MAGISTRATES COURT
TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Kayla Maree Moran

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Kayla Maree Moran ('Ms Moran')
b) Ms Moran died as a result of action taken by her alone , with the intention of ending her own life;
c) Ms Moran's cause of death was hanging; and
d) Ms Moran died between 18 and 20 August 2019 at Romaine, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Moran's death which includes:

- The Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- An opinion of the pathologist, Dr Terence Brain;
- Toxicological and analytical report prepared by the forensic scientist Juliette Tria of Forensic Science Service Tasmania;
- Affidavit of Mr Justin Murrell, former husband of Ms Moran;
- Affidavit of Mrs Janet Moran, mother of Ms Moran;
- Affidavit of Mr Dean Moran, father of Ms Moran;
- Affidavit of Mr Benjamin Moran, brother of Ms Moran;
- Affidavit of Mr Hayden Traill, former partner of Ms Moran;
- Affidavits of Ms Samantha Riley, Mr Traill's mother;
- Affidavit of Constable Brennan Dempsey;
- Affidavit of Senior Constable Ashley Arnold;
- Affidavit of Sergeant Katrina Chivers;
- Affidavit of First-Class Constable Caroline McGregor;
- Affidavit of Detective First-Class Constable Joshua Wood;
- Affidavit of First-Class Constable Daniel Eastwood;

- Statutory Declaration of Mr Shane Leonard, Youth, Family and Community Connections (YFCC);
- Internal documents from YFCC;
- Medical records and reports obtained from the Burnie GP Super Clinic, Cooee;
- Medical records and reports obtained from the Somerset Medical Centre;
- Medical records obtained from the Tasmanian Health Service (THS); and
- Forensic and photographic evidence.

Background

1. Ms Moran was born in Burnie on 17 September 1987. At the time of her death, she was 31 years of age, had been married and separated, had no children, and was living alone at Romaine; a suburb of Burnie on the north west coast of Tasmania. She was employed as a youth support worker.

2. Ms Moran was born to Janet and Dean Moran. She had one younger sibling, her brother, Ben. Ms Moran went to Yolla and West Somerset Primary Schools before she attended Burnie High School where she was educated to the end of year 10. Thereafter Ms Moran completed some courses at Hellyer College. She was described by her mother as *"your average teenager… just a normal happy girl with a bubbly personality."*. Ms Moran had lots of friends throughout her school years.

3. In 2013, Ms Moran met Mr Murrell and they commenced a relationship. They purchased their first home together in 2015 at Montello in Burnie. They were married in September 2015. Mr Murrell described Ms Moran as a happy and bubbly person. The relationship broke down in late 2016 and she moved in with her parents for a few weeks. From this point on he noticed a significant change in her behaviour. Ms Moran experienced significant anxiety, affecting her all aspects of her life but she would not to talk to Mr Murrell at length about her difficulties. He was not aware she was suffering from depression. The parties eventually separated in August 2018. Ms Moran moved back to her parents' home before into her home at Romaine. Mr Murrell remained in contact with her and assisted her through some financially difficult times which he is aware caused her some distress.

4. From the age of approximately 17 she commenced work at the IGA at Somerset. She worked there for 3 or 4 years before obtaining employment at Green's hotel before she worked at the Butter Factory nightclub for a couple of years. In 2017, Ms Moran was employed by Wilson's Security as a guard at the North-West Regional and Mersey Community Hospitals and then later at Woolworths in Burnie. She resigned from this position after reportedly falling victim to workplace sexual harassment.

5. In or about September 2018, Ms Moran met Mr Traill and they commenced a relationship about 4 months later which continued until just prior to her death. During the relationship, Mr Traill knew Ms Moran experienced significant levels of anxiety however she did not tell him what made her anxious. In early July 2019 Ms Moran took 10-15 tablets instead of the prescribed amount but did not seek medical help despite Mr Traill's suggestion that she should. On at least 3 occasions Ms Moran's anxiety manifested itself to the point that she would scratch at her skin and draw blood. Mr Traill told her that if she did it again, he would take her to get help. Mr Traill did not witness this behaviour again after that time. Ms Moran never expressed any thoughts of suicide to Mr Traill during their relationship but he recalls on 2 occasions she asked him how he would kill himself if he was going to. Ms Moran told Mr Traill on one occasion she had sought advice from a counsellor but he is not sure that she actually went to see somebody as the attitude she expressed was that she knew best.

6. On 11 October 2018, Ms Moran began working for Youth Family and Community Connections as a youth worker.

Medical history

7. I have reviewed Ms Moran's medical records provided by the Burnie GP Super Clinic which is based at Cooee. Ms Moran first attended this clinic in 2011.

8. Ms Moran was diagnosed with depression and anxiety in July 2012. At the time, she described feeling teary, having low moods, and experiencing anxiety attacks for most of the year. She also described low self-esteem but denied suicidal ideation. Ms Moran re-attended the clinic soon after for a mental health plan and referral to a psychologist. She was also prescribed an SSRI anti-depressant. The referral letter to the psychologist says Ms Moran had recently left and emotionally abusive relationship which are friend described as destroying self-esteem. Prior to that relationship she seemed to have no

mental health problems and she had a happy, healthy childhood.

9. Ms Moran visited her general practitioner in July 2013 about increased anxiety. At the time she was working in excess of 70 hours per week at two jobs. Again a mental health plan was prepared and she was referred to a psychologist. Ms Moran's family were unaware she was having any significant mental health problems.

10. It is unclear whether Ms Moran attended the psychologist mentioned in paragraph 8 or the psychologist mentioned in paragraphs 9 as there are no reports on the GP's file.

11. It was not until April 2019 that Ms Moran attended a subsequent mental health consultation with her general practitioner. She stated that she was suffering from post-traumatic stress disorder due to the breakdown of her marriage and a *"significant history"* of sexual assault at work when she used to work as a security guard. Ms Moran said she was receiving counselling but that she was having panic attacks that affected her function in her new job. This made her scratch her arms badly to *"give some relief."* Ms Moran mentioned she was in a new relationship that was supportive. She also said her anxiety and depression pre-dated the sexual assault. The GP recorded Ms Moran was often feeling sad and depressed, has been feeling anxious but recently that symptom had worsened causing sleep disturbance. The notes go on to record Ms Moran was not experiencing *"suicidal thought/idea/plan/attempt, no delusion or perceptual disorder, no formal thought disorder."*

12. In July 2019, Ms Moran requested a medical certificate after taking time off work due to stress. She stated that she felt better and wanted to return to work. The GP administered the Kessler Psychological Distress Scale (K10) and Ms Moran returned a score of 31 out of 50. Literature with respect to that test indicates a score of 30 and over is likely to mean the patient has a severe mental disorder. Despite this the GP certified Ms Moran's medical condition had improved and she was fit to return to her normal work from 2 July 2019. A subsequent attendance in July details and difficulties she was having at work and the need to obtain a further clearance certificate before she returned. That certificate was provided and is dated 15 July 2019.

13. I have also reviewed the records obtained from the THS with respect to Ms Moran's attendances at both the Mersey Community and North West Regional Hospitals. The

records disclose Ms Moran attended hospital for a number of physical ailments on 20 December 2011, 20 August 2012, 22nd of June 2013, 22 February 2015, 3 September 2016, 25 June 2018 and 21 of July 2019. The attendance in 2018 related to an injury she sustained to her right shoulder when she was working as a security guard at the Mersey Community Hospital. She was assisting in dealing with a violent patient. The injury in 2019 also related to a right shoulder injury sustained when she was lifting weights at the gym. There are attendances on 28 June 2013, 28 November 2015 and 7 July 2018 where she is diagnosed with either panic and/or anxiety attacks and depression. The history provided with respect to the attendances in 2015 and 2018 was that she was dealing with a lot of stress related to her work. At the attendance in 2018 she denied homicidal and suicidal ideation. On each of these 3 occasions a letter was sent to her treating general practitioner with respect to the attendance at, and treatment provided by, the hospital. There are no records of Ms Moran ever attending the Spencer Clinic which is the psychiatric unit attached to the North West Regional Hospital.

14. Finally I have examined the records of the Somerset Medical Centre. Ms Moran's first attendance at this practice took place on 30 June 2016 with her file and attendance occurring on the 16 July 2019. On 30 June 2016 Ms Moran attended because she's suffered an ankle injury after falling down some stairs. Annexed attendance on 7 June 2018 related to depression and anxiety arising out of bullying she was subject to a work over a period of about 4 months. She had made a complaint about that and the issue was being investigated. It appears from the follow-up appointment on 25 July 2018 not only did her complaint relate to bullying but also to regular sexual harassment. A further follow-up appointment on 27 March 2019 was due to her anxiety and stress which again arose out of her employment. At each of those appointments Ms Moran denied suicidal ideation, thoughts plans or attempts of suicide. She was considered to have good insight. On 28 May, 7 June, 13 June and 20 June 2019 she attended for treatment of gynaecological issues which included a urinary tract infection. At the final appointment on 16 July 2019 she had taken the last 2 days of work because she felt run down and she also had depression and anxiety. She was also apparently seeing a psychologist. Again she had no suicidal ideation or thoughts or plans of suicide and neither had she attempted suicide. The general practitioner had a lengthy discussion with Ms Moran about practising relaxation techniques when she became anxious. She was to keep in contact. It seems Ms Moran was seeing a GP at this practice as well as a GP at the Burnie GP Super Clinic in July 2019.

15. The records I have reviewed reveal Ms Moran was referred to Gen Practice North West in Ulverstone in 2012 and to Andrew McClymont at the Patrick Street Clinic in Penguin in 2013 for psychological assessment. Checks of both practices reveal they have no records of Ms Moran ever attending.

16. Ms Riley says Ms Moran was diagnosed with stage 4 endometriosis in July 2019 and she required 2 procedures which caused her a lot of pain. Mr Traill confirms she had surgery twice and that he *"went with her to the doctors after her last surgery around July and this was just change over some of her bandages from her surgery."* On this issue the post-mortem report notes her "tubes and ovaries normal" and the histology returned a result from her ovaries that she was "fertile". There is no explanation in that report for the 3 bandages on her abdomen which are depicted in the photographs.

17. I therefore sought the advice of the forensic pathologist Dr Andrew Reid as to what those bandages represent. He believes Ms Moran had undergone laparotomy surgery which was consistent with treatment for the condition mentioned in paragraph 16. He says that surgery must be performed under general anaesthetic and in a hospital environment. There is no record of such surgery in the THS records. That surgery is not mentioned in the GP records. I therefore arranged for searches to be conducted of the North West Private Hospital in Burnie and St Luke's Hospital, St Vincent's Hospital and the Launceston General Hospital in Launceston. None of those hospitals had records for Ms Moran. My office was advised that at the time of Ms Moran's death there was no gynaecological clinic on the north-west coast of Tasmania. Given Dr Reid's advice it is likely Ms Moran had surgery for the condition mentioned by Ms Riley but where that surgery was conducted remains a mystery.

Circumstances of Ms Moran's death

18. Upon examination of medical and work records and affidavits provided by family and friends, I find that Ms Moran experienced significant personal stress in the period leading up to her death.

19. In July 2019, she received the abovementioned endometriosis diagnosis. Ms Riley states that Ms Moran had no support around this time and that she checked herself out of

hospital before she should have. Shortly after, she was told that she needed to leave the property she had been renting as it was being sold. Mr Traill says this resulted in Ms Moran crying frequently.

20. Ms Moran's workplace considerably contributed to her stress. She had been threatened by clients (youths) on a number of occasions. She received repeated threats to her personal safety and she experienced sexual harassment.

21. Around this time, Ms Moran had also begun arguing with Mr Traill, informing his mother, Ms Riley, on or about 12 August 2019 that *"she did not know how much more she could take and that she was close to having a breakdown."* Ms Moran's family and friends noticed her mood changes and held general concerns for in the weeks leading up to her death. However, at no point did she mention wanting to end her own life.

22. Mr Traill does not remember any occasion when Ms Moran expressed that she was suicidal. As such, he did not have any concerns about it. He believed she was receiving counselling, though Ms Moran did not speak to him about this or about her work stress. Ms Moran raised the topic of suicide with him on two occasions when she asked him *"how I [Mr Traill] would kill myself if I was going to."*

23. On 9 August 2019, Ms Moran attended dinner at her parents' house. They described her demeanour as "quiet" but they did not notice any unusual behaviour. In the weeks leading to her death, Ms Moran confided in her mother about her deteriorating relationship with Mr Traill and how this made her feel sad. She told her mother she never felt worthy of Mr Traill, and they fought often.

24. On 13 August 2019 Ms Riley had a conversation with Ms Moran in which Ms Moran said she had been *"really struggling"* and *"had just shut herself off and shut down as she didn't know how to deal with everything going on at the moment."* Ms Moran also said *"she felt like something was wrong with her and that she was a horrible person."*

25. On 15 August 2019, Ms Moran told Ms Riley *"she was having a shit night at work and how shit her job was."* She was stressed by the behaviour of a youth and *"she was about to lose it as this happens every shift"*. It is clear from this evidence Ms Moran was struggling at work in general. At about this time Ms Riley says Ms Moran began looking for another job.

26. On 17 August 2019, Ms Moran met Ms Riley for dinner. According to Ms Riley Ms Moran told her she was not coping and she was suffering from significant anxiety. She advised Ms Riley she had been seeing a counsellor but the counsellor was focusing on incidents from 20 years ago which she said was not going to fix her anxiety. She said the counsellor said she had depression as did her GP but she said she did not. Ms Moran told Ms Riley her biggest fear was ending up in the Spencer Clinic[1] and not been able to get out. Ms Riley learnt that Ms Moran had no friends and she never did anything because she had no one to do things with. Ms Riley offered support and advice throughout this evening before going next door with her younger son for a movie night where she remained until morning. Ms Moran stayed the night at Ms Riley's home and was with Mr Traill until he left for work at approximately 22:15 hours.

27. Ms Moran advised her former husband on about 12 July 2019 she was at the Spencer clinic because she had tried to end her life. Because of this she indicated to him she would not be able to pay back the money he had loaned her. He indicated that was okay. He was worried about her but thought she would have spoken to her mother about her difficulties. Police inquiries made after Ms Moran's death confirm she was never admitted to the Spencer Clinic.

28. Ms Moran's last contact with her mother was by text message on 17 August 2019. Her father says he last saw her on 9 August 2019 when she came over for dinner.

29. On 18 August 2019, Mr Traill told his mother, Ms Riley, that he could not be in a relationship with Ms Moran any longer because he was *"sick of her moods."* However, Mr Traill later stated to police that *"we never spoke about breaking up."* Regardless, I am satisfied given the content of the suicide notes which Ms Moran left she believed her relationship with Mr Traill was at an end.

30. After leaving Ms Riley's home Ms Moran has attempted to contact Mr Traill on numerous occasions via phone but all contact went unanswered. Ms Moran did not have contact with anyone the following day, Monday 19 August 2019.

31. On 20 August 2019, Ms Riley received a call from Ms Moran's workplace. They were calling because she had not shown up for work. This was very out of character for her.

[1] The Spencer Clinic is the psychiatric unit at the North West regional Hospital in Burnie. As mentioned in paragraph 13 there is no record of Ms Moran being admitted to this clinic.

Ms Riley contacted police and requested a welfare check.

Investigations

32. Tasmania Police attended Ms Moran's address to conduct a welfare check. The residence was secured and nobody answered when they knocked. From the window on the top floor police observed notes and photographs on a mattress in the lounge room below. Police door knocked the neighbourhood and neighbours advised they had not seen Ms Moran for a while. Police then attempted to make contact with Ms Riley and Ms Moran without success. Attending officers conducted further checks with Ms Moran's family. They spoke to her father and her brother. Ms Moran's brother advised his sister had been suicidal *"for the past two weeks."*[2] At around 9:50 hours police attended Ms Moran's address again after her father, Mr Moran, sighted her car in the garage. As a result of their concerns, attending police forced entry to the property. They then located Ms Moran in the garage with a cord around her neck, hanging from the roof. She was deceased.

33. A full investigation into Ms Moran's death began. Forensic officers and Criminal Investigation Branch detectives attended the scene. After a search and examination of the scene the attending officers formed the opinion there were no suspicious circumstances and that no other person was involved in Ms Moran's death. Having considered all the evidence I agree with that conclusion and make a finding in those terms.

34. It appeared that Ms Moran had first been unsuccessful in using a garden hose and rigging her car in such a way as to attempt suicide by carbon-monoxide poisoning. Correspondence from Ms Moran found at the scene confirms this was her intention.

35. Police located photographs and notes left on the mattress in the lounge room. Of the notes, some were handwritten and some were typed. In these notes, she spoke of extreme sadness, being hurt, feeling unsupported, and let down by Mr Traill and that he had ended their relationship. Ms Moran also spoke of her mental health struggles and of her love for her family. It is is clear from the contents of these notes Ms Moran intended

[2] To be clear Benjamin Moran says he noticed his sister was upset a couple weeks prior to her death. He had a feeling she was suicidal and that's why he said she was suicidal when he spoke to police. He confirms *"she never told me much, she never spoke about suicide or her mental health to me."*

to end her own life.

36. Dr Terence Brain, performed a post-mortem examination on 21 August 2019. Dr Brain concluded that the cause of Ms Moran's death was hanging. I accept Dr Brain's opinion.

37. A toxicology report was prepared by Juliette Tria, a forensic scientist at Forensic Science Service Tasmania. The report indicates carboxyhaemoglobin was detected within the normal range (6% saturation). Caffeine and nicotine were also detected. Phlocodine was detected at a therapeutic level, possibly attributable to a cough medicine. No alcohol or other drugs were detected. I accept Ms Tria's opinion. I find one of the these substances contributed to Ms Moran's death.

Workplace incidents

38. A workplace incident report, written by Ms Moran, was discovered after her death. It detailed a workplace sexual assault which was alleged to have occurred on 5 July 2019 in her employment at YFCC. However, investigations determined that this was a *"practice"* incident report and that it did not detail a real incident. I extend my appreciation to staff from YFCC for conducting a comprehensive search of all emails, incident registers, staff change-over notes, and submitted incident reports to find communication regarding the incident report or the incident itself. No documentation confirming the incident was found and none of the staff of YFCC had any knowledge of it. I am satisfied the report is indeed a practice one. It references on-call staff who did not work for YFCC and client initials that do not match clients in residence at the time of the alleged incident. Further, at the time the report was written Accommodation Service Staff were practising writing incident reports.

39. Still, it is clear that Ms Moran experienced significant stress in the course of her employment. She advised her mother, partner and his mother that she experienced threats and sexual harassment from a youth she worked with. She was stood down in July 2019 for performance management issues as it was found Ms Moran had made comments to a co-worker that if her boss knew her state of mental health, *"he probably would not have let her work at the shelter on her shifts."* Ms Moran was able to return to work once she obtained a certificate of fitness from her general practitioner. When she saw her general practitioner to obtain that certificate she spoke of verbal abuse from clients and one incident where she was pushed against a wall. She did not want to make a workers

compensation claim. It is clear to me she was very unhappy at work and this was a constant feature of Ms Moran's life at the time of her death.

Comments and Recommendations

40. I am satisfied there are no suspicious circumstances surrounding Ms Moran's death. I find that she took the action of hanging herself alone and with the intention of ending her life.

41. There are a number of theories in the evidence as to why Ms Moran took her own life. They include significant difficulties with her own health, long term stressors at work, the breakdown of her marriage and the subsequent breakdown of her relationship with Mr Traill. There might be others not disclosed by the evidence. The true cause might be one of those factors or a combination of a number of them. It appears from the notes which she left that the last straw was the end of her relationship with Mr Traill. Unfortunately Ms Moran concealed the extent of her psychological difficulties and the reasons for those difficulties from her former husband, subsequent partner and her parents. Ms Moran was a very private person by nature and it seems that despite the treatment she received and the offers of assistance which were made she was unable to seek the necessary help and support from her family and health professionals. In those circumstances I have come to the conclusion her death could not have been foreseen or prevented.

42. I cannot, given the state of the evidence, be satisfied of the exact time of Ms Moran's death. I conclude that it occurred between 18 and 20 August 2019.

43. The circumstances of Ms Moran's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of *the Coroners Act 1995*.

Acknowledgements

44. I extend my appreciation to investigating officer Constable Brennan Dempsey for his investigation and report.

45. I convey my sincere condolences to the family and loved ones of Kayla Moran.

Dated: 21 July 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner