CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 19th day of March and the 13th day of September 2024, by the Coroners Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Matthew Wade Sulley.

The said Court finds that Matthew Wade Sulley aged 46 years, late of 8 Windsong Court, Morphett Vale, South Australia died at Morphett Vale, South Australia on or about the 3rd day of April 2022 as a result of neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Matthew Wade Sulley was born on 23 March 1976 and was found deceased on 3 April 2022 at his home in Morphett Vale. He was 46 years of age.

1.2. An external examination, CT and toxicology was performed by Dr John Gilbert of Forensic Science South Australia on 7 April 2022. Dr Gilbert concluded that the cause of death was 'neck compression due to hanging',[1] and I so find.

2. Reason for inquest

2.1. This is a mandatory inquest pursuant to Section 21 of the Coroners Act 2003 as, at the time of his death, Mr Sulley was in lawful custody serving a sentence of court ordered home detention under the supervision of the Department for Correctional Services (DCS).

[1] Exhibit C2a

3. Background

3.1. Mr Sulley was the son of Roseanne Sulley and Geoff Sulley. Mr Sulley's parents were married, but separated when he was about 10 years old.

3.2. Mr Sulley attended Morphett Vale Primary School and Wirreanda High School. He left school when he was in year 10 and worked as a mechanic.

3.3. He was employed as a landscaper at the time of his death. He received passes from Community Corrections to enable him to work whilst he was on home detention.

3.4. Mr Sulley met his partner Rebecca Donohue[2] in 2009 and they began their relationship in 2012. They were engaged in 2013, but never married, and had two children together.

3.5. Mr Sulley also had two daughters from previous relationships and was a grandfather.

4. Mr Sulley's medical history

4.1. As to his medical history, hospital records indicate Mr Sulley was asthmatic. In terms of his mental health, Ms Donohue described Mr Sulley as 'not depressed' and not taking medications. She described him as an 'over thinker' but was not aware of him being diagnosed with a mental illness.

4.2. A DCS pre-sentence report from 2000 does indicate he suffered depression for many years and had attempted suicide by hanging in 1997.

4.3. Noarlunga Hospital medical notes from 1995 describe him as suffering anxiety. He also presented to Noarlunga Hospital in 2021 for 'suicidal ideation' where he was assessed as experiencing a 'situational crisis' in the 'context of relapse of illicit substance misuse'.[3]

4.4. Mr Sulley was a regular user of methamphetamine. Ms Donohue stated that Mr Sulley used drugs for most of their relationship and would smoke and inject methamphetamine daily. He smoked cannabis and previously used ecstasy, cocaine and gamma hydroxybutyrate (GHB). Mr Sulley started using drugs at about 24 years of age and was also a heavy smoker of cigarettes.

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[2] Exhibit C1a

[3] Transcript, page 3

4.5. Ms Donohue said that Mr Sulley was off drugs for about 17 months but had a relapse. She said he acted like he had PTSD when he was using and would accuse her of cheating on him. She thought he was clean at the time of his death, however the messages he sent her just prior to his death made her think he was using drugs again.

4.6. The toxicology report[4] following the post-mortem examination indicated there was no alcohol in Mr Sulley's blood at the time of death, but benzoylecgonine, a metabolite of cocaine, and methamphetamine, and its metabolite amphetamine, were present.

5. Home detention order

5.1. On 21 February 2022 Mr Sulley attended the Christies Beach Magistrates Court upon charges of driving whilst disqualified and was sentenced to 3 months and 18 days imprisonment, with the sentence to be served on home detention.

5.2. Conditions of the home detention order included a requirement to wear an electronic transmitter and to reside at his home address in Morphett Vale.

5.3. On 21 February 2022 Mr Sulley was fitted with an electronic transmitter by DCS staff.

5.4. He attended meetings with his Community Corrections officer on 24 February, 10 March and 24 March 2022. His Community Corrections officer[5] described him as upbeat and noted no concerns during these meetings.

5.5. Mr Sulley had a negative drug test on 24 March 2022.

6. Circumstances leading to Mr Sulley's death

6.1. On 27 March 2022 Mr Sulley had an argument with his partner, who then left the family home with their two children.

6.2. At 3:42am on Saturday 2 April 2022, a strap tamper alert was received at DCS in relation to Mr Sulley's electronic transmitter. DCS attempted to telephone Mr Sulley but there was no answer. Police were advised.

6.3. At approximately 4:07am the same date, police attended 8 Windsong Court, Morphett Vale after receiving a call from DCS. An electronic transmitter, which appeared

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[4] Exhibit C3a

[5] Exhibit C4

to have been cut off was located on the front porch. The front door was slightly ajar and police entered the property to search for Mr Sulley.

6.4. The house was in disarray and the lights were on. It appeared that a disturbance had occurred, but no person was located inside. The front bedroom of the house, including the wardrobe, was searched.

6.5. Ms Donohue told police that on 2 April 2022 she received a message from Mr Sulley saying that he was sorry and that he had cut off his home detention bracelet. He also sent a series of texts messages indicating that he was going to hang himself.

6.6. Ms Donohue tried ringing Mr Sulley on Sunday 3 April 2022 but her calls were unanswered. About 9pm that evening she attended their home address and found the place in a state of disarray.

6.7. She was about to leave the house when she looked back towards the wardrobe in their bedroom. Mr Sulley was located in the wardrobe hanging by a rope.

6.8. Police and an ambulance attended. Paramedics were unable to find a pulse and Mr Sulley was declared life extinct at 10:10pm.

7. Community Corrections post-incident analysis

7.1. DCS Community Corrections conducted a post-incident analysis which was tendered at the inquest.

7.2. Of particular note is that Mr Sulley remained compliant with his conditions and on a mental health questionnaire dated 7 March 2022 he recorded he had no concerns with his mental health, had no suicidal ideation or previous attempts. He had also reported that he attended Drug and Alcohol Services SA (DASSA) weekly.

7.3. The post-incident analysis notes that confirmation of DASSA attendance would have been valuable as, if Mr Sulley was not engaged with DASSA as reported, he may have benefitted from another referral. DCS was unable to confirm if he was engaged with DASSA due to strict confidentiality requirements.

7.4. The post-incident analysis also recommended regular rollout of suicide prevention training for Community Correctional officers and noted that a program was in the process of development by the DCS Learning Academy.

8. Conclusion and recommendation

8.1. I find that Mr Sulley was in the lawful custody of DCS at the time of his death. The supervision by DCS appears to have been appropriate and Mr Sulley was reportedly doing well on home detention until the days leading up to his death, when he appears to have had a relapse into the use of illicit drugs and a corresponding decline in his mental state.

8.2. I make no recommendations.

Key Words: Death in Custody; Home Detention; Suicide

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

Seal the 13th day of September, 2024.

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State Coroner

Inquest Number 23/2024 (0764/2022)