# CORONERS COURT OF SOUTH AUSTRALIA



# INQUEST INTO THE DEATH OF WILLIAM BRUCE STOCKMAN

**[2026] SACC 28**

**Inquest Findings of his Honour State Coroner Whittle**

**15 July 2026**

## CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man who took his own life in the Riverland after an interaction with police. The inquest explored the circumstances of his arrest and bail by police and the adequacy of measures taken in response to his suicidal statements.

Held:

1. William Bruce Stockman, aged 49 years of Renmark, died at Renmark on 6 October 2019 as a result of hanging.

2. Circumstances of death as set out in these findings.

Recommendations made.

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**Counsel Assisting: MR D EVANS**

**Interested Party: COMMISSIONER OF POLICE**
**Counsel: MS S WILSON - Solicitor: CROWN SOLICITOR**

**Witness: S/C J SUTTON, SGT C CASEY & SGT M O'DONNELL**
**Counsel: MS S WILSON - Solicitor: CROWN SOLICITOR**

**Hearing Date/s: 15/10/2024-18/10/2024, 04/12/2024 & 20/01/2025**

**Inquest No: 40/2024** **File No/s: 2060/2019**

This judgment contains discussion of suicide and may be distressing to some people

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# INQUEST INTO THE DEATH OF WILLIAM BRUCE STOCKMAN [2026] SACC 28

## Introduction

1 The Court heard an inquest relating to Mr Stockman, a man who took his own life in the hours following being arrested, charged, bailed and delivered home by police. The inquest focused heavily on the events that occurred at the charge counter of the Berri Police Station, where Mr Stockman made comments that foreshadowed his actions the following morning.

## Proof and content of these findings

2 The standard of proof to be applied in coronial findings is the civil standard; the balance of probabilities. Where I express a finding of fact in these findings, I have done so on the basis that I am satisfied that that fact was proved as more likely than not on the basis of the evidence I heard and received and consider reliable. In considering making findings which imply or express criticism of individuals, I am guided by the principle enunciated in *Briginshaw v Briginshaw*[1] and I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made taking into account the nature and potential consequences of the finding.

3 In these findings I shall not summarise all the evidence tendered or heard at the inquest but refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

## Mr William Bruce Stockman

4 William, or Bill, Stockman was born on 25 July 1970. He grew up and lived in the Riverland, attending boarding school in Adelaide.[2] He had four children.[3] He took his own life on 6 October 2019. He was 49 years old.

5 When Mr Stockman was 14, he was involved in an accident on the family's pig and sheep farm at Burra.[4] Mr Stockman and a friend had been out shooting and were playing on the driveway of the main house, when Mr Stockman accidentally shot his friend in the throat. His friend died as a result of the accident.

6 Mr Stockman commenced a relationship with his eventual wife, Sharee Stockman, in 1996.[5] Together, they took on running the family farm. The stresses of running the farm took a toll on Mr Stockman and he often drank excessively. There was an incident where he pushed Mrs Stockman and then admitted he needed to get help.[6] On another occasion, Mr Stockman rolled his car while intoxicated and broke a number of ribs.[7]

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1 *Briginshaw v Briginshaw* (1938) 60 CLR 336
2 Exhibit C13 at [2]
3 Exhibit C4 at [2] and [39]
4 Exhibit C13 at [16], Exhibit C4 at [12] and Exhibit C5 at [16]
5 Exhibit C4 at [3]
6 Exhibit C4 at [22]-[23]
7 Exhibit C4 at [27]

7 Mr Stockman's marriage broke down in 2010, with the couple remaining amicable.[8] After living in a house near the farm for about a year, Mrs Stockman moved to the Burra township. Mr Stockman commenced a new relationship.

8 In July 2011, Mr Stockman broke into his girlfriend's house and threatened her.[9] When later found by police, he was detained under the *Mental Health Act 2009*. He was taken to Adelaide and held in a mental health facility for about two weeks. Charges were laid but were later withdrawn at the victim's behest.

9 In 2012, Mr Stockman commenced a new relationship with Kelly Teakle.[10] Ms Teakle said that around this time Mr Stockman had some financial troubles and he had started to drink more and more.[11] Ms Teakle said that when he drank, his behaviour would change. He would be moody, angry and make accusations about her.

10 In 2013, Mr Stockman started a charity event with a friend called 'Ski for Life' which involved water skiing 500 kilometres from Murray Bridge to Renmark to raise awareness for men's mental health.[12] The annual event continues to this day. Entries have recently exceeded capacity and entry is now limited by ballot.

11 In 2014, Mr Stockman made the decision to sell the farm as it was no longer profitable due to dropping pig prices.[13] He then moved in with Ms Teakle in Renmark and they married in April 2014.

12 Mr Stockman and Ms Teakle had a son in December 2014.[14] Ms Teakle said that publicly Mr Stockman was presenting as a person who had overcome his issues with depression, but at home he was miserable and depressed. The relationship ended in 2015 after some incidents of violence.[15] Mr Stockman moved to a granny flat behind a friend's place in Renmark. At this time, Mr Stockman worked as a truck driver carting grapes and doing handyman work.

13 Following the separation, Ms Teakle said that Mr Stockman would often threaten to kill himself if Ms Teakle did not recommence the relationship,[16] however there were no *recorded* suicide attempts during this period. After a particular incident Ms Teakle applied for, and was granted, an intervention order protecting her and two of her children.[17] This was later confirmed in the Berri Magistrates Court. The final order contained conditions not to assault, threaten, harass or intimidate, not to be within 100 metres of the protected persons except when handing over a child, and not to communicate with any of the protected persons, except by SMS to arrange child handover.[18]

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8 Exhibit C4 at [31]
9 Exhibit C4 at [35]
10 Exhibit C8 at [3]
11 Exhibit C8 at [5]
12 Exhibit C5 at [13]
13 Exhibit C8 at [10]
14 Exhibit C8 at [14]
15 Exhibit C8 at [16]
16 Exhibit C8 at [25]
17 Exhibit C8 at [29]
18 Exhibit C8 at Appendix A, p 2

14 Parenting orders were put in place to govern his time with their shared child.[19] It was a condition applying to each occasion of handover of the child that Mr Stockman had not consumed alcohol prior to the visit. That condition had been agreed to without any admission.

15 In 2016, Mr Stockman bought a house at Renmark and got a job as a diesel mechanic.[20] In 2017, Mr Stockman commenced a relationship with Sonya Harmer and in the same year they bought a house together, where Mr Stockman lived with Ms Harmer and her two children.[21] Mrs Stockman moved to Renmark with their three children, but Mr Stockman's relationship with them became strained in light of his new relationship. It was felt that Ms Harmer did not treat Mr Stockman's children well and this appeared to affect him.[22]

16 In November 2018, Mr Stockman visited Dr Hamish Eske and was referred to psychologist Sian Duncan for cognitive behavioural therapy for depression, as well as interpersonal therapy in conjunction with Ms Harmer, who was also referred for therapy. They attended their first session on 3 December 2018 and a second session on 1 February 2019.[23] Mr Stockman said that he had PTSD from the shooting accident and had not received counselling after it. He described having 'survivor's guilt'. Throughout both of Ms Duncan's sessions, Mr Stockman denied any suicidal ideation or intent and spoke about previous attempts at the time of losing the farm, including one which saw him admitted to hospital.[24] Mr Stockman spoke about Ms Harmer's focus on her own children over his children which made him feel like he had lost his family, and Ms Harmer denied it. Following the two sessions, Mr Stockman and Ms Harmer disengaged with Ms Duncan.[25]

17 Throughout the middle of 2019, Ms Harmer said that Mr Stockman's depression had been getting worse and his drinking had been increasing.[26] Mr Stockman had been seeing a doctor regularly to try to keep his medication effective but was continuing to struggle.[27] As a result, their relationship was deteriorating. Mr Stockman began seeing his daughter more frequently and mentioned wanting to move out. He spoke of moving somewhere with his daughter or to Darwin with a friend.[28]

## October 2019

18 Early in 2019, Mr Stockman had trouble with his neck after a workplace injury which required surgery, with six weeks away from work recovering. He would wake up unable to move his neck which would make him depressed.[29] After returning from a football trip where he had developed back pain, Mr Stockman was admitted to the Renmark Hospital on 1 October 2019. A CT scan revealed a disc bulge with nerve impingement.[30] He visited Dr Eske on 3 October 2019 and was referred to his neurosurgeon again for

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19 Exhibit C8 at Appendix B
20 Exhibit C5 at [21]
21 Exhibit C4 at [42] and Exhibit C10 at [3]
22 Exhibit C5 at [24]-[26], Exhibit C6 at [11] and Exhibit C7 at [20]-[22]
23 Exhibit C17 at [5]
24 Exhibit C17, clinical notes
25 Exhibit C17 at [6]
26 Exhibit C1c at [3]
27 Exhibit C27
28 Exhibit C5 at [30]
29 Exhibit C5 at [32]
30 Exhibit C28 at p 29

consideration of further surgery. He attended work on 3 October 2019 with a medical certificate. He told his employer that he felt like he was letting the team down by not being able to work, as there were four other staff members away at the time.[31] His employer told him to look after himself and that they would be able to work around his difficulty. He had a consultation that afternoon where it was confirmed that he would need further surgery.[32] He became worried about the financial consequences of being away from work again.

19 On Friday, 4 October 2019, Mr Stockman went to dinner with his three eldest children and a friend at the Renmark Club.[33] On the way, Mr Stockman was angry, saying that Ms Harmer was going to move out and that he wanted to move to Port Lincoln where a friend had a job for him.[34] During dinner, he repeatedly raised his relationship difficulties. After dinner, Mr Stockman left and sat in the gutter. Friends took him home.

20 On Saturday, 5 October 2019, Ms Harmer had a conversation with Mr Stockman over text message.[35] She told him that he needed to stop drinking and that she was moving out of the house. Mr Stockman said that he was writing his will. Ms Harmer told him not to be silly. She said she did not take this comment seriously as she believed that he would seek help if he needed it, as he had done in the past.

21 Ms Harmer sent a message to Mr Stockman's son telling him that she was splitting up with Mr Stockman and was moving out with her two children.[36]

22 In the afternoon, Mr Stockman went out in his tinny with friends, including a school friend, David Doudle.[37] Mr Stockman told Mr Doudle that if his friends had not come to visit him, he may have committed suicide that morning. While he was out, Ms Harmer sent him a text message saying that she did not want them to come back drunk and he replied that he loved and respected her.[38]

23 Between 8 pm and 9 pm, Mr Stockman spoke to an acquaintance, Dylan Blackley, at the Renmark Football Club. Mr Stockman said, '*I woke up this morning thinking this is it, I want to kill myself. Everyone would be happier if I was dead anyway. The Mrs doesn't like me any more*'.[39] He was very calm as he said this. Mr Blackley reported this to Mr Stockman's son later that night.[40]

24 Mr Stockman left with a group and headed to the Renmark Hotel. Ms Teakle was there and he approached her shortly before 11:30 pm.[41] He appeared to be very intoxicated and used aggressive mannerisms. He made distasteful comments about Ms Teakle. He left

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31 Exhibit C14 at [4]
32 Exhibit C27 at [2]
33 Exhibit C5 at [33] and Exhibit C6 at [17]
34 Exhibit C4 at [47]
35 Exhibit C1a at [4]
36 Exhibit C7 at [34]
37 Exhibit C13 at [11]
38 Exhibit C1a at [7]
39 Exhibit C11 at [4]
40 Exhibit C11 at [8]
41 Exhibit C8 at [37]

the premises and was denied re-entry by security. Ms Teakle said she was scared and called police.[42] A domestic violence disturbance was recorded.[43]

25 Two members of police, Brevet Sergeant Christopher Casey and Senior Constable First Class Jonathan Sutton, had recently commenced their shift. They arrived at the Renmark Hotel just after midnight.[44] They spoke to Ms Teakle about the incident and she provided a statement.[45] She informed police that she would likely refuse to hand over their child the following day because of Mr Stockman's intoxication. They spoke to other witnesses who confirmed Ms Teakle's complaint.[46]

26 Police then attended at Mr Stockman's house, arriving at about 12:30 am.[47] Senior Constable Sutton had formed the opinion that it was necessary to arrest Mr Stockman for the breach of intervention order because of his level of intoxication and that there was to be a further interaction with Ms Teakle the next day in relation to child handover.[48] Senior Constable Sutton considered that this action was in line with SAPOL's domestic violence policy. I will discuss this in more detail later. Mr Stockman answered the door and spoke with police. Ms Harmer came to the door and they explained the situation to her. Mr Stockman was arrested and read his rights and conveyed to the Berri Police Station in the back of a cage vehicle.[49] While driving to the police station, Sergeant Casey looked up Mr Stockman's history, which contained a caution 'may be suicidal'.[50]

27 Senior Constable Sutton and Brevet Sergeant Casey presented Mr Stockman at the charge counter.[51] By this time Mr Stockman had made no comments alluding to self-harm.[52]

28 Sergeant Melanie O'Donnell processed Mr Stockman.[53] She searched him on police systems and saw his 'may be suicidal' caution.[54] During the process, Senior Constable Sutton searched Mr Stockman and then monitored him. Senior Constable Sutton's impression was that Mr Stockman was slightly to moderately intoxicated.[55] His blood alcohol concentration was 0.215% on an alcotest performed at 1:04 am.[56] Sergeant O'Donnell was concerned about Mr Stockman's intoxication and asked the arresting members if there was anyone at home to look after Mr Stockman if he was granted bail.[57] The members advised her that Mr Stockman's partner was at home,[58] making an assumption that she was supportive and not being aware that she was preparing to leave.

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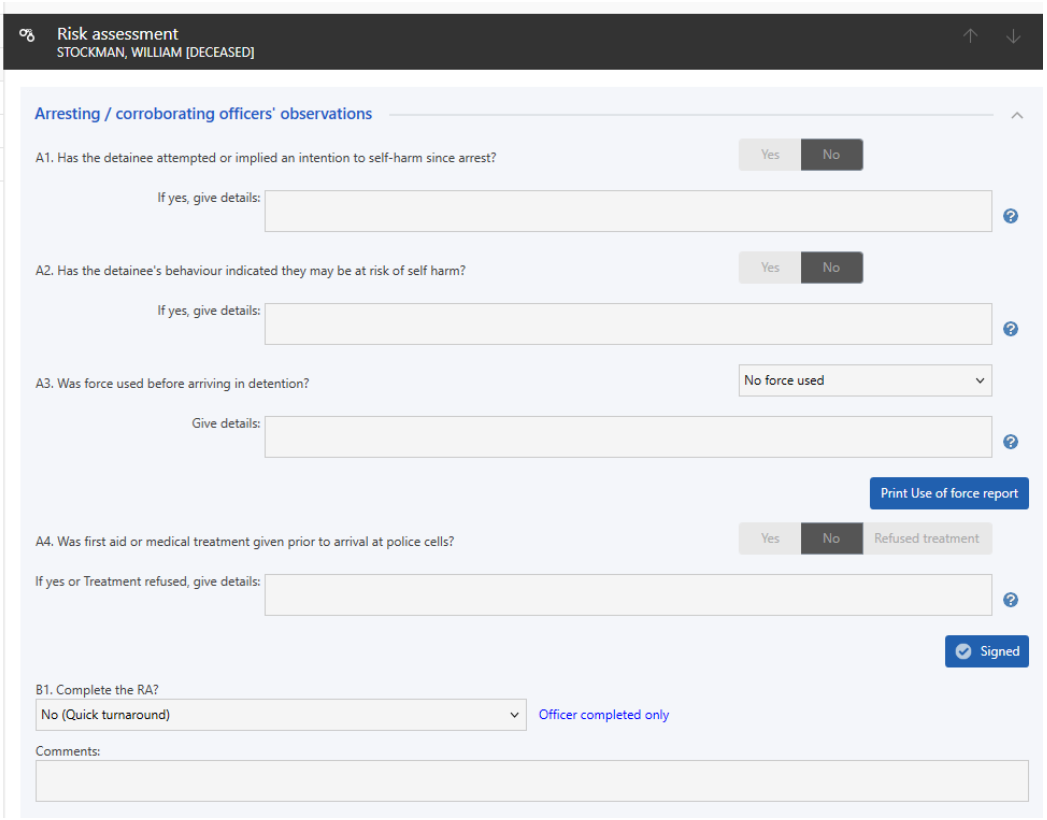
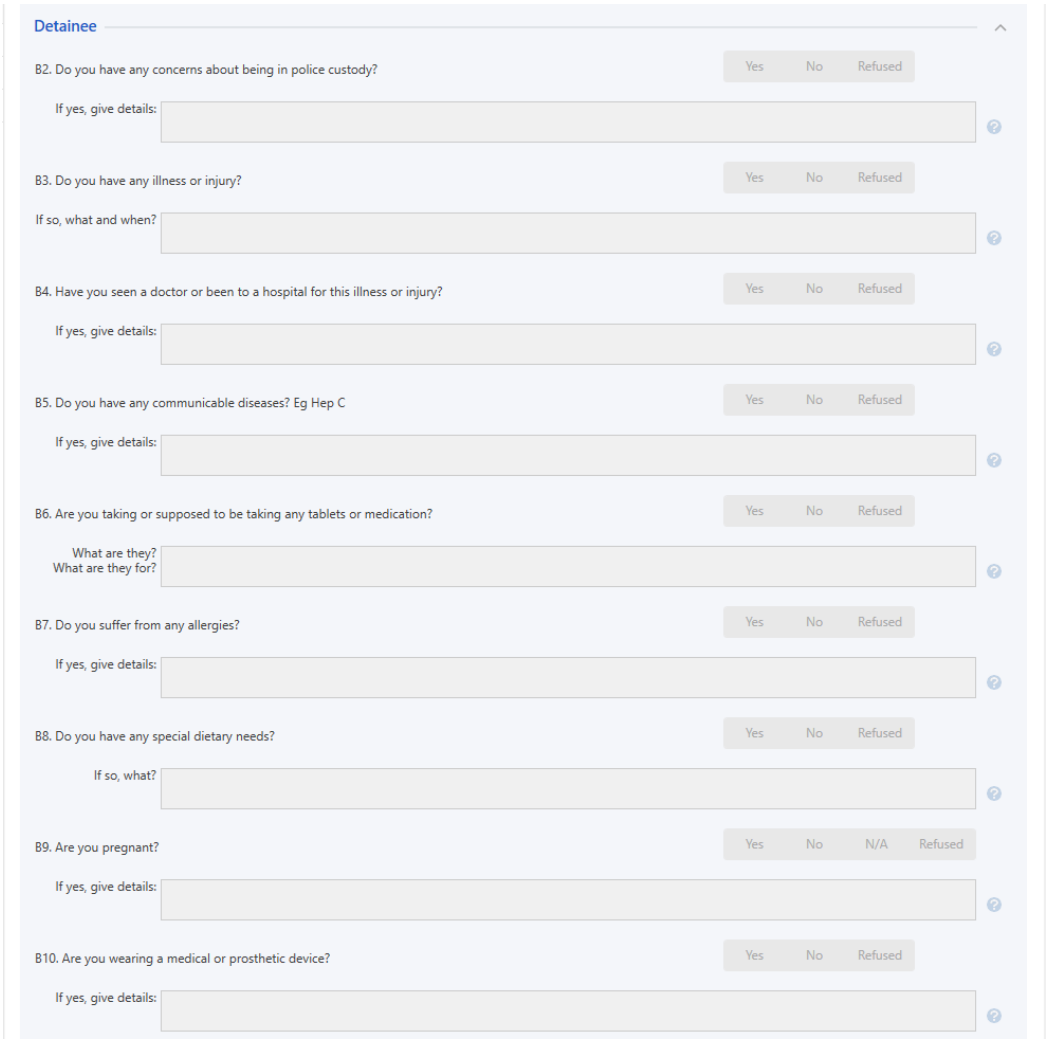
42 Exhibit C11 at [4]
43 Exhibit C35 at [6]
44 Exhibit C30a at [2] and Exhibit C34 at [6]
45 T19
46 Exhibit C34 at [7]-[9]
47 Exhibit C30a at [8] and Exhibit C34 at [11]
48 Exhibit C30a at [1]
49 Exhibit C30a at [11] and Exhibit C34 at [14]
50 T108 and T111
51 Exhibit C30a at [15] and Exhibit C34 at [15]
52 T27 and T116
53 Exhibit C35 at [7]
54 T141
55 Exhibit C30a at [15]
56 Exhibit C36 at p 4
57 Exhibit C35 at [8]
58 Exhibit C34 at [16]

29 Sergeant O'Donnell decided to process Mr Stockman as a 'quick-turnaround' which had the result that she did not complete all detainee risk assessment questions.[59] Sergeant O'Donnell completed the following questionnaire.[60]




59 Exhibit C35 at [8] and T115
60 Exhibit C36



Detainee

B2. Do you have any concerns about being in police custody? Yes No Refused

If yes, give details:

B3. Do you have any illness or injury? Yes No Refused

If so, what and when?

B4. Have you seen a doctor or been to a hospital for this illness or injury? Yes No Refused

If yes, give details:

B5. Do you have any communicable diseases? Eg Hep C Yes No Refused

If yes, give details:

B6. Are you taking or supposed to be taking any tablets or medication? Yes No Refused

What are they?
What are they for?

B7. Do you suffer from any allergies? Yes No Refused

If yes, give details:

B8. Do you have any special dietary needs? Yes No Refused

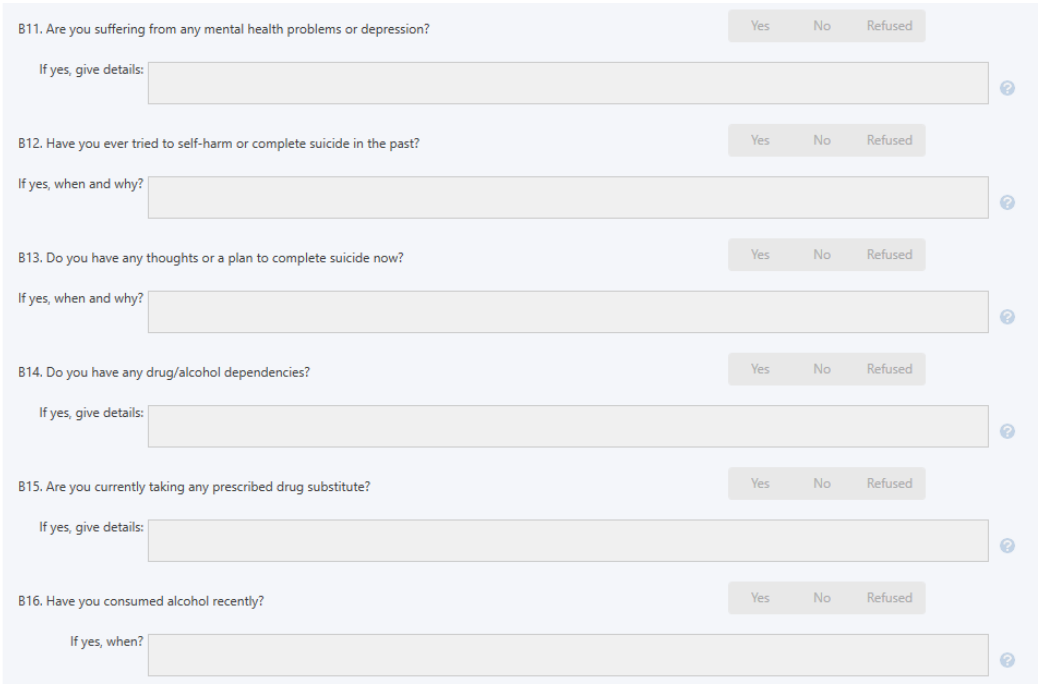
If so, what?

B9. Are you pregnant? Yes No N/A Refused

If yes, give details:

B10. Are you wearing a medical or prosthetic device? Yes No Refused

If yes, give details:



B11. Are you suffering from any mental health problems or depression? Yes No Refused

If yes, give details:

B12. Have you ever tried to self-harm or complete suicide in the past? Yes No Refused

If yes, when and why?

B13. Do you have any thoughts or a plan to complete suicide now? Yes No Refused

If yes, when and why?

B14. Do you have any drug/alcohol dependencies? Yes No Refused

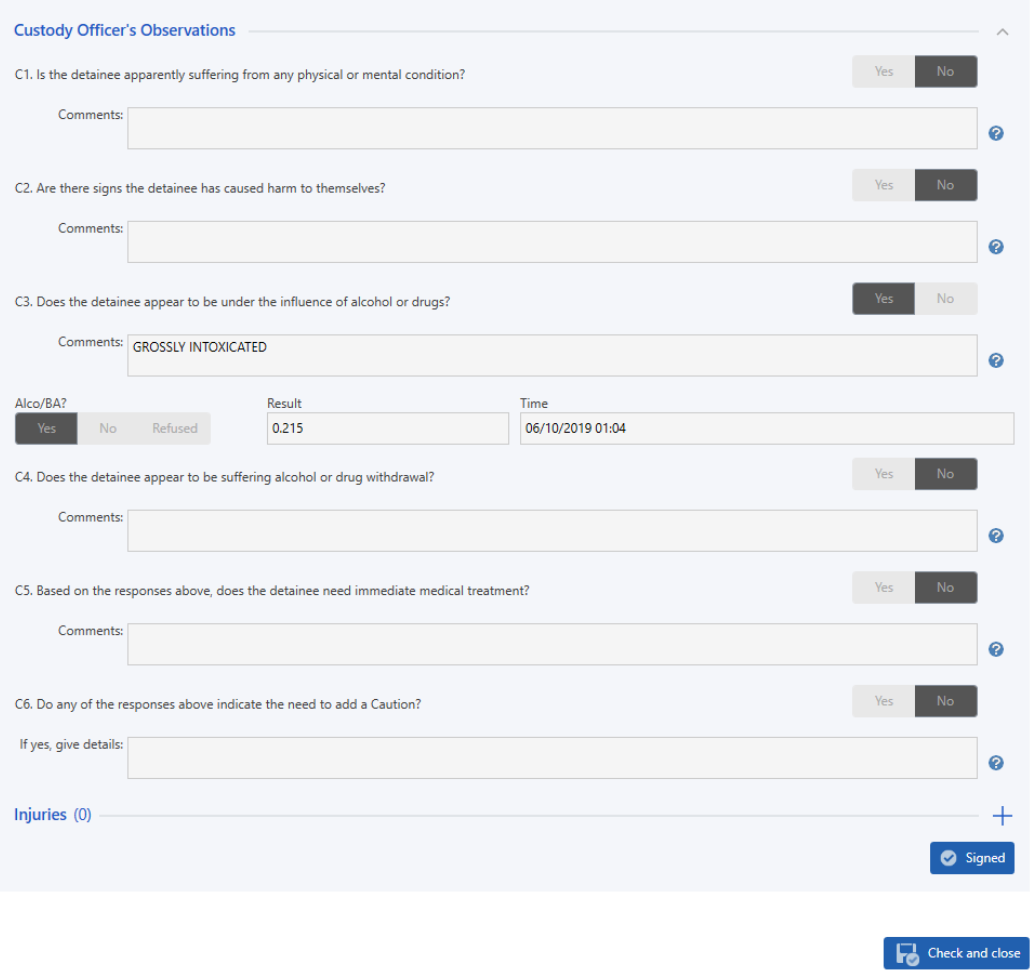
If yes, give details:

B15. Are you currently taking any prescribed drug substitute? Yes No Refused

If yes, give details:

B16. Have you consumed alcohol recently? Yes No Refused

If yes, when?




30 I particularly highlight that questions B2 through to B16 were greyed out due to the quick-turnaround process being selected at question B1, and accordingly not completed.

31 Except for a brief involvement and overhearing questions about mental health, Brevet Sergeant Casey was busy completing charging documents and dealing with other matters, so was not paying attention to the charging process.[61]

32 During the charging process, Mr Stockman said, '*Lock me up all night, I don't care, I'm done with life to be honest*'.[62] He mentioned his history with Ski for Life. He also made a comment, '*Do you know what, I woke up this morning and I felt like topping myself*'.[63] Sergeant O'Donnell asked him whether he had suicidal thoughts and Senior Constable Sutton said that he replied, '*At the moment, no*' and said he needed to use the bathroom.[64] Senior Constable Sutton's impression was that Mr Stockman meant he had had thoughts earlier in the day, but did not have current thoughts.[65] Sergeant O'Donnell's recollection is that Mr Stockman was asked about the topic twice. On the first occasion, he responded by asking to use the toilet. On the second, he responded by saying that he just wanted to go home to bed.

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61 Exhibit C34 at [15]
62 Exhibit C31a (transcribed in Exhibit C32 at line 103)
63 Exhibit C31a (transcribed in Exhibit C32 at line 282)
64 Exhibit C31a (transcribed in Exhibit C32 at line 293)
65 Exhibit C30 at [3]

33 Sergeant O'Donnell said she was satisfied that Mr Stockman would be safe if he was granted bail and returned home.[66] She granted bail and said she asked Senior Constable Sutton and Brevet Sergeant Casey to take Mr Stockman home and explain the barring order to Ms Harmer so that Mr Stockman would not be confused about it in the morning.[67] After dealing with an incident in the cells complex, they took Mr Stockman home, arriving at 3:22 am.[68] He was given a three-month-long barring order for the Renmark Hotel and was walked to the front door. Mr Stockman then apologised for his behaviour and thanked the two police, shaking their hands.[69] The members left when Mr Stockman went inside.

34 Ms Harmer was not awake when Mr Stockman arrived home. On the morning of Sunday, 6 October 2019, Ms Harmer woke up before Mr Stockman. She could still smell alcohol in the air and Mr Stockman was snoring.[70]

35 Ms Harmer went to look at properties in Renmark before coming home and starting to pack.[71] Mr Stockman awoke after 11:30 am and sat on the porch while Ms Harmer and her son were packing.[72] Ms Harmer said he appeared depressed and had a vacant look on his face.[73] Ms Harmer said she told him that even though things were bad, she still loved him. He did not reply. She saw him go to the back of his ute, at the toolbox, before walking to the rear of the property.

36 About five minutes later Ms Harmer's son, Riley, ran into the house and said that Mr Stockman was hanging in the patio.[74] Riley rang triple zero while Ms Harmer went to help Mr Stockman. The call came through at 12:10 pm.

37 Constable Todd Van Dyk responded to the call, arriving at 12:14 pm.[75] He was directed by Riley Harmer to the back of the property. Ms Harmer was standing on a ladder trying to take the weight off a strap that was around Mr Stockman's neck. Constable Van Dyk stepped immediately up onto a nearby lounge and cut Mr Stockman free.[76] With the assistance of a lounge chair, Constable Van Dyk and Ms Harmer broke Mr Stockman's fall. Ms Harmer commenced CPR and Constable Van Dyk found no pulse, so took over the CPR process.[77] A very short time later, paramedics arrived. They recorded their time of arrival as 12:15 pm. At this time, Mr Stockman was cyanosed and unresponsive, with no pulse or respirations. After six doses of adrenaline and two defibrillator shocks, there was no response and Mr Stockman was declared life extinct at 12:58 pm.[78]

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66 Exhibit C35 at [10]
67 Exhibit C30 at [10]
68 Exhibit C30a at [19] and Exhibit C34 at [10]
69 Exhibit C31e and C31f
70 Exhibit C1b at [3]
71 Exhibit C9 at [14]
72 Exhibit C9 at [15]
73 Exhibit C1b at [5]
74 Exhibit C1a at [3] and Exhibit C9 at [16]
75 Exhibit C22 at [3]
76 Exhibit C22 at [3]
77 Exhibit C22 at [4]
78 Exhibit C18 at [9]-[10] and Exhibit C29

38 Police examined the scene. They found a blue ratchet strap, which had been cut, secured with a metal hook to a pergola beam.[79] The strap had been tied into a noose with a granny knot. The ladder was nearby.

## Post-mortem examination

39 A post-mortem examination was conducted by senior forensic pathologist, Dr Stephen Wills.[80] Dr Wills concluded that Mr Stockman's death was as a result of hanging. Toxicological examination[81] found alcohol in Mr Stockman's blood at a level of 0.13%. Other drugs were also found: a high concentration of the antidepressant drug amitriptyline, which had been prescribed for radiculopathy pain, and its metabolite (although the level of this drug can increase after death), a nerve pain relief drug pregabalin, a blood pressure drug amlodipine, another antidepressant venlafaxine and its metabolite, an anti-inflammatory drug meloxicam and a cough suppressant pholcodine.

40 There was no issue with Dr Wills' opinion about Mr Stockman's cause of death and I find that Mr Stockman's cause of death was *hanging*.

## Assessment of witnesses

41 I heard evidence from three members of police and an expert psychiatrist, Dr Victor Lau. There was no challenge to the credibility of any witness, and I was generally impressed by the evidence of each of them. The police witnesses were clearly all upstanding members of the community who have been doing a difficult job, for decades.[82] I have no doubt each gave honest evidence and did their best to assist the Court.

42 I take into account that these members were working in a rural setting which necessarily meant that they were busy performing multiple duties. Working in a smaller community also has obvious impacts on the way they must carry out those duties.

43 In respect of Dr Lau, there was no challenge to his expertise. I was greatly assisted by his expert opinion in relation to the manner in which suicidal ideation and intent is best addressed and the challenges that it presents.

## Assessment of issues

44 I will now consider the issues which arose during the inquest and explore whether Mr Stockman should have been dealt with differently at any stage, and I will then consider whether that might have meant that his death could have been prevented.

### *Decision to arrest Mr Stockman*

45 The first issue explored was whether police acted appropriately in arresting Mr Stockman, noting that members of police have many tools available to them to achieve safety in the community, arrest being effectively the highest intervention.

46 What was clear from the evidence is that both Senior Constable Sutton and Sergeant Casey were aware of their options, which included arrest, but also not arresting Mr Stockman *on the night*, or at all. Senior Constable Sutton gave an explanation about

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79 Exhibit C24 at [16]
80 Exhibit C2a
81 Exhibit C3a
82 T17, T105 and T130

the reasoning behind his decision. He spoke of a general desire among police to take action in relation to allegations of domestic violence. He gave the following evidence:

> A. … No action is not really an option in relation to a breach of intervention order. It's very highly recommended, not prohibited but very highly recommended that we take positive action in relation to domestic violence allegations, particularly in relation to breaches of intervention orders that are put into place for the victim's safety.
>
> Q. Where does that recommendation come from.
>
> A. They're police general orders, policy, previous coroners' recommendations, previous court matters. There's a vast majority of information provided to us to encourage us to take positive action in relation to domestic violence allegations.
>
> Q. So to take positive action, does that effectively mean arrest if you can locate.
>
> A. Not specifically. It is directed by the circumstances but arrest is usually the most preferred because it does address a lot of the risks and the criteria to put a stop to it, make a prompt action essentially, and to address their story promptly at the time. But a report sometimes, especially with intoxication involved, which we had the indication at that stage he was intoxicated at the hotel, if you go and talk with them after that and you report them, they hardly remember what's gone on. And there have been occasions where people have been spoken to when they've been intoxicated and they've rung up the next day and go 'What was all that about', you know, like they don't remember. So arrest is one of the things which does address a lot of the issues at the time.
>
> Q. So in this instance you had made that decision to arrest. Were there any specific factors relevant to this matter, having spoken to the witnesses and Ms Teakle which informed that decision.
>
> A. Yeah, Ms Teakle made the comment about there was a child handover matter that was meant to be occurring the next day, that there was ongoing issues in relation to alcohol and so on, and that Mr Stockman wasn't meant to, according to a family plan or something, not meant to have custody of the kid while he was intoxicated. And she was indicating that she was going to not hand over the child, which also means that there's, you know, another - it's important for us to take action promptly so that we can address this matter before that eventual conflict occurs so that we can correct it, I guess, or make efforts to prevent further offences occurring then. [83]

47 Sergeant Casey was asked whether he agreed with Senior Constable Sutton's decision and he was emphatic that he did.[84] After weighing up the evidence on this topic, I consider that even if more thorough research could have been done into the background circumstances of the intervention order, the decision to arrest Mr Stockman, although not the only decision available, was a reasonable one in all of the circumstances.

*Use of quick-turnaround procedures*

48 Sergeant O'Donnell gave evidence that the quick-turnaround procedures are essentially used where it is identified that a person presented for charging is unlikely to require the use of a cell, that is, they are unlikely to be detained at the end of the charging process.[85]

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[83] T20-21
[84] T118
[85] T136

49 There are two aspects to this issue. First, the initial decision to use quick-turnaround, and second, whether that decision should have been revisited later.

50 In making the decision that the quick-turnaround procedures were appropriate for Mr Stockman, Sergeant O'Donnell gave evidence that she considered:

> The fact that he was not [a] prescribed [applicant], so I was able to give him bail, the fact that he was able to - despite the fact that he was intoxicated, he was able to go home to a stable, sober family member or partner. [86]

51 In respect of the decision at first instance, given that Mr Stockman had not previously been charged with any breach of any intervention order - in fact he had not been the subject of any charges in almost eight years - and that the breach did not involve a threat or any violence, I consider that the initial assessment that Mr Stockman was likely to be bailed was an appropriate one by Sergeant O'Donnell.

52 I will return to the question of whether the use of the quick-turnaround procedures should have been reconsidered when I assess the next issue, the manner of responding to Mr Stockman's comments.

*Manner of responding to Mr Stockman's comments*

53 As I have set out, Mr Stockman made a number of comments which on the face of it raise a level of concern about his safety. A video of the charging process was received into evidence,[87] as was a transcript of the video.[88] Having carefully watched and listened to the video, I am satisfied that the key portions of the transcript are an accurate reflection of the conversations between Mr Stockman and police at the charge counter.

54 At line 103 of the charge process transcript, he said, '*I'm done with life*'.[89] This is a comment which reveals suicidal ideation. That is plain on the face of the words, Senior Constable Sutton conceded that it was a suicidal statement,[90] and that was Dr Lau's evidence. I find that to be so.

55 It is unfortunate that both Senior Constable Sutton and Sergeant O'Donnell made an interpretation of that statement which had the effect of dismissing it or not addressing it in any meaningful way. I heard their explanations for doing that. There was in essence only one real explanation – that detainees say that kind of thing all the time.[91] They were deemed to be 'throw away' comments by Senior Constable Sutton.[92] He said that he had made an assessment that Mr Stockman's demeanour did not match the stated intention.[93] He alluded to the possibility that Mr Stockman was manipulating the situation or '*trying to throw a spanner in the works*'.[94] In my view, that was not what Mr Stockman was doing and, having reviewed the recorded interactions, it was not reasonable to reach that conclusion.

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86 T137
87 Exhibit C31a
88 Exhibit C32
89 Exhibit C31a (transcribed in Exhibit C32 at line 103)
90 T76 and T81
91 For example, at T75 and T168-T169
92 T34 and T74
93 T38
94 T86-T87

56 Such an approach is risky. That is because, as is trite to say, some people who make these comments will go on to commit suicide. Dr Lau gave an estimation based on research of about 50% of suicide cases where it is voiced in advance, which highlights the importance of asking questions to see if there is a real issue.[95] In my view, it is inadequate to say that because a comment is heard often, it need not be addressed in any way at all. I find that dealing with such comments in that way is inappropriate and unreasonable.

57 During the evidence, issues were explored about the potential resourcing consequences of having to take every detainee who makes suicidal comments to hospital for mental health assessment.[96] I consider that a comment like this need not result in an immediate trip to the hospital for mental health assessment. That may be an extreme response to a single comment which is made without a great level of precision. However, it is quite another thing to accept that nothing at all will be done about such comments and I am unable to accept that ignoring such comments is appropriate.

58 Senior Constable Sutton said that a cautious approach would have seen more questioning.[97] I consider that further questioning would have been appropriate. I say that particularly highlighting that Mr Stockman had a 'may be suicidal' caution and that was precisely what was called for – caution.

59 At line 282 of the charge process transcript, Mr Stockman said '*Do you know what, I woke up this morning and I felt like topping myself, I rang my mate*'.[98] By the time Mr Stockman made the comment at line 282, Senior Constable Sutton and Sergeant O'Donnell had heard two comments alluding to suicide, objectively of increasing concern. By that I mean the second comment was clearer in its language and had the component of Mr Stockman indicating that he had relied on an external source to defuse his thoughts. Dr Lau agreed that it was a comment expressing very recent suicidal ideation and I find that it was. Senior Constable Sutton in effect conceded that in his evidence when he said:

> That started to be a bit more of a, bit more of something, but more of along the lines of it's something that's, like, underpinning, or something that's maybe a constant battle for him. And you can see there that if - and he said that he felt like topping himself, and he rang his mate. So, you know, there's people who have thoughts about self-harm quite often, and part of their treatment process, they go through a process of dealing with coping mechanisms and contacting people, and dealing with stuff like that, and it appeared to me at that stage that he was, you know, using those. He said he, yeah, 'I rang my mate', and yeah, so. [99]

60 Sergeant O'Donnell conceded this directly.[100]

61 Of course, this comment was not ignored. Sergeant O'Donnell enquired about it. Sergeant O'Donnell's evidence was that the Shield system allows her to change her quick-turnaround decision at any point in the process, but she did not change it when she heard this comment. She said she would have changed it here only if she had considered the comment genuine.[101] Instead of enabling the full risk assessment and asking the questions

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95 T215
96 For example, at T39, T84 and T200
97 T80
98 Exhibit C31a (transcribed in Exhibit C32 at line 282)
99 T36
100 T167
101 T146

on Shield, she formulated her own question, responsive to Mr Stockman's comment, which was '*Do you feel like topping yourself now William?*' and then '*Do you feel like harming yourself at the moment?*'.[102] Of course, what 'now' or 'at the moment' might relate to is ambiguous and this question might have a temporal problem in that the technical answer might be that it would be impossible to commit suicide while standing in a police station next to a member of police. This could possibly result in a person truthfully answering no, despite intending to commit suicide immediately upon release. It is perhaps for similar reasons that the Shield system offers prompts, to ensure that only questions that are particularly designed to draw out risk are asked.

62 That issue aside, the questioning of Mr Stockman occurred while he was intoxicated, standing at a counter looking at a member of police through glass. It is plain from the footage that it was asked bluntly and not in a particularly compassionate way. In my assessment Mr Stockman gave an impression of deflecting. Dr Lau said that he could not be sure whether Mr Stockman was denying suicidal intent or purely deflecting the question. In my view, whichever of those is correct is not really to the point and that is because of what Mr Stockman went on to say. He said '*That's all that's on my mind at the moment is that I'm busting for a wee and I lost my thongs*'.[103] Those words speak for themselves. In the context of being asked in a blunt manner whether Mr Stockman felt like harming himself *at the moment*, he expressed what was on his mind *at that moment*. That is, he raised an immediate concern of a transient nature. In my view, the interaction that occurred on this topic was not adequate to gain a true appreciation of Mr Stockman's position about his intentions, which by then he had squarely raised twice.

63 Sergeant O'Donnell was asked whether she ought to have asked more and she said that she could have but she did not think she needed to because she believed she had an answer to her query.[104] To accept '*nah I'm busting for a piss*' as a full answer in the negative to there being any thoughts of self-harm after Sergeant O'Donnell had heard two comments of suicidal ideation, against the background of there being a 'may be suicidal' caution on Mr Stockman's record, was not reasonable and was not a sufficient manner of dealing with what was said.

64 This was a point at which the quick-turnaround decision ought to have been revisited and the full risk assessment questions asked. Dr Lau agreed that questions B11, B12 and B13 asked in sequence were likely to elicit a clearer picture about Mr Stockman's risk, or at least force a longer conversation on the topic which would have been helpful.[105] I pause to observe that Mr Stockman was open to discussing his mental health and was actively making references to suicide. Asking these three questions (which were available to Sergeant O'Donnell to view on Shield) would have been a good starting point in order to deal with what Mr Stockman had said in light of what Sergeant O'Donnell knew of him at that point. Dr Lau was clear that more information was needed, more questions needed to be answered in order to truly assess the risk.

65 Dr Lau provided evidence about other things that the members could have done in two categories; exploring protective factors and finding out more information.[106] However,

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102 Exhibit C31a (transcribed in Exhibit C32 at line 293)
103 Exhibit C31a (transcribed in Exhibit C32 at line 311)
104 T179
105 T223
106 T212

you do not actually get to the point of doing those things if you do not see a problem. The members' dismissiveness of the comments because they are commonly made meant that they were never going to reach the point of considering what actions they might take. That was regrettable.

*Mr Stockman's safety upon returning home*

66 Sergeant O'Donnell's idea of having the bail conditions explained to Mr Stockman's partner was a good one. It would have had many positive side-effects. Most importantly, it would have brought about another interaction where more information about Mr Stockman's mental state might have been revealed. It might have clarified an assumption made by the members; that is whether Mr Stockman indeed had a supportive partner at home or not. It might have brought to Ms Harmer's attention that Mr Stockman was experiencing suicidal ideation which might have actually turned her into a protective factor.

67 There were two unfortunate aspects to the implementation of Sergeant O'Donnell's idea. The first is that she did not formally direct the members to carry the task out.[107] She explained that she only suggested it and only did so indirectly through Mr Stockman. She agreed that it would have been preferrable if she had recorded it somewhere.[108] This would have made her expectation clear, made sure the members were reminded of it and were accountable for it. The second unfortunate aspect of this topic is the fact that the members did not carry out the task, even though they both understood that Sergeant O'Donnell expected or wanted them to do it. Senior Constable Sutton gave evidence that he made a decision not to carry out the task and did not have any discussion with Sergeant O'Donnell about that.[109] I have given thought to whether he is open to criticism for that. However, in the end, given that Sergeant O'Donnell had not directed or required him to do the task and the sole purpose of the task actually contemplated was to ensure Mr Stockman understood his bail agreement and not any welfare purpose, there is no criticism to be made. While the task would have had the positive side-effects I have spoken of, Senior Constable Sutton is not to be held responsible for those side-effects not being realised when he was not asked to achieve them.

## Preventability

68 Mr Stockman's arrest came at a critical point, where several stressors were combining in Mr Stockman's life. He had relationship difficulties with a partner about to pack her bags and leave him, he had a back injury and was facing a long period of recovery without any income, he had a custody fight for his young son. Of course, this was all happening against the backdrop of Mr Stockman's chronic poor mental health and prior suicide attempts.

69 I consider it clear that the combination of all of these factors, together with the fact of being arrested and bailed, brought about Mr Stockman's decision to act on his suicidal tendencies. I consider that it is impossible to draw out individual factors as playing any role of more significance than any other. In that, I include the role of the arrest and bail.

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[107] T94, T100 and T182
[108] T182
[109] T92-T93

70 In light of the evidence I heard from Dr Lau, it may be that there is not much that could have been done to prevent Mr Stockman taking his life eventually, although that cannot be said for certain. The question of whether his death could have been prevented on the day it occurred is closer to being proved. However, assessing all of the evidence carefully, and particularly in light of the number of issues which had accumulated, I am not able to be satisfied that Mr Stockman's death was preventable.

## Recommendations

71 The *Coroners Act 2003* requires me to consider whether there are any recommendations that I might make which might prevent, or reduce the likelihood of, a recurrence of an event similar to that which led to Mr Stockman's death, or which concerns the quality of care, treatment and supervision provided to Mr Stockman.

72 Notwithstanding that individual police actions may not have brought about Mr Stockman's death, that might not be the case in a different situation where a small action might make a big difference to another vulnerable person presented to the charge counter. I am persuaded that in this matter there are recommendations that I can make which will materially contribute to safer administrative processes for SAPOL.

73 It is trite to say that even if on most occasions comments made by people undergoing the charge process about ending their life are 'throw away', in rare instances they will be genuine. Members of police are unlikely to be best placed to make that assessment, especially without any further enquiry at all. If a single death can be prevented by treating all comments alluding to a person ending their life as genuine until assessed further, then the exercise is worthwhile.

74 The General Order on Custody Management allows for phone advice to be taken from a mental health triage service for mental health detainees.[110] Extending this to all detainees who express suicidal intent might be a way for SAPOL to minimise the impact on their workload of taking all suicidal comments seriously and assist them to provide a better service to people at risk of self-harm. Of course, exactly how SAPOL implements change is for SAPOL to decide; my point is merely that there appear to be mechanisms in place already that might be able to be used. I therefore make the following recommendations to the Minister for Police:

*One* That SAPOL conduct training of its members concerning suicidal ideation with the aim of dispelling the practice of making assessments on the validity of suicidal comments and not actioning them solely on the basis that they are what is described as 'throw away' or 'off the cuff' comments.

*Two* That SAPOL introduce a mechanism which allows support to be sought from trained professionals when assessing whether or not there is a genuine suicidal issue that requires medical assessment.

75 The inquest highlighted specific issues with the structure of the charge process questionnaire. I am aware from the affidavit of Chief Inspector Epps[111] that SAPOL has

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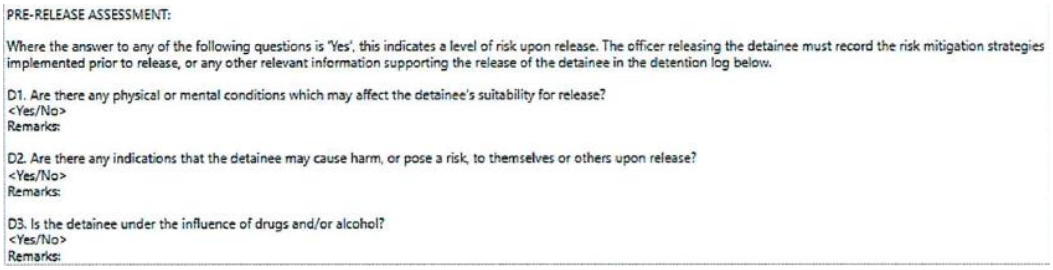
[110] Exhibit C33 at Appendix W, page 43
[111] Exhibit C39a

conducted some work on this issue. Chief Inspector Epps advised that the following has been added to the Shield questionnaire:



PRE-RELEASE ASSESSMENT:

Where the answer to any of the following questions is 'Yes', this indicates a level of risk upon release. The officer releasing the detainee must record the risk mitigation strategies implemented prior to release, or any other relevant information supporting the release of the detainee in the detention log below.

D1. Are there any physical or mental conditions which may affect the detainee's suitability for release?
<Yes/No>
Remarks:

D2. Are there any indications that the detainee may cause harm, or pose a risk, to themselves or others upon release?
<Yes/No>
Remarks:

D3. Is the detainee under the influence of drugs and/or alcohol?
<Yes/No>
Remarks:

76 The issue with this solution is that, in my view, it would not necessarily lead to any member directly questioning the detainee themselves. This process still leaves open the possibility of simply not asking a detainee who presents a risk, and then recording that no risk was detected. This process, particularly question D2, does nothing to address the notion that an 'indication' may be 'throw away' or 'off the cuff' and disregarded as revealing a potential to cause harm. In my view, it is likely that the members involved in Mr Stockman's charging process would have answered that question no. While the underlying problem is that training is needed to remove the notion that any suicidal comments can be disregarded, the situation can be much improved with questions that do not call for interpretation. The question at D2 should therefore ask much more simply 'Did the detainee make any reference to self-harm or suicide?'. It would still be reliant on the topic being raised and explored earlier in the questionnaire.

77 In my view, the solution adopted does not fully address the issue that arose. It is an important issue because this might have been one way that Mr Stockman may have been protected from his own thoughts. Given what we know about Ms Harmer's actions the following day, it had obvious potential to make a difference to what she did. In turn, this has an obvious potential to change Mr Stockman's actions.

78 I make the following <u>recommendations</u> to the Minister for Police:

*Three* Given that the point of arrest can be a significant moment in a person's life, and that it is the consequence of a decision of SAPOL to intervene in that person's life, questions B11, B12 and B13 of the Shield risk assessment should be asked of every detainee presented to the charge counter. In addition, the remaining questions in Part B should not be greyed out and should be available to be asked if the Charge Sergeant feels it is necessary.

*Four* SAPOL should take advice about whether the compound nature of the questions is the best form of the questions in the Shield risk assessment relating to suicide, and whether the questions are otherwise appropriate for their purpose.

79 There is also a clear hole in the risk assessment questionnaire that was highlighted in this inquest – that is, where Senior Constable Sutton reported to Sergeant O'Donnell that Mr Stockman had not implied an intention to self-harm since arrest, even though Sergeant O'Donnell had in fact heard Mr Stockman's first comment at the counter at line 103. In this case, they both formed the same view that it was not a truthful, genuine or valid comment however it is phrased. However, that may not always be so and there might be instances of differing views. Sergeant O'Donnell's evidence was that if she thought a comment was genuine and received a negative response, she might question the member

about it, but if the member maintained that the answer was 'no' she would record 'no'.[112] In that scenario, there is then no prompt to record what she heard herself as custody officer. In order to remedy this, I make the following recommendations to the Minister for Police:

*Five* That question A1 of the Shield risk assessment be repeated as question C1 to give both members involved the opportunity to independently record their observations.

*Six* That the 'help text' under question A1 (and C1) remind members to take comments which express suicidal ideation or intent at face value.

*Seven* That question A1 (and C1) be widened to encompass suicidal intent as well as ideation.

*Eight* That the General Orders be amended to ensure that both the arresting officer and custody sergeant continue to carry an obligation to conduct continual risk assessments of people in custody so that no one is able to make a suicidal comment to a member who is not holding the obligation at the time, resulting in no action being taken.

80 I granted a request by the Commissioner of Police to seek advice from the Chief Psychiatrist, Dr John Brayley, about the recommendations proposed in this matter. Dr Brayley provided a letter that I received into evidence, together with an essay he was provided on the topic of suicide risk.[113]

81 Dr Brayley advised that forms and procedures should not merely be updated, but should also be subject to a requirement for regular review against best practice, as established in literature and the practices of other jurisdictions, and in light of real world practice. Dr Brayley said that this should involve not only policymakers, but also frontline police who apply the procedures, as well as mental health staff. I endorse this wise sentiment and encourage the Commissioner of Police to regularly review all relevant procedures.

82 Dr Brayley warned about the chances of unreliable answers being given, depending on the circumstances within which the questions are asked, for example if other detainees are within earshot.

83 Dr Brayley expressed that where there is uncertainty, there should be an escalation to mental health professionals. This means that the questions need to be sufficient to identify where there is uncertainty, or a risk generated, rather than requiring a binary concern or no concern outcome to be recorded.

84 Dr Brayley explained that contemporary understanding of suicide risk has resulted in an adoption of the language of 'risk identification' in lieu of 'risk assessment' to move thinking entirely away from a stratification model.

85 Dr Brayley observed that Parts A, B and C separate out what the detainee has said and what the custody officer has observed, but he appears not to have been advised that there was a lacuna identified during the inquest where the 'wrong' person heard the comments and so the answer recorded did not reflect the true situation. It is unfortunate that

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[112] T164 and T185
[113] Exhibit C41

Dr Brayley was not provided with the entire transcript of the proceedings, or at least some advice about the issues that arose in the inquest. In particular, that members of police appear to approach the risk identification questions on the basis that if they themselves did not specifically hear suicidal comments, they should answer questions that ask for their view in the negative. In my view, this is a very meaningful issue that arose in the circumstances of Mr Stockman's death that would have materially impacted Dr Brayley's assessment and advice.

86 Dr Brayley said that the use of the language 'detainee' might contribute to the perception that a level of suicidal ideation is to be expected among this population. He suggested that 'person' be used instead. I am grateful for this advice and I agree.

87 The Principal Suicide Prevention Officer within Dr Brayley's office gave advice to a level of granularity that I need not recount here, however I do encourage the Commissioner of Police to take the advice on board and make the practical changes identified.

88 Dr Brayley supported the proposal that is now encompassed in my recommendation three.

89 While Dr Brayley took issue with the proposal to change the language of 'indications' of harm to 'reference' to harm, this was on the basis of Dr Brayley's understanding that the indications approach took on a wider range of sources of information. However, as I have explained in these findings, that is not so in practice. The members of police who gave evidence and who administer these questions day to day appear to take an extremely narrow view about the risk, to the extent that if they did not personally hear direct indications of suicidal ideation, they answer this question in the negative. Framed in light of the issues identified in this inquest, I remain of the view that the better approach is to ask about reference to suicide rather than indications. However, if there was comprehensive training delivered to all members likely to be asking these questions that greater investigational efforts are required to be made before answering this question, then I would accept that Dr Brayley's approach is preferrable. Unless that can be undertaken, and additional resources provided to allow for more time to be taken to ascertain all of the potential information that might underlie the word 'indications', then I remain of the view that the reference approach is appropriate. In any event, I have refrained from making a recommendation about this issue specifically and I will leave it to the Commissioner of Police to consider carefully.

## Condolences

90 Throughout this inquest, I heard evidence about Mr Stockman's last day. Notwithstanding that that was the focus of the inquest, I also heard details about Mr Stockman's life. He championed mental health literacy for men. He was so passionate about it that he commenced a charitable event which continues to grow. That a man so passionate about suicide awareness died by suicide is a particularly tragic aspect of his death. I have no doubt that his loss was felt deeply among not only his family, but also among the Riverland community. I express my sincere condolences to all those who were affected by his death.

*Keywords: Arrest and Detention; Police; Suicide risk – assessment of*