



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, Robert Webster, Coroner, having investigated the death of HN

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

- a) The identity of the deceased is HN;
- b) HN died in the circumstances set out below;
- c) HN's cause of death was drowning following the suffering of chest injuries by him;
and
- d) HN died on 4 May 2022 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Affidavit of the forensic pathologist Dr Christopher Lawrence;
- Affidavit of the forensic scientist Mr Neil McLachlan-Troup of Forensic Science Service Tasmania;
- Medical records obtained from the Royal Hobart Hospital (RHH);
- Medical records obtained from HN's general practitioner;
- Affidavit of LO;
- Affidavit of Claire Overeem;
- Affidavit of Courtney Thirgood;
- Affidavit of Juan Nin;
- Affidavit of Michelle Sumner;

- Affidavit of Rebecca Roland;
- Affidavit of Rhys Long;
- Affidavit of Senior Constable Todd Plunkett;
- Affidavit of Senior Constable Benjamin Fogarty;
- Affidavit of Constable Alice Eastwood;
- Affidavit of Constable Jonathan Reidy;
- Affidavit of Constable Ellaura Wiggins;
- Affidavit of Constable Emily Nalu;
- Affidavit of Senior Constable Jessica Walshe;
- Affidavit of First-Class Constable Oliver Mundy-Castle; and
- CCTV footage, photographs and forensic evidence.

Background

HN was 42 years of age (date of birth 20 September 1979), single, in receipt of a disability support pension and he resided with his grandmother at Rokeby in Tasmania at the date of his death. He never had a relationship with his father and he was raised solely by his mother and his maternal grandmother. HN had two younger siblings who were born in 1990 and 1991. HN never married and he did not have any children.

Throughout his childhood and into adulthood HN primarily resided with his mother and his grandmother. He attended primary school at John Paul II Catholic Primary School which he enjoyed before attending St Virgil's College at Austin's Ferry for his secondary education where he remained until he completed year 10. LO says her son did not enjoy high school because of the time it took to travel to and from school. She says he was an average student who did what was required to pass his subjects.

Throughout his schooling, he was very keen on his sport and took pride in being a member of the school's football and cricket teams. His mother describes him as a very fit and athletic boy. His love of team sports continued into adulthood as he continued to play indoor cricket for a team at Bellerive.

During his life, HN was the proud owner of two Staffordshire bull terriers. He put a lot of time and effort into training them and they were both very well-behaved and obedient. The first dog named *Chance* died at the age of 13 years and two years later HN bought the second dog who he named *Whispers*. HN and *Whispers* went everywhere together.

HN says her son was extremely close to his grandmother. She believes their relationship became close after HN lost her brother in a car accident when he was 19.

Health

HN says her son, during his teenage years, became curious and experimented with illicit substances, which resulted in him from around about the age of 14 smoking cannabis quite regularly. His use of cannabis continued and at around about the age of 17 he was diagnosed with chronic paranoid schizophrenia. His symptoms included paranoia and hearing voices. At the time, HN was treated by the general practitioner Dr Saul and at one home assessment conducted by Dr Saul, he advised HN required emergency treatment at the RHH. HN was therefore treated at the RHH and at one stage his symptoms became so bad HN had to be restrained because he wished to leave. He reflected on this episode many years later when he advised his general practitioner he had been tranquilized and held down by security, that he was full of rage and he tried to break an emergency door down. When reflecting on this episode in 2011, he indicated that he was better informed about his condition and so much better equipped to deal with it.¹

After HN's symptoms were stabilised he was transferred to the Royal Derwent Hospital for further treatment. His mother says the conditions in that facility were very strict and it was "*almost like being in solitary confinement*". Treatment by way of prescribing different medications was then attempted, but in respect of some of those medications HN suffered severe reactions and he became very unwell. After a period of time of trial and error an effective medication was found at an appropriate dose, after which HN received treatment at the Bridge Centre located in Creek Road. However, the treatment received at that facility was not suitable and he returned to the Royal Derwent Hospital for further treatment.

Although LO cannot recall for how long her son received treatment at the Royal Derwent Hospital, she does recall that it was under 12 months and by his 18th birthday he had moved back into the family home with his mother, grandmother and his mother's two other children at Austins Ferry. Approximately a year, later he moved in with his grandmother at Rokeby where he lived up until the time of his death.

Subsequently, HN became a patient at the Clozapine Clinic which was operated by the RHH. I have examined the records of that clinic from 2 July 2009 through until 5 May 2022. HN

¹ Medical records obtained from HN's general practitioner-notes of an attendance on 25 August 2011.

received treatment during that period approximately every four weeks. The longest period he went without treatment was about six weeks. It is surprising to note that for such a serious mental illness HN was consistently described as being psychiatrically stable or psychiatrically well. His mental state examination was more often described as unchanged or normal. There are some notes in the records which indicate that he occasionally heard voices, that they were not commanding him to do anything and that they were not distressing and he was able to cope with them. All in all, it is clear that both HN and his treatment providers managed his mental illness very well. This was in no doubt due to HN's personality whereby he liked to have a schedule, he would take his medication religiously and within an hour he would become drowsy and he would go to bed. He did this to ensure his need for sleep would not interfere with his other daily activities which included helping around the house and on occasions the notes reveal he had some casual gardening work and also in the last few years he assisted his uncle in his electrical business. He apparently enjoyed this work but did find it stressful at times. In relation to his medication, HN followed the guidelines and he knew the treatment he received was working for him. His mother says he never *"touched another illicit drug and never drank except for once every few months when he would not take his medication for a night and would have a few drinks while watching the football with my mother."* His last appointment at the Clozapine Clinic before death took place on 21 April 2022. He obtained his clozapine medication and blood testing was performed as was usual. At the appointment a month earlier, it was noted he was well and had no problems and that he heard voices now and again.

I have also examined HN's general practitioner records which cover the period 4 June 2003 until 28 April 2022. The records reveal HN suffered from irritable bowel syndrome, reflux oesophagitis and type II diabetes myelitis which was diagnosed in August 2017. The records indicate his paranoid schizophrenia was diagnosed in June 2003 although that is well after his 17th birthday. These records indicate HN attended his general practitioner regularly and apart from the normal ailments everybody suffers from, he received advice and treatment for his mental health and he received assistance with diet and exercise. It appears HN's weight fluctuated over the years. For example in June 2003 he was 106 kg, in February 2004 he was 115 kg and by September 2011 he was 126 kg. By September 2017 he was still 121 kg however a radical change in diet and regular exercise resulted in him reducing his weight to 99 kg by late November of that year and it appears from then until his death HN maintained his weight at under 100 kg. These notes also reveal that from time to time he heard voices but they did not

bother him and he was able to ignore them.² His last visit on his general practitioner before his death took place on 28 April 2022. That attendance was a phone consultation at which he was prescribed a prescription for Nexium. No mental health difficulties were raised.

Circumstances leading to death

On 4 May 2022, HN awoke early as he was required to drop his mother at a friend's house in Chigwell as she was travelling to Launceston for a memorial. HN is described by his mother, on that drive, as quiet and he had elected not to bring his dog with him. These two matters were out of character for HN. He dropped his mother off at about 7:40am before leaving to travel back towards Rokeby.

At approximately 8:00am, HN drove the family's vehicle, a black 2003 VW Golf, in the far left hand lane, in a easterly direction, towards the apex of the Tasman Bridge. Once he reached the apex he parked the vehicle and activated the hazard lights. Next HN exited his vehicle and climbed the railing onto the walkway of the bridge on the northern side. Once on the walkway, he then climbed the second or northernmost railing so that he was now on the exterior or outside of the bridge. He waited a short time hunched and squatting in this position at which time he was holding onto the railing with both hands. He then let go and jumped from the railing into the river below.

Investigation

At 8:10am Senior Constable Fogarty and Constable Eastwood were advised by Radio Dispatch Services (RDS) of Tasmania police that a vehicle had broken down at the apex of the bridge and the vehicle could be seen on the cameras. Approximately a minute later, a witness had called and advised a male was over the railing at the apex of the bridge and the caller believed the male was going to jump. A subsequent caller advised the male person had jumped. Police were tasked to check underneath the bridge on its eastern side. At 8:15am Marine and Rescue Services advised RDS were on their way to assist. A cyclist on the southern side of the bridge, Mr Long, contacted RDS at 8:18am and said he could see a body floating on the water below.

Constables Reidy and Nalu arrived at the location of the vehicle, which was registered to HN, and which still had its hazard lights on. Mr Long pointed out the male person in the water

² Medical records obtained from HN's general practitioner-notes of an attendance on 15 July 2020.

which Constable Reidy kept an eye on while Constable Nalu performed traffic control given the VW blocked one lane on the bridge.

Four officers from Marine, Search and Rescue were on the water by 8:23am searching for HN. He was located and retrieved from the water at about 8:35am whereupon they headed to the Cattle Jetty where the VW was towed. A forensic unit attended that location and examined both HN and the vehicle and photographs were taken. The mortuary ambulance arrived and HN was transported to the mortuary. Police then attended HN's address and spoke to his grandmother who advised that his mother, LO, was travelling to Launceston. She was subsequently notified of her son's death by police by telephone and she identified her son at the Hobart mortuary on 5 May 2022.

Dr Christopher Lawrence carried out a post-mortem examination on 5 May 2022. He noted HN's medical history and after conducting both an external and internal examination and after considering the results of a post-mortem CT scan, and the results of histology, toxicology and microbiology he determined HN died as a consequence of drowning following chest injuries which resulted from him jumping from the Tasman Bridge. Dr Lawrence says the autopsy revealed clear evidence of drowning with over expanded lungs, fluid levels in his sinuses and a plume of pulmonary oedema fluid in his mouth. HN also had some chest injuries with a tension pneumothorax, rib fractures and a left displacement of the cardiac outline. I accept Dr Lawrence's opinion.

The results of toxicology returned a positive result for clozapine which is an antipsychotic medication. Mr McLachlan-Troup says this drug is indicated only in treatment resistant schizophrenics. It's prescription in this case was clearly warranted given the medical evidence. In any event, the level of that drug was found at a therapeutic level only and therefore did not cause or contribute to HN's death.

LO says her son had indicated to his cousin that he was worried that when his grandmother and then his mother passed away he would have "*nothing left*". According to his cousin, HN was very distressed about this. HN only became aware of this after her son's passing. The evidence suggests that nobody, including HN's mother, suspected her son would take his own life and nobody was concerned that he was not coping. All the records suggest he was coping and he had coped very well with his mental illness for in excess of 20 years. In addition, there is no record of him ever having self harmed nor had he attempted suicide and nor did he indicate he had any plans to do so.

I am satisfied there are no suspicious circumstances surrounding HN's death. I find that he took the action of jumping off the Tasman Bridge alone and with the intention of ending his life. Given HN had coped very well with his mental illness for over 20 years and he was compliant with his treatment regime, which kept his psychiatric health stable, and given there was no history of suicide attempts or suicidal ideation of any kind, it is my view his death could not have been foreseen or prevented. Perhaps it was his fear of being left alone after the death of his mother and grandmother that led him to take the action he took. At no time was this discussed with his mother or his grandmother.

I extend my appreciation to investigating officer Constable Alice Eastwood for her 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, Coroner McTaggart handed down her findings following a public inquest into the suicide deaths of 6 people from the Tasman Bridge. She made 7 recommendations to prevent further suicides at this site.³ 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.

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.

³ [Deaths from a Public Place.pdf](#)

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.⁴ 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.

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.

⁴ Department of State Growth, *Tasman Bridge Upgrade Project: Project Briefing*, 5 May 2025. Provided to the Coroner’s Office on 3 June 2025.

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 HN.

Dated: 30 June 2025 at Hobart in the State of Tasmania.

Magistrate Robert Webster
Coroner