CCTV system in the Acacia Unit was unfit for purpose...Repeated complaints about the CCTV system had been made over several years by officers prior to Mr Williams' death, but no action was taken to remedy it.'

- With respect to the failure to implement the Comrie Review, which resulted in 32 recommendations being made concerning the improvement of Corrections Victoria's intelligence systems and processes:

  'I consider that Corrections Victoria's failure to implement the recommendations of the Comrie Review had an impact on the safety of Mr Williams.'

- With respect to access to Mr Williams' legal documents:

  'there was no procedure in place to control a prisoner's ability to access legal documentation. If prisoners have unrestricted access to each other's legal documentation, this can breach confidentiality obligations in relation to legal material, or endanger witnesses: for example, police informers who are named in court documents.'

40. The Ombudsman's Report made a total of 57 recommendations arising from the death and, on request, I was provided with an update on the implementation of those recommendations. 55 of the 57 recommendations have been endorsed as fully implemented or closed.

Letter from Ms Bree Stevens

41. As noted above, on 12 December 2013, I received a letter from Ms Bree Stevens which I have treated as a request for an inquest. Her correspondence suggested that my decision whether or not to conduct an inquest into her step-father's death would be influenced by his criminal history for which he was incarcerated and that, consequently, his death would be treated in a manner different to any other 'Australian citizen'. I wholly reject this suggestion. In determining whether or not to hold an inquest into his death, I have not considered Mr Williams' personal or criminal history. I have considered Mr Williams' incarceration only as was directly relevant to the issue of whether issues of Mr Williams' management while incarcerated required investigation by inquest.

42. I also note that Mr Williams' death is one of the most investigated incidents in Victoria's history.

Import of the Reviews/Investigations

43. Having considered the above-noted investigations and reviews,[21] I consider that the matters raised in the Williams family's submission have already been the subject of extensive and

[21] Coronial, criminal, Victoria Police Driver Taskforce, OCSR, Corrections Victoria, Ombudsman's Victoria and the Office of Police Integrity,

comprehensive investigation or investigations. This does not mean however that all the matters raised would necessarily be within the proper scope of a coronial investigation. In this context, I have previously noted the findings I am required to make under section 67 of the Act and that in general a coroner is not required to investigate matters that did not cause or contribute to the death. I further note that a coroner must keep the investigation within reasonable bounds.

44. I note that the Ombudsman's Report considered prisoners' access to media, including newspapers, and that the media had reported for some time that Mr Williams was assisting police in exchange for certain things. I further note that the Taskforce review examined issues with respect to the media and the operation of suppression orders.

Ruling

45. I have considered the Williams family's wishes in reaching my decision, although I note that consideration of their views is by no means determinative on this issue. I acknowledge that Mr Williams was a much loved family member.

46. I have considered the coronial brief of evidence, all the submissions of parties, their replies and, as noted above, the outcomes of the numerous other investigations conducted into Mr Williams' death.

47. I note that the focus of a coronial investigation is to determine circumstances, not to ascribe guilt, attribute blame or apportion liability. I also note that it is not the role of a coroner to ensure that recommendations are implemented.

48. I am satisfied that the identity of the deceased, cause and circumstances of death can be established without holding an inquest.

49. In addition, there are no submissions that allow me to conclude that there is a systemic defect which requires examination by inquest and which has not been addressed by the appropriate investigatory agencies or government bodies. (I note that a number of these agencies' or bodies' investigation documents are publicly available.) Even if this was not the case, case law provides that a coroner should not call evidence for the sole or dominant purpose of making comment.[22]

[22] *Thales Australia v Coroners Court (Vic).*

50. The Act does not provide specific guidance regarding my discretion for deciding whether or not to hold an inquest. I have considered the preamble, purposes and objectives of the Act generally, as well as sections 7, 8 and 9 of the Act.[23] I have also had regard to section 67 provisions.[24] I have not identified a legitimate coronial purpose that is likely to be served by holding an inquest.

51. In the circumstances, pursuant to section 52(6)(b), I have decided not to hold an inquest into the death of Carl Williams.

Signature:

JUDGE IAN GRAY
STATE CORONER

Date: 9/4/2014

NOTE: *Under section 82 of the* ***Coroners Act 2008*** *if a coroner determines not to hold an inquest into a death, the person who requested the coroner to hold an inquest into the death may appeal against the coroner's determination to the Supreme Court within 3 months after the day on which the determination of the coroner is made.*

[23] Section 7 – Avoiding unnecessary duplication; Section 8 – Factors to consider for the purposes of this Act; Section 9 – Fairness and efficiency of coronial system.

[24] Findings of coroner investigating death.