QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Dylon James Ahquee**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Townsville
FILE NO(s):	COR 2015/5131
DELIVERED ON:	24 May 2021
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 September 2019; 10 February 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, suicide of young prisoner, transition from youth justice to adult prison, information sharing, hanging, whether death was suspicious, risk assessment.

REPRESENTATION:

Counsel Assisting:	Ms Rhiannon Helsen
Queensland Corrective Services:	Miss Emily Cooper, Crown Law, instructed by QCS
Townsville Hospital and Health Service:	Mr David Schneidewin, instructed by Corrs Chambers Westgarth
Department of Communities Youth Justice and Multicultural Affairs	Ms Karen Carmody, instructed by DCYJMA

Contents

Introduction

1. Dylon James Ahquee was just 19 years of age when he died in protective custody at the Townsville Correctional Centre (TCC).

2. On 26 December 2015, Dylon was found hanged from a bed sheet tied to the exposed bars above the cell door in a shared cell. Despite assistance rendered by Custodial Correctional Officers (CCOs), prison nursing staff, and Queensland Ambulance Service (QAS) officers he was unable to be revived.

3. While Dylon had a substantial youth justice history for which he had been detained on multiple occasions, the term of imprisonment he was serving at the time of his death was his first significant period in adult custody. He was eligible for parole on 18 April 2016.

The inquest

4. The primary purpose of an inquest is to inform the family and the public about the matters required by s 45 of the *Coroners Act 2003*, including how the person died and what caused the death. An inquest is not an adversarial process in which the coroner makes determinations of civil or criminal liability. Whenever appropriate, a coroner can comment on anything connected with the death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances.

5. At a pre-inquest conference on 19 September 2019, the following issues for the inquest were determined:

    i. The findings required by s 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death.

    ii. Confirm whether any third party contributed to Mr Ahquee's death.

    iii. Determine whether the authorities charged with providing for Mr Ahquee's mental health and physical care at the Townsville Correctional Centre prior to his death adequately discharged those responsibilities.

    iv. Whether sufficient information was shared in relation to Mr Ahquee between juvenile detention centres, Youth Justice and Townsville Correctional Centre upon entering adult custody.

v. Consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or other contribute to public health and safety or the administration of justice.

6. The inquest into Dylon's death was scheduled to be held in Townsville in April 2020 but was adjourned due to Covid-19 restrictions. The inquest was subsequently held at Brisbane on 10 February 2021.

7. As Dylon was in custody when he died, an inquest was required by the *Coroners Act 2003*. A brief of evidence, which included numerous statements, relevant records, audio and video exhibits, photographs and other materials gathered during the coronial investigation was tendered at the commencement of the inquest. Four witnesses were called to give evidence:

- DSC Brendan Anderson
- Mr Dylan Ludlow
- Correctional Supervisor Geoff Pollard

- QCS Deputy Commissioner Peter Shaddock

8. I am satisfied that all relevant materials were placed before me to enable the necessary findings to be made.

The evidence

Personal history

9. Dylon was of Papuan descent but did not have a strong connection to that culture. He was one of five children and had an extremely prejudicial childhood. His father died suddenly while his mother was in final stages of her pregnancy with Dylon. He was born with a cyst on his lower back and was diagnosed with Spina Bifida at around six months. His mother reported that she found it very difficult to manage the special needs flowing from his health issues. Consequently, he was first placed away from his mother at nine months of age.

10. Child Safety records indicate that Dylon experienced chronic prolonged exposure to traumatic events within his family from a young age. As a result, he had considerable involvement with the Department of Communities, Child Safety and Disability Services (the Department). He was in the care of that Department from the age of seven until he reached 18 years.

11. During that time, Dylon experienced over 60 changes in placement including foster care, residential care, youth shelters and juvenile detention. Disruptions in these placements usually occurred after caregivers reported they could no longer to cope with his behaviour.

12. After Dylon reached adolescence his Spina Bifida continued to adversely affect his overall functioning. He exhibited complex behavioural issues centred around violence and sexualised behaviour towards other children and adult carers.

13. A psychological report prepared in 2012 noted that Dylon appeared to have been largely placed in settings ill-equipped to manage his complex needs and extensive behavioural difficulties. "*Despite posing a clear risk to other children, he continued to be placed in high risk environments characterised by insufficiently trained staff, or supervision and monitoring, and access to vulnerable children and youth and he appeared to have capitalised on opportunities to persistently engage in multiple forms of abusive behaviour*".[1] He was reported to have no significant adult attachments. His primary relationships were with other antisocial youth or youth in care.

14. While Dylon was in care, there were five reported incidents of self-harm and suicidal ideation including attempts to run out in front of a car while making himself absent from school. In October 2007 he disclosed to another child that he had attempted to self-harm that day, and he had been found with a rope.

15. Dylon was provided with various health assessments and supports with respect to various medical conditions, although predominantly focused on issues associated with his diagnosis of Spina Bifida.[2]

16. Between 2002 and 2004, Dylon engaged with CYMHS. He received assistance and support for 'Unspecified behaviour and emotional disorder' and 'Developmental disorder of scholastic skills'. However, towards the end of intervention it was reported that he was no longer forthcoming in counselling sessions or responsive to therapeutic intervention.[3]

17. Dylon was also provided with intensive psychological support through various private psychologists while in care. Short periods of improved behaviour and relationship engagement were noticed. However, this was unable to be maintained, regardless of support and intervention. In 2010, Dylon had engaged with a psychologist where attempts were made to provide support to reduce negative behaviours to prevent the future risk of detention. Due to several missed appointments, that referral was closed in December 2010.

18. In October 2011, a comprehensive risk assessment report was compiled by North Queensland Adolescent Forensic Mental Health with whom Dylon had previously engaged. He was diagnosed with Reactive Attachment Disorder of Childhood, post-traumatic stress disorder and conduct disorder (unspecified).

19. Despite his reluctance to engage, the Department continued to seek psychological advice and support for Dylon up until he turned 18 years.[4]

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[1] Exhibit H9.
[2] Ex B29, [17] – [21].
[3] Ex B29, [21].
[4] Ex B29, [40].

20. In terms of assisting Dylon to transition into adulthood, the Department provided him with extensive support and case planning with respect to housing, education, training and life skills. This commenced when he was 15 years of age and continued until he was 18.[5]

21. Mental health records indicate that Dylon had a significant history of exhibiting challenging behaviours, such as extreme attention seeking, destruction of property, risk-taking behaviour and aggression towards children and adults.[6] A referral to Evolve by the Department in 2010 notes that Dylon was presenting with *'increased aggression and sexualised behaviours'.*[7] He had reportedly physically and sexually assaulted and threatened youth workers, sometimes with weapons.

22. Dylon was first referred to CYMHS in 2003 at the age of seven.[8] He had engagement with that service on and off since that time, with assistance sought by different foster carers.[9] He had an EEO in 2007, which was closed the following day. In 2008, Dylon reportedly took knives to school and threatened to kill himself.[10] He had previously been prescribed Epilim for '*explosive temper outbursts'* but this did not change his behaviour.

23. It is clear from records that Dylon had intense and ongoing engagement with various services, who tried to assist in managing his difficult sexualised and aggressive behaviours. Unfortunately, it appears that these behaviours continued to intensify and worsen. Plans were often put in place while Dylon was in detention or care to protect workers and fellow young people.[11]

24. In a progress note made during an appointment with Evolve Therapeutic Services in July 2011, while Dylon was in youth detention, he indicated that if he was returned to a previous placement he would take his own life by way of an overdose or driving a car into a tree.[12] It was further noted that he had '*past attempts of deliberate self-harm by using razor blades*'.[13]

25. In 2012, it appears that Dylon's engagement with Evolve was closed for a myriad of reasons, including his location and '*his refusal to actively participate in any form of assistance*'.[14]

26. Dylon was subsequently referred to NQAFMHS, with an intake completed in May 2012.[15] Assistance was sought in relation to developing coping

[5] Ex B29, [49] – [72].
[6] Ex C.2, pg. 4 & 5.
[7] Ex C.2, pg. 5.
[8] Ex C.2, pg. 15.
[9] Ex C.2, pg. 25.
[10] Ex C.2, pg. 15
[11] Example at Ex C.2, pg. 83, *Interim Behaviour Management Plan.*
[12] Ex C.2, pg. 56.
[13] Ex C.2, pg. 56.
[14] Ex C.2, pg. 188.
[15] Ex C.2, pg. 212-216.

mechanisms and substance misuse. that there was some difficulty with Dylon actively engaging in the service.[16]

Youth Justice History

27. Dylon had a long-term engagement with Youth Justice (YJ) commencing when he was 13 years of age having been sentenced to a community-based order by the Childrens Court at Townsville. Casework and case management responsibilities commenced at that time and remained solely with the Townsville North Youth Justice Service Centre.

28. In terms of self-harm, three risk alerts were recorded by YJ, which correlate with those noted by the Department on 15 May 2007, 30 October 2007 and 19 May 2014.[17] In conjunction with the Department, Dylon was provided with various psychological interventions that included engagement with various private psychologists. Ultimately, he was diagnosed with Post-Traumatic Stress Disorder and Reactive Attachment Disorder, as well as significant concerns around sexualised behaviours.[18]

29. During the time Dylon was in care, there was collaboration and information sharing between YJ, Cleveland Youth Detention Centre, the Department and the various placement providers.[19]

30. In terms of information sharing with Probation and Parole Services, it was noted that the following contact was made with respect to Dylon:[20]

- After being sentenced in November 2013 to a probation order, in December 2013 contact was made with YJ by probation and parole seeking information. Risk assessment information and pre-sentence reports were provided in January 2014.

- Fortnightly stakeholder meetings were commenced at the request of YJ in February 2014.

- Between January and June 2014, probation and parole services were regularly included in email correspondence, placement critical incident report and stakeholder meetings from the Department, YJ and the placement provider. Updates were provided by Probation and Parole to YJ about new charges, case management and Magistrate Court appearances.

- On 1 May 2014, probation and parole advised that Dylon had commenced his first custodial sentence in adult custody. There was no correspondence either to or from the Townsville Correctional Centre in relation to Dylon.

[16] Ex C.2, pg. 262.
[17] Ex B30, [16] – [20].
[18] Ex B30, [21] – [23].
[19] Ex B30, [24].
[20] Ex B30, [30].

31. It was noted that when a young person is transferred from a Youth Detention Centre to an adult correctional centre, it is the responsibility of the Youth Detention Centre deputy director to transfer relevant information about that young person, if the chief executive is satisfied that the disclosure is essential for their wellbeing. It is common practice currently for information about a young person's self-harm or suicide history to be transferred with them.

32. Relevantly, in August 2019, the *Youth Justice and Other Legislation Amendment Act* was passed, which included a range of amendments to the *Youth Justice Act 1992* and other legislation related to information sharing. The new provisions enhanced information sharing between entities to ensure a supported and coordinated approach to the care and management of young people.[21]

Criminal history

33. Dylon had an extensive Queensland criminal history, commencing in July 2009, for property offences committed when he was aged 13 years. He continued to offend and appeared regularly in the Townsville Childrens Court for various offences including, unlawful use of a motor vehicle, assault, unauthorised dealing with shop goods, burglary, trespass, and drug related offences.

34. Dylon was sentenced to his first term of detention in May 2010, for a period of six months to be served by way of conditional release with an indefinite referral to Youth Justice Conference. He received his first recorded conviction for sexual assault, common assault, possession of a knife in a public place and vehicle offences in the Townsville Childrens Court in June 2011. He continued to reoffend following this conviction, primarily by way of property and traffic offences.

35. On 6 December 2012, Dylon was sentenced to 18 months detention for offences involving the indecent treatment of children. His final release from youth detention was on 11 June 2014.

36. Dylon continued to regularly reoffend up until 7 July 2015, when he was sentenced to six months imprisonment at the Townsville Childrens Court for breaching a suspended sentence, which had been imposed in June 2014. He had originally been sentenced for two counts of indecent treatment of a child under 16 to be served concurrently with each other but cumulatively to other sentences to commence on 18 October 2014, including possessing dangerous drugs, burglary, and unlawful use of a motor vehicle. Dylon was detained at the Townsville Correctional Centre for these offences at the time of his death.

37. As an adult, Dylon was first remanded in custody on 29 April 2014 for drug offences, fraud and unlawful possession of stolen goods. He remained at the Townsville Correctional Centre until 12 May 2014, when he was sentenced in the Townsville Magistrates Court to three months imprisonment, which was

[21] Ex B30, [52].

suspended for 12 months, as well as 18 months' probation. He was returned to custody on 16 July 2014, after being remanded for breaching a probation order, assaulting police, *Bail Act* offences and failing to comply with reporting (Child Protection Offender Registry).

38. He was released on parole on 28 July 2014, for various offences, only to return to custody on 4 March 2015 after being arrested for drug offences and stealing. On 7 July 2015, Dylon was sentenced to further imprisonment with a parole eligibility date of 18 April 2016. His full-time release date was 18 July 2016.

Medical History in TCC

39. The period of incarceration Dylon was serving at the time of his death was his first long term period in custody as an adult.

40. During his induction into TCC, Dylon did not declare any self-harm or suicidal ideation.[22] There were no recorded incidents during his terms of adult incarceration where he indicated any intent to commit suicide or attempt to self-harm.

41. Dylon was on medication while incarcerated mainly to manage pain related to Spina Bifida. He also suffered from gastro oesophageal reflux and was lactose intolerant. Accordingly, he was subjected to regular enemas and laxatives to eliminate compaction of the bowel.

42. A majority of the engagement with THHS related to complaints of chronic back pain associated with Dylon's spina bifida.[23] Shortly before his death, he made a complaint to the Health Ombudsman about changes made to his medication as well as a perceived failure to be assessed by a doctor in what he thought was a timely manner.[24] The complaint was finalised after his death.[25]

43. While in custody at TCC, Dylon received Piroxicam (painkiller) in addition to required daily medication which was administered twice a day.

Behaviour at TCC

44. After his induction into TCC on 4 March 2015, Dylon was described as respectful and polite. However, his case notes suggest that he became progressively more abusive and threatening in his behaviour towards prison staff.[26]

45. On 31 March 2015, Dylon was moved to the Detention Unit (DU) after being non-compliant, abusive and threatening. He remained in the DU until 7 April 2015.

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[22] Ex C.7, pg. 3 & 4.
[23] See Ex C.7.
[24] See Ex C6.
[25] Ibid.
[26] See Ex D.1, pg. 14 & 15.

46. Dylon's behaviour while incarcerated alternated between being compliant and abusive. There were several instances recorded where he would cover his cell window and had to be instructed to remove the obstruction. He was also breached on several occasions for abusive language and noncooperation with officers, which resulted in the loss of his employment.

47. Between March and November 2015, Dylon continued to be breached on several occasions for various offences, including damaging his cell and other prison property.

48. On 30 October 2015, Dylon claimed he had been threatened to be stabbed 'at unlock in the morning', and requested to be moved to protection.[27] The following day, he made an *Application for Protection Assessment.* The form stated, *'I was waiting for lockaway at my door when I was approached by Prisoner X who said he was going to stab me in the morning after unlock'.*[28] Dylon was transferred from mainstream to Protection on that day. It appears that the threats were associated with mainstream prisoners becoming aware of Dylon's offending history against children.[29]

49. On 6 November 2015, Prisoner Ludlow contacted the Intelligence Unit at TCC and asked that Dylon be moved into the same unit as him as mainstream prisoners had been yelling out across the yards for Protection prisoners to assault Dylon.

50. IOMS records suggest that Dylon had presented with a 'low mood' from 4 December 2015, and it was intended that he be referred to 'Assessment Services'.[30] A notation suggests that Assessment Services had indicated that they would '*check in with him'*.[31]

Personal issues prior to death

51. In September 2015, Dylon separated from his girlfriend.[32] They had been dating for around 16 months, having known each other for two years.

52. According to his girlfriend, Dylon had threatened on two occasions while he was in custody to kill himself if she left him, either by using a razor blade or by hanging himself.[33] The last time this occurred was around eight months before his death.[34]

53. His girlfriend last spoke to Dylon on Christmas Day 2015 when he called her. He asked if she would come out and visit him, and she agreed that she would.

[27] Ex. D.10.
[28] Ex D.1, pg. 60.
[29] Ex D.7.
[30] Ex D.1, pg. 33 & 34.
[31] Ex D.1, pg. 34.
[32] Ex B16, para. 4.
[33] Ex B16, para. 6.
[34] Ex D.1, pg. 145.

54. An interview was conducted with his girlfriend on 30 December 2015. When asked about the phone call they had on the day before his death, she claimed that he sounded like his normal self.[35] He asked her about the status of her new relationship, which she confirmed was going well.[36] He hung up soon after, although he made plans for her to travel to see him while in custody.

Events leading up to the death

55. At approximately 8:30 pm on 26 December 2015, a headcount was conducted by CCO Pearsall of the Harold Gregg Protection Unit 1 at TCC. The headcount included a visual check of all the cells to confirm the apparent good health of the prisoners.[37]

56. Cell 3, which housed Mr Ludlow and Dylon, was examined during this headcount. CCO Pearsall recalled that he observed a sheet placed over the cell window which he directed the prisoners to remove. Despite some initial resistance, the sheet was removed. CCO Pearsall shone his torch into the cell and saw the two prisoners sitting on the same bed. Both appeared to be in good health.[38]

57. At 9:12 pm, Dylon was found apparently deceased in Cell 3, Mr Ludlow. He claimed he had woken up to find Dylon hanged from the cell door with a bed sheet fashioned into a noose. Mr Ludlow contacted the control room immediately through the internal intercom system.[39] He asked whether he should cut Dylon down and was directed by CCO Slater to hold his weight as officers were on their way.[40]

58. Mr Ludlow stated that he had gone to bed sometime between 8:00 and 9:00 pm after head count and during a televised 'Big Bash' cricket game. He recalled handing the television remote control to Dylon before wrapping a t-shirt around his head to reduce light and noise.

59. Mr Ludlow said that when he went to use the cell toilet, he noticed that Dylon appeared to be seated in an unusual position. He asked Dylon what he was doing. When he received no response, he realised that he was hanging. Mr Ludlow tapped Dylon's face and then turned the light on. He saw that Dylon's face, hands and feet were purple. He checked for a pulse on his wrist and neck but could not feel one. He dismantled a prison issued razor to cut through the sheet, causing Dylon to fall to the floor. He then made the call to CCOs to advise them what had occurred. The time of this call was recorded as 9:12 pm.[41]

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[35] Ex D.1, pg. 144.
[36] Ex D.1, pg. 146.
[37] Ex B11, para. 4-6.
[38] Ex B11.2.
[39] Ex B12, para. 4.
[40] Ex B12, para. 5 & 6.
[41] Ex D.1, pg. 151, *Precis of call.*

60. At 9:12 pm, a Code Blue was called by Alpha Zero (the controller of TCC) for Unit 1, Harold Gregg Cell 3. This was shortly after the completion of the village and S11 headcount.[42]

61. CCOs Derek Lee, Andrew Wright, Keith McGuinnen, Dave Pearsall, Lou Hartig, Dave Brown and Marnie Wakeley, as well the Night Shift Supervisor CCO Marek Molokac, responded immediately. CCO Arron Wilson assisted by opening access doors for the responding officers and also moving the CCTV (Pan Tilt Zoom 6104) to face the entrance to the lower level and activated record. Unfortunately, due to the angle, it was not possible to obtain a visual past cell 1, and the camera constantly had to be repositioned due to automation.[43]

62. Nurse Emma Heerschop heard the Code Blue call over the radio, and responded immediately with the emergency trolley.[44]

63. Upon arrival at the cell, CCO Molokac looked through the observation window and could see a male person slumped in a seated position against the cell door with a bed sheet tied around his neck and the bars above the cell door.[45] Mr Ludlow was standing in the left corner of the cell and appeared to be visibly shaken.[46] CCO Molokac directed CCO Wright to open the door following which Mr Ludlow was ordered to remain in the cell and not to move.[47]

64. CCOs Lee, McGuinnen and Pearsall entered the cell at 9:14 pm. They saw the ligature in place around Dylon's neck, with a cut portion tied to the bars above the cell door. He was moved to the cell hallway so that CPR could be more easily administered. CCO Pearsall checked for a pulse, and after failing to detect any signs of life CPR was commenced by CCO Lee.[48] CPR was in progress upon Nurse Heerschop's arrival on the scene at approximately 9:15 pm.[49]

65. Nurse Heerschop immediately assessed Dylon attaching an Automatic External Defibrillator (AED) at 9:20 pm and administering oxygen. Four heart rhythm checks were conducted by the machine and 'no shock' was advised on each occasion.[50] Attempts to clear Dylon's airway, which was congested with regurgitated food, were made manually and with suction and a Guedel airway was inserted.[51] Nurse Heerschop noted that Dylon remained unresponsive during treatment.[52]

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[42] Ex B5, para. 4.
[43] Ex B14.1.
[44] Ex B6, para. 15.
[45] Ex B9, para. 6.
[46] Ex B9, para. 7.
[47] Ex B9, para. 8.
[48] Ex B7, para. 11.
[49] Ex B6, para. 12; Ex B7, para. 12.
[50] Ibid.
[51] Ibid.
[52] Ibid.

66. A call was made to the Queensland Ambulance Service (QAS) at 9:18 pm. Advanced Care Paramedics, David De Valter and Peter Kerkhoffs were dispatched to a 'code 2 job' at TCCC in relation to the strangulation of an inmate.[53] While en-route at approximately 9:24 pm, it was upgraded to a Code 1 via the QAS communications as CPR was being performed on Dylon.[54] Upon arrival at TCC at approximately 9:28pm, the gates were open and a staff member directed QAS officers to the location.

67. CPR was continued until QAS staff arrived at the scene at 9:35 pm. Upon arrival and assessment, QAS replaced the AED with a Lifepack 12. CPR was continuously administered during this time. Further life saving measures were carried out including clearing the airways, which were partially blocked, and ventilating the patient. The Lifepack 12 indicated that Dylon was asystole. Intubation and cardiac arrest formula were administered with ventricular fibrillation occurring after administering sodium bicarbonate intravenously. Four shocks of the Lifepack 12 were administered without success. By 9:50 pm, further QAS teams had arrived at the scene, including a critical care paramedic.[55]

68. The on-call Doctor was called for advice at 10:08 pm, in accordance with internal procedures. CPR subsequently continued for another 10 minutes with 1 mg of adrenaline being administered.

69. No improvement was noted and following a further discussion with the on-call Doctor, CPR was ceased at 10:20 pm.[56]

70. Dylon was declared deceased at 10:21 pm on 26 December 2015. A crime scene was immediately declared.

71. Mr Ludlow was moved out of the cell and isolated from other prisoners awaiting interview.[57] He told CCO Molokac that he had cut the sheet with a razor blade, which was located on the bedside table within the cell.[58]

Police investigation

72. Detective Sergeant Seery from the Corrective Services Investigation Unit (CSIU) was charged with investigating the circumstances of Dylon's death. During his inquiry, statements were obtained, and interviews conducted with significant witnesses, including relevant staff, medical staff, inmates and Queensland Ambulance Service officers who attended to assist Dylon, as well as next of kin. Medical and offender records, CCTV footage, audio exhibits and photographs were also obtained.

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[53] Ex B4, para. 4.
[54] Ex B4, para. 5.
[55] Ex B4, para. 25.
[56] Ex B4, para. 37 & 38.
[57] Ex B7.1; Ex B9, para. 16-20.
[58] Ex B9, para. 16-20.

73. A coronial report was subsequently prepared and tendered at the inquest. As DS Serry has retired, evidence was given at the inquest by the officer who assisted him in the investigation of Dylon's death, DSC Brendan Anderson.

Cell examination

74. First response police officers, Sergeant Jayson Cooke and Constable Thomas Pearce, attended and conducted a visual search of the cell, which appeared to be neat and tidy with no signs to indicate any type of a struggle. [59]

75. Cell 3 of the Harold Gregg Unit 1 is a double up cell with a bunk bed situated on the right-hand side of the room. A small desk with a television below a barred window that had been covered with a blanket, as well as a fan, were present. A bathroom, which consists of a toilet and shower are separated by a small wall at the toilet end, and a glass wall that extends to the ceiling. There was no door to obstruct a full view of the room when the CCOs conduct observations from the cell door window. A mattress and pillow were located on the floor, which was consistent with Dylon's habit of sleeping on the floor against the door.

76. Mr Ludlow occupied the lower bunk bed, which was near the location of Dylon's bedding.

77. The cell was a single door with a lock from the outside. It could only be accessed with a key held by the CCO. Prisoners are able to communicate with a CCO through an internal intercom system located within the cell.

78. A cell examination was conducted as part of the investigation, and a disassembled prison issued razor and three blades were found and secured.

79. Torn strips from a sheet were also found tied together and placed into a plastic bag on the lower shelf within the cell. The CCOs advised that these were known as a 'fishing line' and were used to pass objects between cells during lockdown.

Interviews with inmates

80. All the prisoners in the Harold Gregg Unit 1 were interviewed in relation to Dylon's death. Most described Dylon as happy and positive and were unable to offer any information as to why he might have taken his own life.

Account provided by Mr Ludlow

81. Mr Ludlow was interviewed by Investigators on three occasions. During the interview conducted on 28 December 2015, Mr Ludlow stated the following:

- At around 6-7:00pm that evening, Mr Ludlow and Dylon ate dessert in their cell and were watching Big Bash Cricket.
- He described Dylon's mood as 'happy' and they were laughing.

[59] Ex B10, para. 15

- He referred to Dylon's ongoing back problems, which he suffered throughout out 'juvie'.

- He described turning the television down, wrapping a shirt around his head and rolling over to go to sleep on the bottom bunk.

- Around 40 minutes later, he went to the bathroom and then saw Dylon hanging. He saw the sheet first with his feet crossed.

- Mr Ludlow claimed he asked Dylon what he was doing and then checked for a pulse. He states that he raced for a razor and cut him down. After this, he called the officers over the intercom.

- He claimed that he thought he heard Dylon say something while the officers were assisting him.

- He denied that he and Dylon ever discussed suicide. He claims that they had made plans to get together when they were both released from custody.

82. In a further interview conducted on 29 December 2015, Mr Ludlow made the following statements:

- He recalled that Dylon placed a sheet over the window while watching the cricket, which he was told by an officer to remove.

- Dylon normally slept on the floor as the room was hot.

- He described an instance where Dylon tried to choke himself after a phone conversation with his mother, where there had been an issue with his sister.

- Mr Ludlow denied helping Dylon commit suicide. He acknowledged that they had been close mates since he was 13 years of age.

- He also claimed that he had no knowledge that Dylon had committed sexual offences against children, or that was the reason he was in protection.

- He could not offer any explanation as to why Dylon decided to commit suicide.

- Mr Ludlow described conversations previously had with Dylon about self-harming and slashing up. He recalled that after Dylon had a conversation with his ex-girlfriend on Christmas Day where he told her he loved her and she did not respond, he then spoke about self-harming. Hanging was never discussed.

- Mr Ludlow denied that he heard Dylon take any steps to hang himself.

83. In a final interview conducted on 30 December 2015, Mr Ludlow stated that Dylon did not show any signs of being depressed on the day he committed suicide. He appeared to be happy that day. Mr Ludlow said that if he had known what Dylon was planning to do he would have stopped it.

84. Records from the Cleveland Youth Detention Centre (CYDC) indicate that Dylon and Mr Ludlow had spent various extended stints in detention together since age 13.[60]

85. At the inquest, Mr Ludlow confirmed that he knew Dylon well and that they were friends from around the age of 13. He said that he had encouraged Dylon to move to the protection side of TCC because he was aware that Dylon was having issues in mainstream and would be safer in protection.

86. Mr Ludlow said that he and Dylon were initially in different sections within the Harold Gregg Unit, but he had moved to Harold Gregg Unit 1 after he heard that officers were looking to make room in unit 2. He then suggested that he and Dylon share a cell. His evidence at the inquest was largely consistent with the account he gave to police officers at the time of Dylon's death, noting that it was over five years since the death.

87. Mr Ludlow recalled that on 25 December 2015, Dylon was feeling depressed and sad after a telephone call with his former girlfriend and expressed that he wanted to die. Mr Ludlow said that he spoke to him late into Christmas night saying it was not worth taking his life over a relationship breakdown. He said that the next day Dylon seemed happy and chirpy and was playing cards and gambling. Dylon made no further threats of self-harm.

Investigation findings

88. Detective Sergeant Seery concluded that Dylon died from hanging by placing a rolled-up sheet around his neck, which he had tied to the bars above the cell door of Cell 3 in Harold Gregg Protection Unit 1. It was fashioned in such a manner that it enabled Dylon to be suspended from the floor to cause his death. Detective Sergeant Seery concluded that he may have been depressed following a negative phone call with his girlfriend.

89. DS Seery noted that, 'in retrospect there were signs Dylon may have been considering suicide such as covering his head and attempting to choke himself on Christmas Day and taking about 'slashing up'.'[61] However, DS Seery considered that any mandated requirement that Mr Ludlow should have notified an appropriate person of his intentions of self-harm on Christmas Day, may 'place far too much burden on a young offender who has had the same institutionalised upbringing and has perhaps developed a cautionary nature when dealing with authority'.[62]

[60] Ex C.3, pg. 2 & 3.
[61] Ex A8, pg. 18.
[62] Ex A8, pg. 18.

90. In relation to the response times and assistance provided by CCOs and QAS, DS Seery concluded that the response times and measures taken were more than satisfactory.[63]

91. In considering whether there were any suspicious circumstances in relation to Dylon's death, DS Seery considered the minor discrepancies in the accounts provided by Mr Ludlow over the course of his three interviews.

92. Based on the lengthy history together in custody, DS Seery considered it likely that Mr Ludlow and Dylon had discussed suicide attempts to gain medical attention and 'time out' in the Crisis Support Unit while in prison. While Mr Ludlow's recollection of events in terms of whether he cut Dylon down first or called the CCOs was not strictly accurate, this was not suspicious given the trauma associated with such an event.

93. Ultimately, DS Seery concluded that there was insufficient evidence to implicate any person in Dylon's death. Furthermore, there was no act or omission by any person, which amounted to negligence resulting in his death.

Autopsy

94. An external and partial internal post-mortem examination was performed by Professor David Williams on 30 December 2015 at the Townsville Mortuary.[64] A number of histology and toxicology tests were also undertaken.

95. The external post-mortem examination revealed minimal recent injuries, with no obvious marks around the neck linked to the sheet material. Vomit was found on the sheet.

96. Professor Williams noted that as there had been a degree of resuscitation administered to Dylon, it was difficult to know what injuries may have been caused by the insertion of the endotracheal tube and those which were definitely linked to hanging having used a sheet as a ligature.[65] Further examination of tissue samples taken from the neck did demonstrate a few areas of internal bruising to the neck.[66]

97. Toxicology testing indicated that Dylon had no alcohol or drugs of abuse in his system. Therapeutic levels of the anti-arrhythmic drug, Amiodarone, and Paracetamol were found.

98. Professor Williams found that the cause of Dylon's death was due to hanging. There was no evidence to suggest that this hanging was suspicious.[67]

[63] Ex A8, pg. 17.
[64] Ex A3.
[65] Ex A6, para. 6.
[66] Ex A6, para. 7 & 8.
[67] Ex A6, para. 12.

Office of the Chief Inspector Investigation Report

99. Following the CSIU investigation, the Office of the Chief Inspector (OCI), Queensland Corrective Services appointed investigators to examine the circumstances of Dylon's death under the powers conferred by s.294 of the *Corrective Services Act 2006.* In 2017, a comprehensive report was prepared detailing the findings of this investigation.[68]

Psychological assessments

100. Dylon was interviewed upon his admission to TCC on 4 March 2015, by Mr Adam Stringini, Provisional Psychologist, who performed an Immediate Risk Needs Assessment.

101. The Assessment noted that Dylon had a history of violent offending, and he was flagged as a sex offender on IOMS. It was also noted that he suffered from physical impairments in relation to his medical condition, for which he agreed to seek assistance if needed while incarcerated. He acknowledged that he had seen a counsellor before his current incarceration, and he planned to continue engaging with them after his release.[69]

102. As a result of the Assessment, a SHEH flag (Self harm episode history flag) was not raised, despite a disclosure of a self-harm episode while he was a juvenile, which resulted in scarring on his arm that was sighted during the assessment. He reported that he had not engaged in self-harming behaviour since this time.[70] The IRNA stated that:[71]

> *As per procedural requirement, Prisoner Ahquee is recommended to be accommodated in a modern suicide resistant cell due to his history of at risk behaviour.*

103. On 4 December 2015, an IOMS case note from Program Delivery Officer, Karola Hoffman, indicated that Dylon ceased activity halfway through and was wanting to return to his unit. He appeared to be in a low mood, and the matter was referred to Assessment Services to check on him.[72]

104. On 9 December 2015, Dylon indicated to program facilitators, including Ms Hoffman that he was feeling better and would be attending the program. This was noted in the IOMS case notes.

105. There were no case notes that suggest that Assessment Services had checked in with Dylon as had been requested.[73]

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[68] Ex D12.
[69] Ex D12, pg. 11 & 12.
[70] Ex D12, pg. 12.
[71] Ex D12, pg. 12.
[72] Ex D12, pg. 12.
[73] Ex D12, pg. 12.

106. Investigators noted that they had accessed to all QCS procedures and related guidelines which psychologists must comply with, including the '*Practice Directive – Risk of Harm to Self*' which stated that if a prisoner presented a history of self-harming behaviour or suicide attempts, a senior psychologist had to be notified. The senior psychologist was required to activate the SHEH warning flag.[74]

107. The need for a SHEH warning flag in IOMS for prisoners with a history of self-harm or suicide is also reflected in the *Management of Elevated Baseline Risk Prisoners,* which notes that individuals with this history are considered to be at an elevated baseline risk (EBLR) for self-harm or suicide and require specialised management.[75]

108. Prisoners who are identified as being at EBLR, as part of the monthly case note auditing process, are to be allocated a supervisor or manager who assumes responsibility for regularly reviewing case notes where practicable. This manager provides ongoing reviews of the prisoner's case notes, considering their stability and self-regulation.[76]

109. Prisoners with an elevated baseline risk must also be accommodated in a modern suicide resistant cell (i.e. a cell with reduced hanging points).

110. It was noted in the Report that had the SHEH flag been raised, the Elevated Baseline Risk process should also have been commenced with respect to Dylon, and more oversight would have been given to him.[77]

111. Inspectors referred to and considered the *Guidelines for Completing at Risk Assessments* which note that a history of self-harm or a previous suicide attempt *'greatly elevates a person's risk of suicide. This elevated risk is independent of the apparent level intent of previous intents.'*[78]

112. In relation to the request for Dylon to be seen by Assessment Services, it was noted that the process in place at the time was that upon receipt of such a request, the prisoner was placed on a spreadsheet and Assessment Services had seven days to act upon the request.[79] Assessment Services advised Investigators that they 'may' look at IOMS to see if any flags had been raised (such as SHEH flag), which might then expedite the process.

113. In Dylon's case it was noted that while a phone call was placed to Assessment Services by the Program Facilitator this did not result in him being added to the register and he was not seen by Assessment Services. There is no explanation as to why this did not occur.[80]

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[74] Ex D12, pg. 12.
[75] Ex D12, pg. 13.
[76] Ex D12, pg. 13.
[77] Ex D12, pg. 13.
[78] Ex D12, pg. 14.
[79] Ex D12, pg. 14.
[80] Ex D12, pg. 15.

114. Investigators concerns included[81] that the Program Facilitator should have completed a Notification of Concern as Dylon had a history of self-harm/suicide attempts and ideation and was demonstrating indicators of being at risk. If this had been done, the Assessment Services Team would have been procedurally obligated to see him as a matter of priority.

115. The Report noted that under the practices in place at TCC at the time, Dylon had been missed by various processes several times, including identification via the 'self-harm flag' or the EBLR process, and was later missed for follow up by Assessment Services.[82]

Request to be moved to Protection

116. On 30 October 2015, Dylon provided staff with a letter advising that he had been threatened and was to be stabbed at unlock due to knowledge of his offending against children being made public. He asked to be moved to protection. Dylon was placed on a 'safety order' until a 'protection needs assessment could be conducted.

117. On 2 November 2015, Dylon was subject to a 'Protection Needs Assessment' following which his placement in the Harold Gregg Unit was approved. It was noted that this accommodation does not contain cells, which are considered to be 'suicide resistant'.[83] He also signed a 'double up' consent form for shared cell accommodation.

Double up with Mr Ludlow

118. Mr Ludlow and Dylon had known each other for a considerable time, having served in youth detention together since they were teenagers. They had a close friendship, and Mr Ludlow asked that Dylon be placed in the protection unit with him after threats were made by general population inmates.

119. On 29 November 2015, Mr Ludlow self-harmed with a razor blade and was placed in the safety unit on 30-minute observations.[84] A Notice of Concern was raised on 30 November 2015. Despite this recent attempt, on 1 December 2015, Dylon was placed with Mr Ludlow in a shared cell. There were no case notes for Dylon which recorded this placement nor if any risk assessments were taken into consideration, who approved it and what factors were considered.[85]

120. Correctional Supervisor, Mr Geoff Pollard, gave evidence at the inquest. He recalled that Dylon had been involved in several breaches of prison rules and regulations. On 29 November 2015, he had conducted a 'breach hearing' with Dylon. While the case note did not state which 'Incident' the breach hearing related to, the result was a guilty finding with a penalty/sanction of 4-days separate confinement.

[81] Ex D12, pg. 15 & 16.
[82] Ex D12, pg. 16.
[83] Ex D12, pg. 18.
[84] Ex D12, pg. 26.
[85] Ex D12, pg. 28.

121. Understandably, Mr Pollard had little recollection of the approval for the double up with Mr Ludlow. He was aware that Dylon and he were mates, and that the transfer of Dylon into the protection unit had been approved by intelligence officers. The shortage of cells required that prisoners share with other prisoners. Case notes from the time leading up to this placement did not contain any reference to self-harm. Mr Pollard said that prisoners were interviewed in relation to their willingness to share with a particular offender. Prisoners with a SHEH flag were not automatically excluded from sharing. It was important to consider the date of the relevant episode. It was also important to try to keep the same type of prisoners together.

122. Mr Pollard said that the process had changed considerably since Dylon's death following implementation of the OCI Report recommendations.

OCI Conclusions

123. Inspectors found that Dylon was not, when he ought to have been, identified as having had a history of self-harm by the raising of, and maintaining a 'SHEH Flag' when he entered TCC on 4 March 2015.[86] TCC local management oversight and audit process for EBLR failed to identify that his SHEH flag had not been activated or that other mandatory EBLR procedure requirements had not been observed.

124. Practice directives in relation to raising a Notification of Concern when a prisoner displays indicators of risk behaviour, and in relation to shared accommodation placements were not adhered to with respect to Dylon.[87]

125. Inspectors noted that tragically, Dylon hanged himself from a louvre in an older style cell at TCC in circumstances where his admission assessment specifically recommended a modern suicide resistant cell.[88] It was concluded that there was no evidence that the shared cell placement with Mr Ludlow and Dylon had increased the risk or likelihood of such an incident from occurring.

126. Inspectors determined that no intelligence or other information existed prior to the incident to indicate that Dylon was contemplating suicide or self-harm in the circumstances.[89]

127. Inspectors found that the response following Dylon being found hanging was timely and effective, and highly commendable in the circumstances.[90]The response was well documented with times and actions taken outlined in the incident report.

[86] Ex D12, pg. 37.
[87] Ex D12, pg. 38.
[88] Ex D12, pg. 38.
[89] Ex D12, pg. 38.
[90] Ex D12, pg. 39.

128. The findings and recommendations made in the OCI Report were as follows:[91]

(1) Dylon was not, when he ought to have been, identified as having a history of self- harm by the raising of, and maintain a 'SHEH flag' when he entered TCC on 4 March 2015.

<u>Recommendations:</u>

(1) It was recommended that an audit of prisoner files to ensure all prisoners who have a history of self-harm have the appropriate warning flags activated on IOMS.

(2) Specific orientation and induction are provided to staff relieving in offender development supervisory and management positions.

(3) A review of local process and practices for raising SHEH flags and commencing the EBLR process.

(2) TCC local management oversight audit process for EBLR failed to identify that Prisoner Ahquee's SHEH flag had not been activated or that other mandatory EBLR procedure requirements had not been undertaken.

<u>Recommendations:</u>

(1) Review of local process and practices for raising SHEH flags and commencing the EBLR process.

(2) A review of the agency EBLR process to ensure effectiveness and efficiency in identifying and responding to prisoners' risk of suicide/self-harm.

(3) A notification of concern could have been raised with Mr Ahquee displayed a change in mood and mental state. A local referral process was used however, this was ineffective in ensuring that he had timely access to a member of the Assessment Services Team.

<u>Recommendations:</u>

(1) Review of local processes to ensure they are complaint with COPD requirements and best practice standards.

(2) Review of local training, supervision and practice support provided to staff in regard to at risk management and assessment.

(3) Review of agency training, supervision and practice support provided to staff in regards to at risk management and assessment.

[91] Ex D12, pg. 44 – 46.

(4) Practice directives regarding shared cell placements were not adhered to.

Recommendations:

(1) All staff at TCC are reminded of their responsibilities in regard to COPD requirements for shared cell placements.

(2) Review of local process to ensure compliance with COPD requirements.

(3) Amendment to local forms to ensure shared cell placements are adequately assessed, identified risks are mitigated and appropriate record keeping is maintained.

(5) Overstate prisoner numbers are impacting upon single occupant cell availability.

Recommendations:

(1) All staff at TCC are reminded of their responsibilities in regard to COPD requirements for shared cell placements.

(2) Review of local process to ensure compliance with COPD requirements.

(3) Agency review of prisoner numbers and capacity utilisation to identify and implement strategies to reduce overcrowding.

(6) Prisoner Mr Ahquee hanged himself from a louvre in an older style cell at TCC.

Recommendations:

(1) TCC review accommodation placement model and decisions to ascertain all reasonable efforts have been taken to ensure prisoners with a self-harm history and ELBR are accommodated in modern suicide-resistant cells.

(2) Agency review of infrastructure to ascertain all reasonable efforts have been taken to ensure adequate accommodation for prisoners with a self-harm history and an ELBR.

QCS response to OCI recommendations

129. In response to the OCI findings and recommendations, QCS Assistant Commissioner, Mr Peter Shaddock provided the following update on behalf of QCS and gave evidence at the inquest:

I. *Finding 1*

(a) *audit of prisoner files to ensure prisoners who have a history of self-harm have the appropriate warning flags activated on IOMS*

In September 2016, TCC completed a centre-wide audit to ensure compliance with the raising of flags. Since this time, the Custodial Manager, Offender Development conducts an audit on the reception into the complex, and reports on compliance each month via a report.[92]

(b) *Specific Orientation and induction are provided to staff relieving in offender development supervisory and management positions*

Since January 2017, a new induction process has been put in place which includes provision of TCC Assessment Services New Staff Book, TCC Offender Development Induction Information book, online IRNA training, shadowing by senior staff and signed off as 'competent' before conducting assessments on their own.

(c) *A review of local processes and practices for raising SHEH flags and commencing the EBLR process*

A review of local processes and practices was undertaken which resulted in the implementation of a local instruction developed for the management of At Risk prisoners in the Harold Gregg Units, a POC Panel was established for all offenders of concern and meetings are now held on a fortnightly basis; and an Operational Instruction and Practice Directive for prisoners who are of an elevated baseline risk (EBLR) were introduced.

II. *Finding 2 – a review of local processes and practices for raising SHEH flags and commencing the EBLR process*

The recommendation implementation form has been introduced, which is now in place at TCC. Essentially, it states that:[93]

- If a prisoner is identified through the IRNA process as posing an immediate risk of suicide or self-harm a full assessment of the prisoner's at-risk status must be conducted by a psychologist. The IRNA process is to take place prior to a prisoner's placement in accommodation and recorded within the first 24 hours of admission.

- If during IRNA process a prisoner presents with a history of self-harming behaviour or suicidal behaviour either in custody or the community a senior

[92] Ex B33, [7].
[93] Ex B34, pg. 15 onwards.

psychologist must be notified. The Senior Psychologist must activate the self-harm episode history warning indicator in IOMS. Sufficient comments must be made when raising a SHEH flag to describe self-harm history information obtained. The relevant correctional supervisor must also be advised and then must ensure that the information is disseminated as soon as practicable to all relevant staff members involved in determining the prisoner's accommodation.

- A prisoner with a SHEH warning indicator in IOMS is to be accommodated in a safer cell unless other reasonable factors warrant against such placement. Safer cell placement is the minimum management requirement for this group to reduce environmental risk factors.

- Staff are to remain vigilant in identifying and recognising any warning signs, triggers and imminent at-risk factors and respond accordingly.

- If identified during the IRNA process that a prisoner presents with ongoing risk factors that place them at an elevated risk of suicide and/or self-harm but is not assessed as posing an acute or immediate risk of suicide or self-harm, the assessing officer must make a referral for consideration under the EBLR procedure. A senior psychologist and correctional supervisor must be notified, and the relevant information is to be recorded in IOMS as a case note.

- If identified that a prisoner has a history or a current diagnosis of mental illness or has previously had contact with a mental health service provider, including immediately prior to admission to custody, the assessing officer must make a referral to Prison Mental Health Service for assessment. The information must be communicated with the senior psychologist and placed in a case note under the relevant category.

- The prisoner's records and IOMS should be accessed to ascertain the prisoner's self-harm and suicidal behaviour history and psychiatric and psychological history.

- If identified during the IRNA process that a prisoner presents with any other significant vulnerability factors that indicate the need for special care, support or monitoring, the assessing officer must make a referral for consideration under the Prisoner of Concern (POC) procedure.[94] This information is also to be communicated with the senior psychologist and correctional supervisor, and recorded in IOMS as a case note, as well as in the IRNA under the relevant category.

III. *Finding 3 – review of local process to ensure they are complaint with COPD requirements and best practice standards*

A review of the current TCC local processes in relation to managing At Risk behaviour and the process for raising a Notification of Concern was undertaken and compliance with Custodial Operations Practice Directives requirements and best practice has been achieved. Clear and detailed processes have been

[94] Ex B34, pg. 134.

incorporated into a process of instruction. All accommodation managers have been provided with a copy that is displayed in all officers stations.

IV. *Finding 4 – All staff at TCC are reminded of their responsibilities in regard to COPD requirements for shared cell placement*

The Accommodation Manager forwards regular emails centre wide to staff reminding them of their responsibilities and COPD reporting requirements relating to shared cell placement. A local instruction was also generated in relation to Shared Cell Accommodation – it is required that TCC be 100% compliant with the COPD, which negated the need for the implementation of the draft local instruction.

Further it was noted that in response to the inefficiencies identified in the OCI report as to the compliance of shared cell practices at TCC, practices have now been embedded in reporting processes resulting in shared cell case note auditing by Accommodation Managers. This audit process occurs through Reporting Services and is saved weekly to the Governance and Accountability Framework Folder on the file server for Accommodation Managers.

V. *Finding 5 – All staff to be reminded of their COPD requirements for shared cell placements and review of local processes to ensure compliance with COPD compliance*

This is reflected in the Recommendation Implementation Form now in effect.[95] This Form, which is dated 4 October 2019, notes that:

- An EBLR Implementation Action Plan has been endorsed which includes the development and improvement of training, supervision and practice support to staff in regard to at risk management and assessment. Includes the development of a Risk Assessment Team induction training package for RAT members and psychological services staff.

- In June 2019, ORMS commenced delivery of mandatory training to all psychological services staff within QCS in the management of prisoners identified as EBLR under the new Custodial Operations Practice Directives. All are to have completed the training by December 2019, which contained practical elements.

VI. *Finding 6 – TCC review accommodation placement model and decisions to ascertain all reasonable efforts have been taken to ensure prisoners with a self-harm history and ELBR are accommodated in modern suicide resistant cells*

Since Dylon's death, a thorough review of accommodation placement practices relating to at-risk prisoners has been conducted at TCC. TCC acknowledges the absence of modern suicide resistant cells in the Harold Gregg Protection Unit however has developed risk mitigation strategies to accommodate at risk

[95] Ex B34, pg. 163.

prisoners in ‘safer cells’ in line with the Deputy Commissioner’s Operational Instruction.

Findings Required by s 45

130. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where, and how he came by his death. After considering all the evidence I make the following findings:

Identity of the deceased –	Dylon James Ahquee
How he died -	Dylon had a history with the child protection and youth justice systems from his infancy until he was first imprisoned as an adult in March 2015. He was identified as being at Elevated Base Line Risk of self-harm on entry to prison, but a Self-Harm Episode History (SHEH) flag was not raised on the Integrated Offender Management System. Neither was he placed in a suicide resistant cell due to his history of at risk behaviour. On 2 November 2015, Dylon was assessed as needing protection within the prison and he was placed in the Harold Gregg Protection Unit. Dylon did not express any intent to self-harm, apart from to his cellmate late on Christmas Day 2015. The following evening, he fashioned a ligature from a bed sheet and intentionally hanged himself from exposed metal bars above the cell door.
Place of death –	Townsville Correctional Centre, Stuart, Queensland.
Date of death –	26 December 2015.
Cause of death –	Hanging.

Conclusions on the issues for inquest

Whether any third party contributed to Mr Ahquee’s death

131. I am satisfied that Dylon caused his own death after he hanged himself in his cell using a bed sheet as a ligature.

132. The post-mortem examination confirmed that the cause of death was hanging and there were no indications that the death was suspicious.

133. Mr Ludlow's account at the inquest of the events of 26 December 2015 was consistent with the findings of the police investigation. There remains some inconsistency about whether Mr Ludlow cut Dylon down before or after calling for assistance. However, this is reasonable given the traumatic nature of the event and the distress it caused Mr Ludlow. It was apparent that Mr Ludlow and Dylon were friends from an early age.

134. After considering the evidence at the inquest, including that of Mr Ludlow and autopsy findings, I am satisfied that there is no basis to suggest that any other party caused or contributed to Dylon's death.

Whether the authorities charged with providing for Mr Ahquee's mental health and physical care at the Townsville Correctional Centre prior to his death adequately discharged those responsibilities

135. I adopt generally the conclusions reached in the report of the Office of the Chief Inspector in relation to this issue.

136. It was clear that from soon after his birth, Dylon's mother expressed that she found it extremely difficult to care for him. It was unfortunate that the child safety system was not able to offer him a permanent and stable family where he could develop meaningful attachments with his carers. Instead he was moved over 60 times between his family, foster carers, residential care, and youth shelters. Unsurprisingly, he ultimately ended up in juvenile detention and then in adult prison.

137. I acknowledge that Dylon's presentation was very complex, difficult to manage and complicated by Spina Bifida, which also adversely affected his overall functioning.

138. As a child, Dylon had attempted or threatened suicide or self-harm on several occasions between 2007-2014. The last reported incident was in 2014 when a suicide alert was completed after he threatened to self-harm if not given pocket money.

139. Dylon was also a recidivist juvenile offender with an extensive criminal history that commenced in 2009, with his first period of detention in May 2010. The term of imprisonment he was serving at the time of his death was Dylon's first significant period in adult custody. He was eligible for parole on 18 April 2016.

140. During his induction into TCC in March 2015, Dylon did not declare any self-harm or suicidal ideation. However, a self-harm episode history flag should have been raised following his disclosure of self-harm as a juvenile.

141. This failing was recognised in the OCI investigation, where it was noted that had the SHEH flag been raised, the Elevated Baseline Risk process should have been commenced. If this had occurred, more oversight may have been given to him. However, I am not confident that would have changed the outcome. I am satisfied that steps have since been taken by way of training and changes to TCC procedures to address this shortcoming.

142. While it was recognised that Dylon should have been accommodated in a suicide resistant cell given his history of at risk behaviour that did not occur. Mr Shaddock acknowledged that there are no safer cells in the Harold Gregg Protection Unit, but QCS has developed risk mitigation strategies to accommodate at risk prisoners who cannot be placed in 'safer cells'. He noted that Dylon was not on any observations regime at the time of his death and was the subject of positive case notes. It was his view that the at risk management process could adequately manage Dylon's risk within the Harold Gregg Protection Unit.

143. Apart from his disclosures to Mr Ludlow on 25 December 2015, there were no recorded incidents during Dylon's terms of adult incarceration where he indicated an intent to suicide or had attempted self-harm.

144. IOMS records suggest that Dylon had presented with a 'low mood' from 4 December 2015, and it was intended that he be referred to 'Assessment Services'. A notation suggests that Assessment Services had indicated that they would 'check in with him'. However, this was not done, and was a departure from the requisite policy and procedure in place. However, I am also not confident that follow up at that time would have resulted in a different outcome.

145. Dylon was reportedly feeling better on 9 December 2015 and intended to reengage with the program. The local process for requests for assessments was considered by OCI investigators and subsequent changes have been made to ensure more intense oversight and checks are in place.

146. Mr Ludlow's evidence suggested that Dylon was struggling on the evening of Christmas Day 2015 after a telephone call with his former partner. However, by the following day he was reported to be a better mood by Mr Ludlow and other prisoners. There was no overt indication he was feeling suicidal on 26 December 2015 or required responses from those charged with his care different to those he received on that day.

The sufficiency of information sharing between correctional centres, including youth justice detention and adult correctional facilities

147. Dylon's Child Safety and Youth Justice records were voluminous. His Child Safety file alone comprised over 12,000 pages.

148. The records demonstrate that while in the care of the Department of Communities and the Department of Youth Justice, Dylon was provided with ongoing and targeted assistance, including physical health assessments, case work and psychological support to attempt to address the challenging aggressive, violent, and sexualised behaviours he exhibited.

149. Dylon was eventually diagnosed with Post-Traumatic Stress Disorder and Reactive Attachment Disorder. There were also significant concerns around his sexualised behaviours.

150. I agree with the submission of counsel assisting that that during the time Dylon was in care, there was sufficient collaboration and information sharing between Child Safety and Youth Justice (including the Cleveland Youth Detention Centre) and TCC and various placement providers. The relevant records contain many examples of such collaboration.

151. Mr Shaddock told the inquest that at a strategic level QCS has a good working relationship with Youth Justice. At the local level in Townsville there had been shared projects and several QCS staff have also moved to work with Youth Justice.

152. I also accept that Youth Detention Centres can transfer relevant information about a young person to QCS, including information about a young person's self-harm history and that information sharing has been supported by the 2019 amendments to the *Youth Justice Act 1992*.

Comments and recommendations

153. The *Coroners Act 2003* enables a coroner to 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.

154. I have been advised that 72 cells within the Harold Gregg Protection Unit at Townsville Correctional Centre are waiting to be modified to remove and reduce access to ligature points. The upgrading of those cells has been given some priority within the QCS capital works program, but no firm date is set for that occur.

155. I have commented on the issue of hanging points within Queensland Correctional Centres in my findings in relation to the death of SVE, which were handed down on the same day as these findings. I have recommended that the Queensland Government publish annual updates detailing its strategy for the implementation of safer cells and progress against that strategy.

156. The measures being implemented and considered by TCC and QCS State-wide Operations in response to the OCI Report are appropriate. I am satisfied that the recommendations already made, and the actions taken with respect to them, will contribute towards preventing a death in similar circumstances.

157. Having regard to the QCS response to the OCI recommendations, I accept that there are no other comments or recommendations to be made that would assist in preventing similar deaths in future.

158. I offer my condolences to Dylon's friends and family. I acknowledge that despite his challenging behaviour his family maintained regular contact with him while he was in custody. He was loved and is missed by them.

159. I close the inquest.

Terry Ryan
State Coroner
Brisbane
24 May 2021