



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of CF

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

- a) The identity of the deceased is CF, date of birth 27 October 1998.
- b) CF was a national of Bangladesh. He was 24 years of age and lived in Sorell with his cousin, Mr Golam Sajid. CF arrived in Tasmania in February 2019 as a university student. He studied ICT at the University of Tasmania for three years and graduated in 2021. In September 2022, CF commenced employment with the Department of Justice (Tasmania) as a Data Analyst Graduate Officer. He remained in this employment until the time of his death. Since arriving in Tasmania, he had not returned to Bangladesh to visit his family.

According to available medical records, CF experienced his first acute episode of psychosis in December 2022. However, his diary entries in previous years suggest he experienced significant ongoing emotional turmoil over a lengthy period of time.

In early December 2022 CF made allegations of workplace bullying to his manager, Andrew Smith. He also made allegations that his work colleagues were manipulating his computer search history, sending burnt pizza to his home and taking his fingerprints when they shook his hand. These allegations were obviously untrue and upset his colleagues.

Mr Smith, in managing the matter in the workplace, formed the view that CF required psychiatric assistance. Therefore, on 16 December 2022, Mr Smith took CF to the Royal Hobart Hospital Emergency Department (ED). At the ED, CF denied suicidal ideation but indicated that he previously had plans to jump from a

bridge. He reported delusional thoughts and bizarre thought content. He underwent physical examination, drug screening, blood tests and a CT brain scan—all of which were normal. He subsequently left against medical advice before further assessment could be made.

On 18 December 2022, CF was seen in the community by the Acute Care Team. Due to his delusional mental state, he was taken by police in protective custody to the ED. He was admitted to the Mental Health Unit as a voluntary patient and treated with antipsychotic medication. He slowly improved and was discharged on 23 December 2022 into the care of the Acute Care Team. Further adjustments to his medication were made and, by 29 December 2022, CF was not showing overt psychotic symptoms. He continued to be monitored by mental health services and was recommended to commence the medication olanzapine, an antipsychotic. His compliance with prescribed medications was poor.

In January 2023, Mr Smith transitioned CF to a different work team in an effort to assist him. A mental health assessment on 30 January 2023 recorded that CF had ceased taking his medication but he remained stable and had some insight. He was discharged from the mental health team on 10 February 2023 with a plan for general practitioner follow-up. Unfortunately, he visited his general practitioner on one occasion only on 16 February 2023. Over the following three months, CF appeared happy at work and he did not exhibit further mental health issues.

On 18 May 2023, Mr Sajid saw CF in person for the last time.

On Friday 19 May 2023, CF called Mr Sajid and advised that he was taking a work trip to Launceston. At 9.30pm that evening, Mr Sajid sent a text message to CF but received no response. CF's family in Bangladesh had also been trying to contact him during this time without success.

Later investigations, namely Tasman Bridge camera footage, revealed that on the same day at 6.44pm CF jumped from the rails of the Tasman Bridge into the Derwent river. This act caused his death, but it was not witnessed or known until two days later.

On Sunday 21 May 2023, a deceased person was found on a beach in Tranmere by a couple taking their Sunday afternoon walk. Police were called and officers promptly attended. They inspected the scene and commenced an investigation. Police found no evidence of identification at the scene.

However, on Monday 22 May 2023, Constable Alisha Barnes, an Associate stationed at the Coroner's Office, opened an email titled "about my death" from CF's email address. The email was sent on Friday 19 May 2023 at 6.40pm, four minutes before CF's suicide. The email mentioned workplace bullying and the psychotic episode which had affected his chance of permanent residency. There is no evidence in the investigation that these facts are correct.

Investigations were conducted by Constable Barnes. The identity of the author of the email was confirmed to be that of CF and his address was obtained. It must be noted that the Coroner's Office emails are only monitored on weekdays during business hours and not on weekends.

Further investigations revealed that a cyclist riding across the Tasman bridge on the early hours of 20 May 2023 found CF's backpack, removed items from it and discarded the backpack beside the bridge. When the deceased person was found on 21 May 2023 police investigators organised for Mr Smith and Mr Sajid to identify the body. They identified the body as being CF.

Based upon investigations, I am satisfied that CF acted alone and that there were no suspicious circumstances surrounding his death. CF suffered mental illness involving severe psychosis for several months which did not resolve. Unfortunately, he made the decision to take his own life.

- c) CF's cause of death was blunt trauma and drowning due to intentionally jumping from the Tasman Bridge in order to end his life. Toxicology testing revealed that no prescription medication was in his system at the time of death.
- d) CF died on 19 May 2023 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into CF's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Opinion of the forensic pathologist regarding cause of death;
- Toxicology report of Forensic Science Service Tasmania;
- Medical records for CF;
- Correspondence from JK, father of CF;
- Affidavit of Golam Sajid, cousin and housemate of CF;
- Affidavits of Sean Harper and Laura Williams, who found CF's deceased body;

- Affidavits of CF's Manager, Andrew Smith, and colleague, Nitesh Gupta;
- Affidavits of attending and investigating police officers, together with body worn camera footage;
- Affidavit and photographs from Constable Scott Hartill;
- Affidavit of Coroners Associate Constable Alisha Barnes;
- Personal diary entries of CF;
- Emails and report regarding bullying incident from Department of Justice; and
- CCTV from the Tasman Bridge capturing CF's suicide and the cyclist who found CF's backpack; and
- Review of CF's mental health treatment by Dr Anthony Bell, coronial medical consultant.

Unfortunately, CF developed his first known episode of psychosis five months before his death. Although his condition improved with treatment and medication, he stopped taking his medication in the months before his death and did not continue to see his general practitioner as recommended. As such, there was a relapse in his psychosis, and this was a significant factor in his decision to end his life.

I extend my appreciation to investigating officer Constable Joshua Pearce for his investigation and report.

Comments on Tasman Bridge

The Tasman Bridge, one of this state's most prominent and iconic public structures, continues to be the site of frequent, preventable suicides. It is situated centrally within Hobart, and pedestrians have access to the pathways at all times. The outer barrier is low in height, easy to climb and provides a direct drop into the river at a height that will usually cause death.

In November 2016, I handed down findings following a public inquest into the suicide deaths of 6 people from the Tasman Bridge. I made 7 recommendations to prevent further suicides at this site.¹ These included a recommendation that the government formulate a plan for structural modifications to the Tasman Bridge.

In investigating this death, together with 8 other deaths from the Tasman Bridge that are published simultaneously with this finding, the Coroners have commissioned the Coronial Research Officer, Ms Runi Larasati, to conduct a detailed analysis of suicides from the bridge since those the subject of the inquest in 2016.

¹ [Deaths from a Public Place.pdf](#)

The report prepared by the Coronial Research Officer (“the Report”) is based upon data from the Tasmanian Suicide Register and should be read with these findings. It is located at: [Tasman Bridge Report](#) The coroners are very grateful to Ms Larasati for the Report which comprehensively outlines facts and issues associated with suicides, suicidal behaviour and suicide prevention at the Tasman Bridge.

The Report provides a helpful summary of progress of the 2016 coronial recommendations relating to preventing suicides on the Tasman Bridge. I acknowledge the work of the Tasman Bridge Cross Agency Working Group in implementing the recommendations, including enhanced camera surveillance and crisis telephones.

Despite plans made by the government, structural modifications to the bridge have not been made. As described in the Report, the government released its concept design for the Tasman Bridge upgrade in 2022, which included raising the height of its safety barriers alongside transport improvements by widening its pathways. Following detailed assessments, widening the pathways was deemed unfeasible due to structural constraints and budget limitations. Therefore, in 2024, this plan was rescinded.

As of June 2025, the Department of State Growth has indicated that it is conducting community consultations on an amended concept design, which is stated to be “at a very early stage”, with further assessments and tendering process still to take place.² The Department states that the project’s primary objective is “to address the significant concerns related to the occurrence of suicides from the bridge”, and noting that pathway improvements will also be delivered.

The current project is jointly funded to \$130 million by the Australian and Tasmanian governments. In addition to installing higher safety barriers to prevent suicides, the project scope includes establishing localised passing bays to support transport activities on the bridge. Construction period is expected to commence late 2025 or early 2026 for a period of approximately 12 months.

Without structural modifications to the safety barriers, suicides will continue to occur at this high-risk location. As outlined in the Report, between 1 January 2016 and 30 June 2024, 22 people have died, either by intentionally jumping or falling from the Tasman Bridge. Additionally, police attend an average of 195 concern for welfare incidents on the bridge each year, including where possible suicidal behaviour of an individual is reported.

² Department of State Growth, *Tasman Bridge Upgrade Project: Project Briefing*, 5 May 2025. Provided to the Coroner’s Office on 3 June 2025.

The research studies described in the Report provide strong evidence that the installation of appropriate safety barriers on the Tasman Bridge will actually reduce the total number of suicides and not simply result in a substitution of means.

Recommendations

Pursuant to section 28 of the *Coroners Act 1995*, it is appropriate to make the following single recommendation to prevent further suicides from the Tasman Bridge.

I **recommend** that the government urgently implement structural modifications to the Tasman Bridge with a key aim of eliminating suicides at the Tasman Bridge.

I convey my sincere condolences to the family and loved ones of CF.

Dated: 4 July 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner