CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of AJO**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2020/2567
DELIVERED ON:	19 September 2023
DELIVERED AT:	BRISBANE
HEARING DATE(s):	12 July 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, suicide, death in custody, hanging, remand prisoner, risk assessment.

REPRESENTATION:

Counsel Assisting:	Mr Joseph Crawfoot
Queensland Corrective Services:	Ms Josephine Villanueva (QCS)
GEO Group Australia:	Mr James Hall and Mr Doug Johnson (Ashurst)

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Introduction

1. AJO[1] was a 34 year old man who was found deceased in his cell in Unit B3 at the Arthur Gorrie Correctional Centre (AGCC) on 20 June 2020.

2. AJO was arrested on 21 May 2020 for weapons and drug related offences, and failing to comply with reportion obligations under the *Child Protection (Offender Reporting and Offender Prohibition Act) 2004*.

3. He was remanded in custody and transferred from the Toowoomba watchhouse to AGCC on 25 May 2020. This was not his first time in custody. He had previously been imprisoned from October 2014 to April 2016 for offences of indecent treatment of a child.

4. On 18 June 2020, AJO was told during a telephone call that he was being investigated in relation to images of a child that had been found on his telephone following his arrest. He was not aware of this investigation until that call. He denied taking any images of children with his phone. He was last seen alive on during a head count at 8:08pm on the night of 19 June 2020.

5. In addition to the findings required by s 45 of the *Coroners Act 2003*, these findings consider the appropriateness of the mental health assessment on AJO's admission to custody at Arthur Gorrie Correctional Centre.

The investigation

6. The investigation into the circumstances leading to AJO's death was conducted by Detective Senior Constable Watt[2] from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). Her report tendered at the inquest.[3]

7. After being notified of the death CSIU officers attended AGCC together with a scenes of crime officer. AJO's cell was inspected. A search of the cell revealed no suspicious circumstances. A fingerprint examination confirmed AJO's identity.

8. CSIU detectives arranged the seizure of all prison records relating to AJO. They conducted interviews with other prisoners in Unit B3 at AGCC. Statements were also obtained from corrective services staff in Unit B3 at AGCC, and staff who conducted risk assessments for AJO on his entry to prison.

9. I am satisfied that the police investigation was professionally conducted and that all relevant material was accessed.

10. A parallel investigation was conducted by the Operational Inspection and Major Incident Review Group in QCS. Those investigators prepared a report which was tendered at the inquest.

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[1] These findings have been anonymised following a non-publication order under s 41 of *Coroners Act 2003*.
[2] Now Acting Senior Sergeant
[3] Ex A5

The inquest

11. As AJO died while in custody an inquest was required under the *Coroners Act 2003.* The inquest was held at Brisbane on 12 July 2023. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

12. Leave to appear was granted to Queensland Corrective Services (QCS) and the GEO Group Australia Pty Ltd, the operators of AGCC at the time of the death. Two staff members from AGCC who had interviewed AJO on his reception to prison gave evidence, together with Detective Senior Constable Watt.

13. There were two issues for inquest:

    - 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;

    - The appropriateness of the mental health assessment on admission to custody at Arthur Gorrie Correctional Centre.

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

The evidence

Personal circumstances and correctional history

15. AJO was one of six children. He was raised in western Queensland and Toowoomba. He was close to both his parents. He enjoyed working on motor vehicles with his father and siblings. AJO had completed agricultural studies at university.

Mental Health History

16. On 28 December 2007, AJO presented to the Toowoomba Hospital, Adult Mental Health Unit (AMHU) reception asking to see someone. He advised that he had bipolar disorder[4] and his mental state had deteriorated over the past few weeks. He cited feelings of hopelessness. He had no current suicidal ideation, plan or intent.[5] At the time he was diagnosed with dysthymia, a persistent depressive disorder.

17. On 28 January 2008, AJO presented to the Toowoomba AMHU with superficial lacerations on his forearm, made with a razor. AJO disclosed feeling depressed, having poor sleep and impaired concentration and motivation. He told the clinician that the cuts were self-harm due to a build-up of frustration and not an attempt to take his life.[6] AJO continued to engage with the AMHU service until 10 March 2008, shortly after he was charged with indecent treatment of a child.

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[4] No records indicate he was diagnosed with bipolar disorder

[5] G2 – Toowoomba Hospital Chart MH Notes, p5

[6] G2 – Toowoomba Hospital Chart MH Notes, p16

18. On 10 October 2010, AJO called the AMHU seeking assistance for personal issues, having experienced a relationship breakdown two weeks prior. AJO was referred to a number of services at this time. He was closed to the AMHU service on 18 October 2010.

19. On 8 January 2011, AJO presented to the Toowoomba Hospital Emergency Department expressing suicidal ideation and poor sleep. He experienced a recent relationship breakdown, and was experiencing symptoms of low mood, poor sleep, poor appetite, anhedonia, amotivation and low self-esteem. He disclosed that he wanted to walk in front of a car, but he had no actual plan to do this. He also disclosed being diagnosed with depression by his General Practitioner six months ago but stopped taking after a week. AJO was voluntarily admitted to the hospital but asked to be discharged about 12 hours later. He was subsequently discharged at his own risk.[7]

Criminal History[8]

20. AJO had a Queensland Criminal History commencing in 2006, with his final conviction in 2018. The most serious convictions were in 2009 and 2014. On 5 March 2009 he was sentenced to 6 months imprisonment, wholly suspended for a period of 18 months after pleading guilty to two counts of indecent treatment of a child under 16.

21. On 28 October 2014 he was convicted following a jury trial of two counts of indecent treatment of a child under 16. He was sentenced to 18 months imprisonment and given a parole eligibility date of 27 July 2015. He was released from prison on 27 April 2016.

22. As a result of his 2009 conviction, AJO became a reportable offender under the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004* and was placed on the register of offenders for a period of 8 years.

23. AJO had four subsequent convictions for failing to comply with the relevant reporting obligations. Following his 2014 convictions, he became a reportable offender for life. On 3 May 2016, AJO was served with notice of his ongoing reporting obligations.

Circumstances of custody

24. On 21 May 2020, AJO was arrested on the following charges and remanded in the Toowoomba watchhouse:

- 5 x failing to comply with reporting obligations
- 3 x possession of drug utensils
- 2 x possessing a dangerous drug
- 1 x unlawful possession of weapons category A, B or M
- 1 x contravening a direction (not providing access to his mobile phone)[9]

25. On 22 May 2020, AJO appeared in the Toowoomba Magistrates Court and was refused bail.

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[7] G1 – CIMHA Medical Records – Toowoomba Hospital
[8] C1 – Queensland Criminal History
[9] H1.5 – IOMS Prisoner Profile

26. After being arrested on 21 May 2020, AJO was remanded in custody at the Toowoomba watchhouse. On entry to the watchhouse he was asked a series of questions about his health, including questions relating to mental health and suicidal ideation. He advised that he had previously been subject to a Mental Health Plan for depression and had previously attempted suicide. He denied having any thoughts of suicide or self-harm during the past three months.

27. On 22 May 2020, AJO was given the opportunity to speak with a mental health liaison officer at the watchhouse but declined. The QPS person report completed at the watchhouse does not identify any concerns or complaints being raised by AJO. He described an instance where he experienced pain associated with a back spasm, but his mental health remained unchanged.

28. On 25 May 2020, AJO was transferred from the Toowoomba watchhouse to AGCC. Upon his admission an 'Immediate Risk Needs Assessment' (IRNA) was conducted by a counsellor, Kevin Donovan. This was required to identify any immediate risks or needs that required attention. During that assessment AJO reported a previous suicide attempt over five years earlier by cutting his wrist. When AJO was questioned further about this, he was unclear if this was a suicide attempt or self-harm behaviour. He denied any recent or current suicidal or self-harm ideation.

29. There was no available information to the contrary. No information was received from arresting or transporting officers indicating a risk of suicide or self-harm, which based on the QPS Person Report from the Toowoomba Watch House this would be correct.

30. The assessment referred to IRNA documents from 30 October 2014 which recorded that AJO then reported he had attempted suicide over 12 months earlier due to stressors associated with the charges he was facing at that time.

31. Mr Donovan referred AJO to Psychology Services for further assessment having regard to the risk factors identified in the IRNA. He also noted that AJO had sought a protection placement and recommended that a Protection Needs Assessment be conducted.[10]

32. On 25 May 2020, AJO was also assessed by Psychologist, Natasha Petherick. AJO reported no mental health conditions and that he was not currently medicated. However, he reported some current depression and anxiety related symptomology. No salient suicidal or self-harm risk indicators were identified. AJO expressed concerns for his dog, and who would care for it while he was in custody. AJO was assessed as being at minimal risk of engaging in suicide or deliberate self-harm at the time of the interview. Ms Petherick did not consider he was suitable for 'elevated base line risk' or 'prisoner of concern' referrals.[11]

33. AJO was initially accommodated in Unit A1 to complete his 14-day isolation period, due to the Covid restrictions in place at the time. The Integrated Offender Services team reviewed relevant information about AJO and concluded he was suitable to be placed in "new or old stock cells". Old stock cells are those with exposed bars.

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[10] H1.6 – IRNA Assessment Notes; H1.7 – IOMS Entries

[11] H1.8 – Psychologist Assessment notes by Natasha Petherick

34. On 27 May 2020, a Protection Needs Assessment was conducted by the Deputy General Manager at AGCC and AJO's protection status was activated. The Deputy General Manager found that AJO had valid concerns for his safety, given the nature of his criminal history, and his first custodial period was spent in protection in 2014.[12]

35. On 8 June 2020, AJO was moved to Unit B3. He was initially placed in shared cell accommodation with another prisoner in Cell 2. On 11 June 2020, the other prisoner was moved out and AJO remained in Cell 2 as the sole occupant.

36. On 14 June 2020, AJO was moved to Cell 24. He was the sole occupant of that cell until the time of his death. Cell 24 was on the lower level of B3 and on side B of the hallway, and was an old stock cell with exposed bars.

Events leading to the death

37. On 18 June 2020, there was a phone call from AJO to R, a family member. This was the last phone call AJO made and lasted seven minutes. During this call R disclosed to AJO that the police were going through his phones "*real good*" and that police had found an image of her daughter, B, on his phone. R told him that B was going to be interviewed by police on 20 June 2020. She was worried that her daughter would be removed from her care.

38. AJO denied that there were any photos on his phones (he had several). He said "*There was nothing on my phone. I check it all the fucking time R, there was nothing on my phone*". He suggested that B had been playing with this phone while she was in his care and he was unwell.

39. On 19 June 2020, at approximately 4.36pm, prisoners in Unit B3 were locked down for the night. Unit B3 was unstaffed throughout the nightshift, from 6.00pm to 6.00am the following morning.

40. At 8.08pm, Corrective Services Officers (CSO) conducted the first headcount. CSO Armstrong conducted the check of Side B.

41. At 4.36am on 20 June 2020, the second headcount of the shift was conducted. CSO Griffiths conducted the check on lower level B3, Side B. CSO Armstrong conducted the check of Side A. CSO Nevin remained in the officers station.

42. When CSO Griffiths approached AJO's cell she observed the viewing window in the door was covered with brown paper and she could not see inside to conduct a welfare check. She knocked on the door and directed AJO to remove what he had covering the window. There was no response, so CSO Griffiths knocked and called out again. Again there was no response. CSO Griffiths completed the welfare checks of the rest of the lower level and went to the officers station to confirm if Cell 24 was occupied.[13]

43. CSO Griffiths confirmed that AJO was the sole occupant in Cell 24. This time CSO Armstrong knocked on the door and called out but also received no response.

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[12] H1.11 – Protection Needs Assessment
[13] D29 – Nikola Griffiths – Officer Report

44. At approximately 4.40am, Correctional Supervisor Alan Spiers was advised of the situation. CSO Griffiths obtained keys and gloves from the officers station and returned to outside Cell 24.

45. At approximately 4.42am, CSOs Alexander and Griffioen attended Unit B3 to assist CSOs Griffiths and Armstrong.

46. At approximately 4.43am, permission was sought from CS Spiers to open Cell 24 and the CSOs were authorised to enter the cell.[14] When the officers opened the cell, they observed AJO hanging from bars located near the louvres with a makeshift ligature, made out of material.[15] The lower half of AJO's legs were encased within a pillowcase and clothing tightly packed around his legs.

47. CSO Armstrong called a Code Blue (medical emergency) and Code Yellow (officer requiring assistance). CSOs Griffiths and Griffioen lifted AJO while CSO Alexander used the 911 cut down knife to cut the ligature. The CSOs carried AJO up the stairs of lower level B3 and into the common area and commenced CPR.[16]

48. At about 4.47am, registered nurses (RN) attended the scene along with the correctional supervisors.

49. The Queensland Ambulance Service was on scene at approximately 5.01am. CPR was ceased at the direction of the QAS, and AJO was declared life extinct at 5.03am.

Autopsy results[17]

50. On 23 June 2020, Dr Rebecca Williams conducted an autopsy consisting of an external examination of the body.

51. The external examination showed a linear injury encircling most of AJO's neck consistent with a hanging furrow. CT Scans showed the deep neck structures were intact, as is usually the case in hanging.

52. Toxicological testing identified a cannabis derivative in the blood but no other drugs were detected.

53. Dr Williams concluded that the cause of death was hanging.

Investigation findings

54. Detective Senior Constable Watt's investigation did not identify any evidence that AJO had disclosed his plans to take his own life. Other prisoners noted that he still buying items from the prison shop and he had not given any property away. There was no change in his behaviour observed by prisoners or CSOs.

55. During resuscitation attempts to revive AJO, a bundle of letters was located on his person. Three letters were addressed:

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[14] H1 – OIMIRG Review – p11
[15] D29 – Nikola Griffiths – Officer Report
[16] D29 – Nikola Griffiths – Officer Report
[17] A3 – Autopsy Report

- To R
- To my friend S
- To my loving mother and father

56. Each letter was sealed in an addressed envelope. All three envelopes were wrapped in another piece of paper with the words *“please send or give to my family”*.

57. To R he wrote:

> *I do not know any other way to prove I did not do any wrong nor harm to her. all I do know is I can not go through this again. I will always be gratful for all you have done. I give you my word and my life….*

58. To his parents he wrote:

> *To my loving mother and father. This is not a desision I made esley at all but I can not go through it all gain. I am so sorry doing this to you both. But I can’t see any other way. Not will change I will all way be hunted for things I never did. I hate what all this shit has mad me become. Just know I loved you both. Your son, … xxx*

59. Also found in his cell was a handwritten document titled, “last will and testament”.[18]

60. The QPS occurrence report[19] of 15 June 2020 detailed AJO’s reporting obligations under the *Child Protection (Offender Reporting and Offender Prohibition Act) 2004*. As part of his reporting obligations, he was required to report details of any reportable child contact within 24 hours of having contact with a child. This included having physical contact with a child and supervising or caring for any child.[20]

61. On 16 May 2020, an 8 year old female child “B” and her 13 year old brother stayed over at AJO’s house. Police conducted a forensic download of his mobile phone and located a video taken on 16 May 2020 of B undressing in the bathroom. The video was of B’s whole body and included vision of her genitals. The camera on the phone turned around and displayed AJO’s face in full. The following day the children returned to their mother, R. Forensic examination identified that the video was deleted from the phone on 18 May 2020. As of 21 May 2020, AJO had not reported his contact with either child as required.

62. On 17 June 2020, police contacted R and determined the child in the video was her daughter, B. An appointment was arranged with R for an iCare interview to be conducted with B on 20 June 2020. This was the same day that AJO died, and the interview was postponed to 24 June 2020. On this date, R attended the police station and advised that she did not want her child to participate in an interview as it was not in her best interests, particularly as no prosecution could proceed.[21]

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[18] F2 – Scene photographs – pp54 - 60
[19] C6 – CEM Report
[20] *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004*, s 9A
[21] C6 – CEM Report

63. R had her final conversation with AJO the day after police first contacted her. There is no evidence to suggest that AJO disclosed this conversation with anyone else or that he appeared distressed after this phone call. Fellow prisoners who had longstanding relationships with AJO were interviewed. They did not hear or see anything that made them consider he was thinking of ending his own life at this time.

64. A review of ARUNTA calls between 29 May 2020 and 18 June 2020 did not identify any disclosures by AJO of suicidal ideation.

65. DSC Watt concluded that no one else was involved in AJO's death. DSC Watt concluded there was no act or omission by any person that amounted to negligence which resulted in the death; and that he was provided adequate medical care while a prisoner in QCS custody.

Operational Inspection and Major Incident Review Group Review

66. At the time of AJO's death, AGCC was under the private management and control of GEO Group Australia. The responsibility for AGCC operations transitioned to QCS on 1 July 2020.

67. A full operational review was conducted by Inspectors appointed under the *Corrective Services Act*.

68. Inspectors questioned the procedure which meant Unit B was not staffed during nightshift. This was the process under GEO management for all units in AGCC, except for the medical and observation units. The midnight shift was managed by two headcounts commencing at approximately 8.00pm and 4.00am. This remained the practice when AGCC transitioned to QCS management. During this time, prisoner cell intercoms were connected to the AGCC master control room to enable prisoners to seek assistance from staff if required.

69. The Inspectors concluded that there was no intelligence or other information which indicated that AJO was contemplating or planning suicide.

70. The Inspectors found that the overall assessment and management of AJO following his admission to AGCC was appropriate and in accordance with the Custodial Operations Practice Directives (COPD).

71. The time elapsed between CSO Griffiths not receiving a response from AJO during the second headcount and when his cell was opened was approximately 5 to 6 minutes. The GEO procedure was that backup was required from other officers before opening a cell door; and required permission from the correctional supervisor. This procedure was for officer safety due to the possibility of an ambush or attack by a prisoner who could be waiting for the door to open. The procedure remains the same under QCS management. Inspectors were satisfied that there did not appear to be any unnecessary delay in opening AJO's cell.

72. Minor breaches of some COPD requirements were identified. However, it was determined that those breaches did not influence AJO's actions in taking his own life and did not affect the GEO staff response to the incident or compromise the later QPS investigation. This related to the CCOs undergoing their debrief together prior to the arrival of CSIU investigators.

73. No recommendations arose from the operational review.

Conclusions

74. Prior to his transfer from the Toowoomba watchhouse AJO was subject to regular cell checks while on Watchhouse remand and did not raise any concerns or complaints for his wellbeing.

75. AJO was remanded in custody on 21 May 2020 and transferred to AGCC on 25 May 2020. There was no indication that AJO was experiencing thoughts of self-harm during his 26 days on remand at AGCC. During his induction, AJO was recorded as strongly denying suicidal ideation. He cited his parents as a strong protective factor and was future oriented.

76. When received into custody at Arthur Gorrie Correctional Centre, AJO participated in an Immediate Risk Needs Assessment performed by social worker, Mr Donovan. I am satisfied that Mr Donovan had access to relevant information when conducting his risk assessment. Mr Donovan appropriately referred AJO for further psychological assessment.

77. AJO was then reviewed by Provisional Psychologist, Ms Petherick. He demonstrated future planning in terms of his release after custody. While he was assessed as requiring protection, due to his past convictions for child sexual offences, there was nothing in his mental health assessment that identified any risk factors requiring he be placed on any observation cycle.

78. It was the assessment of the OIMIRG, following their investigation into AJO's death, that the requirements for the Custodial Operation Practice Directive concerning 'At-Risk Management' had been complied with.

79. On being processed into Arthur Gorrie Correctional Centre, AJO was placed in Unit B3, Cell 24 which was a single cell. No notification of concerns raised for AJO at any time prior to his date of death. Other prisoners housed in Unit B3 were interviewed and none identified any changes in AJO's behaviour that would give rise to any cause for concern.

80. Noting the timing of the ARUNTA call between AJO and R on 18 June 2020, investigators also interviewed Correctional Services Officers that were on duty between than time and the commencement of the shift on the night of 19 June 2020. Those officers both confirmed there were no changes in AJO's behaviour, and that if there had been, they were both familiar with the notification of concern process for a prisoner.

81. Having regard to all of those circumstances, I am satisfied that the mental health assessment of AJO on his admission to Arthur Gorrie Correction Centre was careful and appropriate.

82. AJO's handwritten "last will and testament" was dated on the day of his telephone conversation with R.

83. There is no evidence, except for that of his mother, to suggest that AJO was at risk of suicide or self-harm at the time of his final custodial period. He was in protective custody, at his request, due to his criminal history of offending against children.

84. Given the nature of the video recovered on AJO's phone, it is likely that his suicide was a response to the possibility of facing new charges of indecent treatment of a child under 12 years, and the fact that child was R's daughter, who he was caring for at the time the video was filmed.

85. Prior to this phone call and becoming aware of police finding an image of B on his phone, AJO was actively discussing his other charges and possible legal arguments, and arranging the sale of his car to pay for his legal bills.

86. I agree that there was no basis upon which prison staff or management could or should have formed a concern about risk of self-harm or suicide. There were no suspicious circumstances surrounding the death.

Findings required by s. 45

87. I am required to find, if possible, the cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all the evidence, including the material contained in the exhibits, I make the following findings:

Identity of the deceased –	[anonymised]
How he died –	AJO was remanded in custody at Arthur Gorrie Correctional Centre for a range of offences, including failing to comply with reporting obligations under the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004*. He knew that he faced a further term of imprisonment. In the days leading up to his death he became aware he may also face additional charges of indecent treatment of a child. AJO intentionally hanged himself using a piece of fabric tied to exposed bars in his cell while incarcerated at Arthur Gorrie Correctional Centre.
Place of death –	Arthur Gorrie Correctional Centre, Wacol Queensland, 4076 AUSTRALIA
Date of death–	19 - 20 June 2020
Cause of death –	Hanging

Comments and recommendations

88. Section 46 of the *Coroners Act*, as far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

89. The Queensland Government has committed to the refurbishment of the old stock cells at AGCC that do not have safer cell specifications in place.

90. On 24 May 2021, I delivered findings into the death in custody of a 43 year old prisoner, SVE, who also died at the Arthur Gorrie Correctional Centre as a result of hanging. In those findings I recommended that "*the Queensland Government publish annual updates detailing its strategy for the implementation of safer cells and progress against that strategy*".

91. A response to this recommendation from 31 May 2022, and published on the Coroners Court's website, indicated that Queensland Corrective Services was developing a document which will detail the implementation of safer cells strategy and will provide a progress update against the strategy. Subject to approval, the document will be published on the Queensland Corrective Services website with an annual progress update.

92. In July 2023, QCS advised that "*as at 30 June 2023, 92.9% of all secure cells in Queensland Correctional Centres have safer cell design. This equates to 7,212 (95.5%) built beds within secure safer cells. Upgrading the older style cells at Arthur Gorrie Correctional Centre and Townsville Correctional Centre remains a priority. QCS will publish its progress in upgrading cells on an annual basis in its Annual Report*.

93. QCS also advised that it was not able to publish a strategy detailing future plans to implement safer cells as to do so would pre-empt the Queensland Government's budget process.

94. I acknowledge that in this instance AGCC applied appropriate risk management processes in identifying AJO's risk of suicide. However, as I have previously noted those processes cannot predict every attempt at suicide. The removal of access to hanging points in prisons should continue to feature in suicide prevention strategies.

95. I close the inquest.

Terry Ryan
State Coroner
BRISBANE