FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

PT

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends, youths and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of PT with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Dates

3 , 4 and 5 April 2024

Representation

M Wilson SC – Counsel Assisting the Coroner

L Taylor – Counsel for Department for Education, Children and Young People

Introduction

1. PT was born in Hobart, Tasmania on 30 July 2007, the son of CT and MD. He had an older brother, MB.

2. He died on 8 April 2022 at the Royal Hobart Hospital in Hobart as a result of brain infarction, due to hypoxia following self-inflicted hanging. He was just 14 years old.

3. At the time of his death, PT was enrolled in grade 9 at Taroona High School. He lived week on/week off with his mother CT at Tranmere and his father and stepmother GM at their home in Lauderdale. At the time of his death, he was staying with his father and stepmother.

4. The evidence is that towards the end of grade 7 his parents noticed he had lost weight, had stopped eating and become obsessed with his body and his image. He seems to have spent a significant amount of time on Snapchat. He was diagnosed as suffering from anorexia nervosa and bulimia, and he was admitted to the Eating Disorder Clinic at the Royal Hobart Hospital in November 2020. Treatment as an outpatient followed for approximately 12 months including fortnightly weigh-ins and therapy – individually and with his family.

5. In November 2021 PT, having maintained an appropriate weight for a suitable time, was discharged from the clinic.

6. There is some evidence that PT had a history of self-harm by cutting but apparently not to the extent that he had ever required medical treatment for any self-inflicted injuries. There is no documented or reported history of any previous suicide attempts.

The role of a coroner

7. Before considering the circumstances of PT's death in further detail, it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death that appears to "*have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury*".[1] A death as a result of hanging meets this definition.

8. A coroner may hold an inquest (which is a public hearing) into any death that the coroner has jurisdiction to investigate "*if the coroner considers it is desirable to do so*".[2] In the case of PT's death given his age and some issues associated with the engagement of state instrumentalities, I considered it was desirable to hold an inquest.

9. When conducting an inquest, a coroner performs a role different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. In an inquest, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 (the "*Act*") asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.

10. A coroner is required to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

11. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or compensation are for other proceedings, in other courts,

[1] Section 3 of the *Coroners Act 1995*.
[2] Section 24 (2) of the *Coroners Act 1995*.

if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

12. As was noted above, one matter that the *Act* requires, is a finding (if possible) as to how the death occurred.[3] '*How*' has been determined to mean '*by what means and in what circumstances*',[4] a phrase which involves the application of the ordinary concepts of legal causation. [5] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

13. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[6]

14. A coroner is not bound by the rules of evidence in holding an inquest and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit. To be properly received at an inquest, the evidence must be capable in some way of assisting the coroner to determine the matters under section 28 (1) or, in appropriate circumstances, to assist in making a comment or recommendation. A coroner has significant latitude in receiving evidence, providing the evidence is something more than "*mere supposition, guess or intuitive hypothesis*". The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.

15. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[7] A coroner must ensure that any person (and person includes legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

Evidence at the inquest

[3] Section 28(1)(b) of the *Coroners Act* 1995.
[4] *Atkinson v Morrow* [2005] QCA 353.
[5] See *March v MH Stramare Pty Ltd and Another* [1990 – 1991] 171 CLR 506.
[6] (1938) 60 CLR 336.
[7] See *Annetts v McCann* (1990) 170 CLR 596, *Attorney General v Copper Mines of Tasmania Pty Ltd* [2019] TASFC.

16. A number of witnesses gave evidence at the inquest. They were in order:

- Mr MD (PT's father);
- Ms CT (PT's mother);
- KE (PT's friend);
- Constable Emma Wiggins (Tasmania Police);
- Mr James Trainer (Taroona High School);
- Mr Quentin Maddox (Department for Education, Children and Young People);
- Ms Jackie McKenzie-Hanslow (Department for Education, Children and Young People); and
- Ms Claire Lovell (Department for Education, Children and Young People.

17. In addition to the witnesses who gave evidence at the inquest, a significant amount of other evidentiary material in the form of affidavits, recordings, medical records and suchlike was tendered. A complete list of the documentary exhibits received by me at the inquest is attached to this finding and marked as Annexure 1.

18. All of this material informed the findings which follow.

Issues at the inquest

19. In advance of the inquest specific issues were identified, over and above those required by section 28 of the *Act*, to be examined. Those issues were:

a) The interagency (Tasmania Police and Strong Families Safe Kids being the agencies in question) response in relation to the procedures for mandatory reporting regarding sexual assaults and online bullying/harassment; and

b) The delay of one year in Tasmania Police receiving the relevant referral.

20. Strong Families Safe Kids Advice and Referral Service was described in evidence as a "*single front door and central point of contact for anyone with concerns about the safety and well-being of a child or young person and as an information source for family support service options*".[8]

21. Consistent with the requirement to afford procedural fairness referred to above in paragraph 15, those agencies were apprised of the fact of the inquest, warned (as

[8] Exhibit C 30 – Affidavit Claire Lovell, sworn 18 January 2024.

appropriate) of the potential for adverse finding, provided with full disclosure and invited to participate (or otherwise) in the inquest.

Background

22. PT started grade 7 at Taroona High School at the beginning of the school year in 2020. He moved to year 8 in 2021 and was in year 9 in 2022.

23. It is not unfair, I think, to say he had some behavioural issues whilst at Taroona High. He was suspended several times for using drugs, being in possession of drugs (including LSD) and verbally abusing and spitting on (or at) staff members. On the other hand, he appears to have had a good group of close friends and, by grade 9, distanced himself from some students exhibiting particularly bad behaviour, especially in relation to drug use.

24. In June 2021, an allegation was made that PT had engaged in conduct with a female student at The Friends' School which, if substantiated, may have amounted to an indecent assault. The alleged conduct involved an attempt by PT to touch the girl's breasts, or breast. I should make it very clear that it is evident that PT denied any wrongdoing at all.

25. The evidence at the inquest was that a video clip of some type was in circulation – on social media – during June 2021, which was said to show PT doing the act alleged. The clip itself was not located during the investigation and thus what it showed (if anything), who saw it (if anyone) and whether it even existed cannot be verified.

26. The evidence was that PT was assaulted on two occasions in the CBD of Hobart, once in the Elizabeth Street bus mall (8 June 2021) and one other occasion in Liverpool Street not far from the intersection with Elizabeth Street (later in 2021).[9] He sustained at least a black eye in one of the assaults. Both assaults appear to have been linked to the alleged indecent assault. To what extent, if any, PT had been the subject of bullying or even comment on social media is impossible to determine, although there seems little doubt that he was in fact so bullied.[10]

27. Both his parents attempted to engage with him about the assaults. PT appeared (on the surface at least) to regard the incidents as having been without any particular significance, although experience tends to suggest that that is not an abnormal reaction from a young person of his age.

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[9] Exhibit C 29 – Affidavit James Trainer, sworn 22 June 2023.
[10] *Supra,* paragraph 39.

28. In addition to the assaults in the CBD, PT was also assaulted on his way to school by another student – a YL - in September. He was kicked and punched and required first aid. MD collected him from school. Police were notified and YL was suspended for 10 days.[11] That assault also appears to have been linked to the video clip.

Allegation against PT

29. As noted above, in June 2021 the existence of a video clip said to show PT behaving inappropriately towards a female student from The Friends' School became known to various people including Mr Trainer at Taroona High School. He informed a colleague at The Friends' School who, he said, later confirmed that an allegation of '*sexual assault by PT… [had been] handed over to Police*'.[12]

30. PT's parents were both informed and were given to understand that the matter was unlikely to be taken any further.

31. Strong Families Safe Kids were notified as required by The Friends' School. Various actions were then undertaken by Strong Families Safe Kids. But what did not occur was Strong Families Safe Kids actually making a formal referral to the matter to Tasmania Police, although I am satisfied the matter was discussed by a Child Safety and Wellbeing Worker from Strong Families Safe Kids and an officer at Bellerive CIB.[13]

32. That a formal referral had not been made was not identified until after PT's death during an audit.

33. Nonetheless, I do not consider that the evidence at the inquest would support a conclusion that the allegation surrounding the girl from The Friends' School or any assaults of which he was the victim (and all of which I am satisfied occurred) had any connection with his decision to take his own life. I am also quite satisfied that the failure to make the formal referral was an oversight and had no connection with PT's death either.

Circumstances of Death

34. The evidence makes it clear that in the days, weeks and months leading up to PT's death, his family and friends all had reason to think that he had "turned the corner" particularly in relation to his eating disorder. He was described as happy, being his

[11] *Supra*.
[12] *Supra*, paragraph 23.
[13] Exhibit C 31 – Affidavit Quentin Maddox, sworn 11 January 2024.

normal self and exhibiting signs that his "*relationship*" (if one can call it that) with his mobile phone was somewhat healthier.

35. His close friend, KE, who interacted with PT during the weekend immediately preceding his death described him as "*normal*".[14]

36. The night before his death, PT posted a video on Snapchat.[15] The post, a video clip in the nature of a 'selfie' in which PT is wearing only underpants, appears to have attracted a number of adverse and disparaging comments. The evidence of KEsuggests that the clip was in wide circulation, at least in his year group at Taroona High School. I observe that the decision to post the clip might be thought to be a poor one, but experience tells us that young people make poor choices all the time. Social media makes those choices publicly available for ridicule and makes the impact of such poor choices so much worse.

37. It certainly seems clear PT was reluctant to go to school on the morning of 5 April 2022. His father said in his evidence that he and his son spoke that morning. In the conversation, PT said he did not wish to go to Taroona High School anymore. This was not the first time the subject had been raised and it was evident that the family as a whole were open to exploring other options for PT's education. MD asked his son if anything specific had happened, but PT said words to the effect that he was just sick of the students and the staff. He denied feeling unsafe. His father indicated he would discuss it with PT's mother to arrange something. MD then left for work at about 6.50 am.[16]

38. GM said in her evidence that she spoke to PT at approximately 7.00 am, just before she took the family dog for a walk. She said he "*seemed really chirpy and appeared happier*". The pair had a discussion about whether she was going to work that day and she confirmed she was.[17] This was the last confirmed sighting of PT being alive.

39. GM returned home after walking the dog, saw that PT's school bag and lunch was still at the house, and looked for but could not find him. She left for work at 8:45 am and told MD that she thought PT might have been skipping school.

40. Between 8.25 am and 9.40 am PT's father sent him a series of text messages, all of which went unanswered. At 9.30 am PT sent a text message to some friends

[14] Exhibit C 12, Affidavit KE, sworn 30 October 2022.
[15] Exhibit C 28L.
[16] Exhibit C 9, Affidavit MD, sworn 25 April 2022.
[17] Exhibit C 11, Affidavit GM, sworn 1 July 2022.

(including KE) thanking them for being good friends. No one seems to have seen that message until later in the day.[18]

41. At about 10.00 am, MD returned to the house where, after a short search, he found PT hanging by a rope around his neck in the outdoor patio area. He cut him down and rang emergency services before commencing and continuing CPR until the arrival of paramedics and police. A note, in PT's handwriting and in its terms of a suicide or farewell note, was found nearby.[19]

42. Paramedics managed to establish the return of spontaneous circulation before rushing him to the Royal Hobart Hospital for further resuscitation.

43. He was stabilised and then moved to the hospital's intensive care unit but remained in a critical condition. Despite the best efforts of his treating team he did not recover and was pronounced brain dead at 12.50 pm on Friday, 8 April 2022.

44. A post-mortem was conducted by Forensic Pathologist Dr Donald Ritchey on 12 April 2022 at the Royal Hobart Hospital. Dr Ritchey provided a report which was tendered at the inquest[20] in which he expressed the opinion that the cause of death was hypoxic encephalopathy (that is brain injury caused by lack of oxygen). I accept Dr Ritchey's opinion.

Discussion and conclusion

45. I am quite satisfied that there are no suspicious circumstances associated with PT's death. The evidence satisfies me to the requisite legal standard that the actions which caused his death were undertaken voluntarily, alone and with the express intention of ending his own life.

46. Ultimately, even though I have concluded that there was a failure by Strong Families Safe Kids in making the necessary formal referral to police about the June 2021 video in a timely way (or at all), there is no evidence that would support a conclusion that that failure had any connection, temporal or otherwise with PT's death.

Formal Findings pursuant to Section 28(1) of the *Coroners Act* 1995

47. Based on the evidence at the inquest I make the following formal findings pursuant to section 28 (1) of the *Coroners Act* 1995:

[18] Exhibit C 12, Affidavit KE, sworn 30 October 2022.
[19] Exhibit C 20.
[20] Exhibit C 5.

a) The identity of the deceased is PT;

b) PT died in the circumstances set out earlier in this finding;

c) The cause of PT's death was hanging by rope ligature around his neck at Lauderdale on 4 April 2022; and

d) PT died as a result of a brain infarction caused by hypoxia on 8 April 2022, aged 14, at the Royal Hobart Hospital, Liverpool Street, Hobart in Tasmania.

Comments and recommendations

48. The circumstances of PT's tragic death do not require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

49. I thank both counsel involved in the inquest for their considerable assistance with this sad case.

50. In conclusion, I express my sincere and respectful condolences to PT's family on their terrible loss.

Dated: 29 August 2024 at Hobart in the State of Tasmania.

Simon Cooper
Coroner

Annexure I

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	POLICE REPORT OF DEATH	Cst E WIGGINS
C2	HOSPITAL REPORT OF DEATH	ROYAL HOBART HOSPITAL
C3	DONATE LIFE	ROYAL HOBART HOSPITAL
C4	IDENTIFICATION AFFIDAVIT	Cst R EAVES
C5	POST-MORTEM	Dr D RITCHEY
C6	TOXICOLOGY REPORT	N McLACHLAN-TROUP
C7	MEDICAL REPORTS - THS	RHH
C8	MEDICAL REPORTS - GP	LINDISFRANE CLINIC
C9	AFFIDAVIT - SNOK	MD
C10	AFFIDAVIT	CT
C11	AFFIDAVIT	GM
C12	AFFIDAVIT	KE
C13	AFFDAVIT	P NIELSEN
C13a	AFFIDAVIT	P NIELSEN
C14	AFFIDAVIT	Cst E WIGGINS
C15	AFFIDAVIT	Cst T MEECH
C16	AFFIDAVIT	Cst A BOWDEN
C17	INCIDENT REPORT	Det Cst M PERSHAW
C18	AFFIDAVIT	Cst C MEDHURST
C18a	PHOTOGRAPHS	Cst C MEDHURST
C19	PHONE + LAPTOP EXAMINATION	TASMANIAN POLICE

C20	**SUICIDE NOTE**	**TASMANIAN POLICE**
C21a	**OFFENCE REPORT (670331)**	**TASMANIAN POLICE**
C21b	**OFFENCE REPORTS (683240)**	**TASMANIAN POLICE**
C22a	**INTEL LOGS 19/8/21**	**TASMANIAN POLICE**
C22b	**INTEL LOGS 21/8/21**	**TASMANIAN POLICE**
C22c	**INTEL LOGS 26/8/21**	**TASMANIAN POLICE**
C22d	**INTEL LOGS 31/8/21**	**TASMANIAN POLICE**
C23a	**OCCURRENCE LOGS 17/11/20**	**TASMANIAN POLICE**
C23b	**OCCURRENCE LOGS 15/11/2021**	**TASMANIAN POLICE**
C23c	**OCCURRENCE LOGS 31/5/22**	**TASMANIAN POLICE**
C24	**INCIDENT REPORT 000073-05042022**	**TASMANIAN POLICE**
C25	**ATLAS REPORT**	**TASMANIAN POLICE**
C26	**DECYP RECORDS**	**DEPARTMENT OF EDUCATION**
C27	**TAROONA HIGH SCHOOL RECORDS**	**DEPARTMENT OF EDUCATION**
C28	**USB – POLICE BWC, ASSAULT VIDEO & SNAP CHAT (a,b,c,d,e,f,g,h,I,j,k,l)**	**TASMANIAN POLICE**
C29	**AFFIDAVIT - (a,b,c,d,e,f,g)**	**J TRAINER**
C30	**AFFIDAVIT - (a,b,c,d,e,f)**	**C LOVELL**
C31	**AFFIDAVIT - (a,b)**	**Q MADDOX**
C32	**AFFIDAVIT - (a,b,c,d)**	**J HANSLOW**
C33	**AFFIDAVIT - (a,b,c)**	**M BAKER**

C34	**CONVERSATION SUMMARY REPORT - REDACTED**	**CARDI**
C35	**MISC**	**CORRESPONDENCE**