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, Leigh Mackey, Coroner, having investigated the death of IB

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

a) The identity of the deceased is IB.

b) IB died as a result of drowning subsequent to sustaining blunt force injuries which occurred as a result of a fall from a height;

c) IB's cause of death was drowning; and

d) IB died on 1 June 2019 at Hobart, Tasmania.

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

- Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Affidavit of the forensic pathologist Dr Donald Ritchey;
- Forensic Science Service Tasmania – toxicological and analytical report;
- Medical records of IB obtained from the Tasmanian Health Service (THS);
- Affidavit of DR together with photographs;
- Affidavit of Glenn Cannell;
- Affidavit of Mathew Stocks;
- Affidavit of Constable Gareth Auker;
- Affidavit of Constable Lucas Brouwer;
- Affidavit of Constable Aaron Woolen;
- Affidavit of Senior Constable Bernadette Heyward;
- Affidavit of Constable Michael Fogarty;

- Affidavit of Constable Ian Bellete;
- Tasmanian Health Service Final Root and Cause Analysis Report (RCA);
- Report of Dr Elijah dated 16 September 2024;
- Report of the medical advisor to the coroner Dr Anthony Bell MB BS MD FRACP FCICM;
- Tasmanian Civil and Administrative Tribunal (TASCAT) records, including records of the Mental Health Tribunal; and
- Forensic and photographic evidence.

Background

IB was 21 years when he died. At that time he was a resident of Mistral Place and under a Treatment Order for mental illness. Both Mistral Place and the Treatment Order will be discussed in greater detail later in these findings.

IB was born into happy and comfortable circumstances in Hobart. His parents were DR and YU, and he had two sisters, OE and JF. IB attended a private boys school in Hobart and during his primary and early teen years he enjoyed and was skilled at sports particularly soccer and tennis.

In late 2004 IB's parents separated, and his mother remarried to PC, IB's stepfather. By that marriage two stepsisters were introduced into the merged family, EG and MN. In 2011 IB moved with his mother and stepfather to Canberra. In Canberra he attended school but toward the latter years of his education became increasingly disengaged. His attitude and behaviour appear to have commenced to decline when he was in year 9 with DR describing him as becoming at that time "increasingly belligerent" and confrontational.[1] By 2013, when he was in year 10, he had become hostile and "openly aggressive".[2]

IB left the family home and was effectively itinerant from the age of 18 years. His health and safety were of significant concern to his family. Whilst they provided support for him, he became isolative and consciously separated himself from them. The reason for his withdrawal is unknown but was most likely a product of his mental health. The extent to which he maintained in contact with his family members from this time was limited and sporadic. However, IB's family continued to offer him support and attempted to assist him and his care as much as was possible in the circumstances.

[1] Tasmanian Health Service patients records document headed "Canberra – July 2015" and notated as "history from IB's mother".
[2] Tasmanian Health Service patients records document headed "Canberra – July 2015" and notated as "history from IB's mother".

IB's mental health

In 2017 IB developed a fixed and obsessive focus on what he ate. He engaged in veganism, fruitarianism and fasting at various times. He was reluctant to attend school, engage in sports or socialise. He spent long periods of time in his room. Concerned for his mental state, action was taken by his family to have him admitted to the Alfred Hospital. He was admitted from 3 March to 21 April 2017. At this time he presented as malnourished and received treatment for malnutrition and psychiatric assessment. On discharge from the Alfred Hospital IB lived with his father for a short period before moving to Queensland and then to the Northern Territory.

In 2018 IB left Australia for South America with a plan to attempt to live off the land in the Amazon Forest and survive without external assistance. His adventure turned into misadventure. He became lost and wandered into a village malnourished and unwell. He was medically evacuated back to Australia where, on arrival, he received inpatient hospital care.

Upon his return to Australia and his physical recovery, IB moved to Alice Springs and presented to the Central Australian Health Service on 23 October 2018 after a caseworker at a hostel where he was living raised concerns regarding his health. At that time, he described a two-week period of inability to make his own decisions regarding studying, working and eating. He was admitted into inpatient hospital care and then discharged at his request on 31 October 2018 with a diagnosis of schizophrenia and referred for community-based management. Thereafter, IB disengaged from health services and demonstrated poor compliance with treatment, including medication management, resulting in him coming under various orders mandating his treatment and requiring periods of inpatient care in the Northern Territory, Queensland and Victoria.

Complicating his mental health and compliance with treatment IB used illicit substances and lived an itinerant lifestyle. Whilst the extent of his use of illicit substances is unknown, it is known that he was a long-term user of cannabis and that this use negatively impacted his decision making and the therapeutic value of his prescribed medication.

In March 2019, IB moved to Hobart in Tasmania. By doing so he avoided compliance with various treatment orders that were active in other Australian jurisdictions. He had no fixed abode and lived on the street or in temporary shelter arrangements.

On 19 April 2019, IB presented to the Royal Hobart Hospital (RHH) and was admitted as an inpatient at the psychiatric unit until discharged on 3 May 2019. At that time, he gave a history of experiencing persecutory delusions, he felt that he was being watched and filmed. He admitted to methamphetamine use which he had recently ceased. His discharge plan was

for admission to Launch Youth, a homeless shelter, whilst he waited for a bed to become available at Velocity Transformations, a residential drug rehabilitation facility.

On 7 May 2019, IB presented to the emergency department of the RHH and gave a history of hearing voices telling him to kill himself. He described having gone to a road bridge in Moonah with the intention of jumping. He was admitted. The clinical thinking following assessment was that he had been under treated for schizophrenia. His depot and oral aripiprazole were continued and supplemented by oral olanzapine and diazepam to which there was a positive response. He was reviewed by a psychiatric registrar at the RHH on 27 May 2019 and whilst he reported ongoing paranoia, he denied suicidal ideation or planning. The decision was made to transition his care from the hospital setting to Mistral Place.

Mistral Place

Mistral Place is a step-down community-based facility at which residential psychiatric care is provided. The service is delivered by the Tasmanian Health Department through Statewide Mental Health Services. The facility is offered to hospital inpatients who are assessed to have reached a level of stability such that they can participate actively in their treatment plan but continue to require ongoing care and support. The facility is located close to the RHH and provides services from psychiatrists, medical officers with experience in psychiatry, nurses, and allied health practitioners, most particularly social workers. Unlike the RHH, Mistral Place Is not an approved hospital for the detention of patients under the *Mental Health Act* 2013.

When at Mistral Place, residents have greater autonomy and freedom than in a hospital inpatient setting. The facility is an open one and residents are able to come and go during the day and have access to flexible visiting hours. Formal psychiatric reviews occur less frequently than in an inpatient context however continue to occur, usually on a weekly basis. A medical officer is on site daily.

IB was transferred from the RHH to Mistral Place on 29 May 2019. His "*current situation"* was described in his referral to Mistral place as a "*relapse of schizophrenia in context of cannabis use*" and presenting with "*…paranoia and auditory hallucinations. Largely resolved by increase in aripiprazole depot from 200 to 400mg. Ongoing intermittent paranoia*".[3] The risk assessment recorded suicidal ideation, self-inflicted harm, threats/harm to others as "no". On arrival at Mistral Place,IB was noted to have developed a friendship with another patient

[3] Tasmanian Health Service Records Mistral Place referral form.

and cannabis use was suspected. He was accordingly counselled to not use illicit substances or alcohol.[4]

On 30 May 2019, IB was noted to leave Mistral Place several times during the day with Mathew Stocks, another patient at the facility, and was reminded by staff to inform them of his movements to which he agreed.[5] The notes from Mistral Place record interactions occurring between IB and medical, nursing and allied health practitioners at the facility during the period of his stay there. He described issues with sleeping, he isolated himself in his room and slept with the mattress on the floor. He described his mood as "*ok*" and said that he felt "*safe*".[6] He remained resistant to engaging with his family.

On 31 May 2019, IB spoke with the clinical nurse at the facility and was provided with 5mg of Diazepam and 100mg of quetiapine to assist with anxiety. He gave a history of experiencing suicidal thoughts but stated that he "*felt safe*" at Mistral Place. That evening he requested quetiapine PRN 100mg as he was "*not feeling right*". The nurse spoke to IB on the morning of 1 June 2019 and he appeared "*fine*"[7] at that time.

The events of 1 June 2019

IB was last seen on the unit at Mistral Place on 1 June 2019 at 3.00pm. He is described in the notes as being "*his usual quiet self*".[8] The records of Mistral Place do not reveal a reason nor cause for him to deviate from the previous way in which he was presenting and responding to his treatment and care at the facility.

IB left Mistral Place in the company of Mathew Stocks. Together they walked to the railway roundabout and smoked cannabis. IB told Mathew that he did not want to return to Mistral Place and wanted to walk to the Tasman Bridge. The two walked to the bridge and accessed the northern side walkway and headed toward the Eastern Shore. The walkway is open and accessible to pedestrians who wish to walk across or go onto the bridge. As he was nearing the crest of the bridge IB increased his pace putting distance between himself and his companion before quickly and with ease pulling himself up and over the bridge's outer railing. Mr Stocks's efforts to grab and hold onto him to stop him from falling were unsuccessful and and IB fell from outside the northern walkway of the bridge into the Derwent River below.

[4] Tasmanian Health Service Records Mistral Place 29.5.19 entry.
[5] Tasmanian Health Service Records Mistral Place 30.5.19 entry.
[6] Tasmanian Health Service Records Mistral Place 31.5.19 entry.
[7] Affidavit Glenn Cannell sworn 1 June 2019.
[8] Tasmanian Health Service Records Mistral Place 1.6.19 entry.

A fall of that distance resulted in blunt force traumatic injuries to IB's chest and abdomen. He landed in a body of water and, incapacitated by his injuries, drowned. Tasmanian Police were alerted by motorists of his fall from the bridge and deployed members quickly to the area including Marine Police who located and retrieved him from the river. By that time IB was deceased.

I am satisfied from the investigation that IB's fall was not the result of misadventure nor the intervention of third parties but was due to his decision to jump from the bridge to end his life.

The holding of an inquest

A matter for consideration in this matter is whether an inquest should or must be held as part of the investigation into IB's death. A Coroner with jurisdiction to investigate a death must hold an inquest if the deceased was, immediately before their death, a person held in care.[9] The *Coroners Act* 1995 (Act) defines a "*person held in care*" as a person "*detained"* or "*liable to be detained*" in an approved hospital within the meaning of the *Mental Health Act* as amended from time to time.[10]

On 10 May 2019, application was made to the Mental Health Tribunal, now Tasmanian Civil and Administrative Tribunal (TASCAT), for a Treatment Order regarding IB. The information supporting the application included that IB had a 10 day admission at the RHH and discharged on 3 May 2019 with a relapse of schizophrenia. He was presenting with symptoms of paranoia and auditory hallucinations. He believed others were watching and taking film of him. He described auditory hallucinations commanding him to kill himself. Whilst in the emergency department of the RHH he had not been compliant with leave conditions and had left the department for two hours. Without treatment he was described as being a risk of harm to himself considering the deterioration in his mental condition, previous attempts at suicide and the auditory hallucinations. It was noted that he had poor engagement in the past with mental health services and had moved from State to State to avoid treatment orders in those jurisdictions.

A Treatment Order was made by TASCAT on 14 May 2019. In its terms the Order gave authority for IB to be "*admitted and if necessary to be detained in an approved facility for the purposes of receiving treatment*".[11] The power to detain was conditional on it being necessary, reflecting the language of the *Mental Health Act* 2013 under which the Order had been applied for and made. The Order authorised "*a combination of treatment settings and for the*

[9] *Coroners Act* 1995 s25(1)(b).
[10] *Coroners Act* 1995 s3.
[11] Treatment Order made 14 May 2019.

admission or readmission of the patient to those settings, this includes treatment in the community".[12] The Order specified IB was:

1. Required to take specified "*medication (depending on clinical indication)*";
2. Undergo "*standard medical and/or blood tests as well as physical and radiological examination as clinically indicated and as directed to by the treating team*";
3. Undergo "*blood and/or urine testing as directed by the treating team for the purpose of monitoring the use of illicit drugs*"; and
4. Required to "*attend appointments at Adult Community Mental Health Services and including home visits from the Adult Community Mental Health Service team and/or Case Manager*" when in the community.[13]

The Order identified the "*treatment setting*" as an "*Approved Facility…[The] Royal Hobart Hospital*"[14] and was set to expire on 13 November 2019.

On 30 May 2019, the Order was varied to reflect the transfer of IB's medical management from the approved hospital setting, RHH, to a community setting, Mistral Place. Otherwise the Order as varied was in the same terms as the original order. The variation was made by TASCAT despite the original order contemplating treatment in a community setting. IB was not accordingly transitioned from the approved hospital to a community setting under the terms of the original order but rather under the order as varied, that variation having been sought and made by TASCAT to facilitate the transition to Mistral Place.

Mistral Place is not an approved hospital for the purposes of the *Mental Health Act* 2013. Accordingly, immediately prior to his death, IB was not a person that was detained in an approved hospital. The question remains, however, whether he is a person liable to be detained in an approved hospital. If he was, he was a person held in care and an inquest into his death must be held.

The phrase "*liable to be detained*" is not defined by the Act. To understand its meaning it is necessary to consider the text and context of the phrase and the policy or purpose underlying its use in the Act.

The Oxford English Dictionary defines "*liable*" as "*bound or obliged by law or equity or in accordance with a rule or convention; answerable*" and "detained" as "*to keep in confinement or under restraint*". Accordingly, the meaning of "*liable to be detained*" is to be bound or obliged by law to be confined or restrained. In a textual sense the liability to be detained is an

[12] Treatment Order made 14 May 2019.
[13] Treatment Order made 14 May 2019.
[14] Treatment Order made 14 May 2019.

immediate obligation. It is actionable per se and not contingent on other matters to exist or steps to be taken.

The definition of a person held in care under the Act explicitly references the *Mental Health Act* as enacted in various forms over time and confines its application to those persons who are detained or liable to be detained in hospitals approved under the *Mental Health Acts*. Accordingly, the context for the phrase "*liable to be detained*" in the Act is to be informed by the *Mental Health Acts* as they have applied over time.

The State's approach to mental illness has changed over the years to keep step with an evolving understanding of and a changing attitude toward mental illness. A stark expression of this can be found in a comparison of the *Mental Deficiency Act* 1920 which operated in Tasmania until 1963 and the subsequent *Mental Health Acts*. The *Mental Deficiency Act* applied to adults and children who had a "*mental deficiency*" of which there were four categories: "*idiots"*, "*imbeciles*", "*feeble-minded*" or "*moral imbeciles*".[15] The *Mental Deficiency Act* 1920 imposed a regime of institutionalisation with the effect that a "*defective*", who is subject to an order that they be sent to an institution, "*shall be* ***liable to be detained*** *in the institution accordingly*" (my emphasis).[16]

The *Mental Deficiency Act* 1920 was repealed by the first of the *Mental Health Acts* to operate in Tasmania. Over the years there have been three iterations of the *Mental Health Act* reflecting the evolution of how compulsory care and treatment of the mentally unwell has changed over time. In contrast little has materially changed (with one exception not relevant here) to the definition of a person "*held in care*" in the Act from the commencement of the Act to date.

At the time the Act commenced the *Mental Health Act* 1963 had been in operation for some time. The phrase "*liable to be detained*" was used liberally in the *Mental Health Act* 1963 and was defined as applying to:

> "*a person who in pursuance of any application, order, or direction, is liable under this Act to be detained in a hospital, whether or not he is for the time being absent from that hospital with leave or otherwise*".[17]

It was the making of an application, order or direction for treatment in a hospital under the *Mental Health Act* 1963 that rendered a person liable to be detained. A patient in an approved hospital was liable to be detained.[18] A patient who was subject to an order and

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[15] *Mental Deficiency Act* 1920 s5.
[16] *Mental Deficiency Act* 1920 s28.
[17] *Mental Health Act* 1963 s3.
[18] *Mental Health Act* 1963 ss21 & 28.

who was for the time being absent from a hospital on leave, or otherwise, remained liable to be detained.[19] The liability to detain required nothing further than the application, order or direction for hospital treatment under the *Mental Health Act* 1963.[20] The parameters in the *Mental Health Act* 1963 for the compulsory accommodation and treatment of patients was narrow and limited to a hospital setting. The *Mental Health Act* 1963 did not envisage a model which included accommodation and treatment occurring in a community setting. The liability for detention was a liability to be accommodated and treated in an approved hospital, which continued despite absences on leave, but accommodation and treatment in the community was not then in contemplation. This is the context in which the meaning of the phrase "*liable to be detained*" in the Act should be interpreted.

Following the repeal of the *Mental Health Act* 1963 by the *Mental Health Act* 1996 the phrase "*liable to be detained*" was all but dropped from the lexicon of the Act save for its use in transitional provisions. The *Mental Health Act* 1996 continued a system of detention of involuntary patients in approved hospitals. An order for admission made in respect of an involuntary patient was an authority to detain the patient.[21] As such, it could be said that a patient in respect of whom an Admission Order had been made was liable to be detained. However, if such a patient was non-compliant and outside of the hospital setting authority was required from the "*controlling authority*" before the patient could be taken into custody and returned.[22] They were not when outside of the hospital setting liable to be detained, until such an authority had been obtained.

Treatment in the community was recognised in the *Mental Health Act* 1996 through Community Treatment Orders. For the period that a person was an involuntary patient at an approved hospital a Community Treatment Order was automatically suspended.[23] The *Mental Health Act* 1996 did not authorise the detention at an approved hospital of a person for breaching a Community Treatment Order. As such, involuntary patients treated in an approved hospital who were liable to be detained by an order issued under the *Mental Health Act* 1996, were distinct from patients who, albeit under compulsion through a Community Treatment Order to access treatment in the community, were not, under the *Mental Health Act* 1996, liable to be detained.

The *Mental Health Act* 1996 was repealed and replaced by the *Mental Health Act 2013*. The *Mental Health Act* 2013 remains current and was in force at the time of IB's death. It

[19] *Mental Health Act* 1963 s3.
[20] *Mental Health Act* 1963 s21.
[21] *Mental Health Act* 1996 s26.
[22] *Mental Health Act* 1996 s38.
[23] *Mental Health Act* 1996 s44.

introduced "service delivery principles".[24] These called for a therapeutic and least restrictive approach to the care and treatment of those suffering from mental illness and included:

> *"(a) to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;*
>
> *(b) to interfere with or restrict the rights of persons with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the relevant service;*
>
> …
>
> *(j) to promote the ability of persons with mental illness to make their own decisions including decisions about the person's assessment, treatment and recovery that involve a degree of risk;*
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> …
>
> *(n) to promote and enable persons with mental illness to live, work and participate in their own community;*
>
> …
>
> *(v) to provide a mental health service that –*
>
> > …
> >
> > *(iii) promotes recovery in the least restrictive manner that is consistent with the needs of persons with mental illness*".

The use of the phrase "*liable to be detained*" in the *Mental Health Act* 2013 is limited to Chapter 4 Part 3 of the Act, Interstate Control Agreements, which provide for Australian States agreeing to return to each other involuntary patients who are "*liable to be detained*" in an approved facility and who are "*found at large*" in another state. The *Mental Health Act* 2013 provides for detention of a patient in three circumstances:

1. For the purposes of assessment (s17);
2. Under an Assessment Order (s27); and
3. Under a Treatment Order (s42).

The *Mental Health Act* 2013 allows for the accommodation and treatment of a patient under a Treatment Order to be at an approved facility or at a combination of settings.[25] A Treatment Order only authorises the detention of a patient if that detention is necessary and is at an approved facility.[26] The *Mental Health Act* 2013 provides for the circumstances in which a patient can be detained if there has been noncompliance or compliance with a Treatment Order. Specifically the *Mental Health Act* 2013 authorises the detention of a

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[24] *Mental Health Act* 2013 s15 and sched 1.
[25] *Mental Health Act* 2013 s39.
[26] *Mental Health Act* 2013 s39(2)(b) and s42(2)(a).

patient at an approved hospital if that patient has failed to comply with a Treatment Order and if the treating medical practitioner is reasonably, satisfied of a number of matters specified in section 47, and has applied to TASCAT and obtained a variation of the Treatment Order to admit and if necessary detain the patient in an approved facility or sought to admit and if necessary detain the patient under the Treatment Order pursuant to section 42.[27] If the patient is compliant with a Treatment Order that "*provides for a combination of treatment settings and for the admission and re-admission of the patient to those settings*" they may be detained if necessary in an approved hospital if the treating medical practitioner is satisfied reasonably of a risk to the health or safety of the patient, or to another, of serious harm which "*cannot be adequately addressed except by way of the patient's admission or re-admission to and, if necessary, detention in an approved hospital*".[28]

The context in which the phrase "*liable to be detained*" was used at the time of its introduction into the Act was in respect of patients who by reason of an application, order or direction were required to be resident at and treated in an approved hospital. Practices for the compulsory treatment of mental illness has evolved somewhat from then to now and encapsulate a less restrictive practice of community accommodation and treatment to which the concept of detention has less relevance.

From a contextual perspective, I have concluded that the phrase "*liable to be detained*" as used in the Act, refers to a patient being assessed for or subject to a Treatment Order which requires their detention at an approved hospital. It does not extend to those patients subject to Treatment Orders that provide for their accommodation and/or treatment in a community setting (not at an approved hospital) until those matters, where relevant, identified in sections 47 and 47A of the *Mental Health Act* 2013 as necessary for the detention of a noncompliant or compliant patient in the community have been satisfied. At that point detention in an approved facility becomes necessary and the liability arises.

Consideration of the meaning of the phrase "*liable to be detained*" in the Act also calls for the purpose or object of the Act to be identified so that an interpretation that promotes that purpose or object can be applied.[29] The circumstances in which an inquest is mandated to be held in the Act include when the deceased was, immediately before their death, a person held in care (s24(1)(b)), held in custody (s24(1)(b)), the death occurred whilst the deceased was escaping or trying to escape from a form of compulsory detention (s24(1)(d)) or the death occurred in the process of attempting to detain a person (s24(1)(e)). These circumstances have a commonality to the extent that in each the death has occurred at a

[27] *Mental Health Act* 2013 s47.
[28] *Mental Health Act* 2013 s47A.
[29] *Acts Interpretation Act* 1931 s8A.

time when the State has subsumed or are attempting to subsume an individual's freedom of movement and choice. The death does not have to be causatively linked to the loss of those freedoms. The mandating of an inquest in these circumstances merely requires a temporal connection.

If an inquest is mandated as death occurred whilst a person was in care or custody, or whilst escaping or attempting to escape, a coroner must report on the care, supervision or treatment of the person whilst they were held in care or custody.[30] It can be gleaned from this requirement that the purpose of mandating an inquest in such circumstances is protective by requiring independent judicial oversight of the State's exercise of power at those times when a person, whose freedoms of movement and choice have been taken, has died. There is a clear public interest in ensuring the exercise of the powers to compulsory detain are subject to coronial scrutiny through inquest. The policy imperative is less obvious when the power to detain is not immediately exercisable or not being exercised at the time of death. In such circumstances the compulsory actions of the State would be less likely to be temporally or causatively relevant to the death and the purpose of an inquest to review the exercise of those powers would not be achieved.

From this analysis of the textual and contextual use of the phrase "*liable to be detained*" and noting the purpose of the provision in the Act, I conclude that a patient subject to a Treatment Order that requires nothing more than their treatment and accommodation in a community setting is not then liable to be detained and, as such, is not a person held in care under the Act.

I further observe that the general authority to detain in respect of a Treatment Order found in section 42 of the *Mental Health Act* 2013 should be read subject to the specific requirements for detention in sections 47 and 47A of that Act. As such, the power to detain under the *Mental Health Act* 2013 only arises when, those matters identified in sections 47 and 47A as required before the detention of a patient in an approved hospital can occur, have been satisfied.[31] The making or varying of a Treatment Order to one requiring community treatment and accommodation, does not of itself give rise to a liability for a patient to be detained. It is the variation of the Order under section 47 of the *Mental Health Act* 2013 to an order requiring detention at an approved hospital or the belief of the need for admission to an approved hospital by the treating practitioner arising from the reasonable likelihood of harm to the patient or others under sections 47 and 47A that gives rise to the liability to be detained under section 42 of the *Mental Health Act* 2013.

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[30] *Coroners Act* 1995 s28(5).
[31] *Mental Health Act* 2013 s47A.

The phrase "*liable to be detained*" has been subject of consideration previously in the Coroners Court. In the matter of Molly Smith (2017 TASCD 444) Coroner McTaggart considered the phrase in the context of a deceased who whilst not formally subject to an order under the *Mental Health Act* 1996 (which applied at the time of her death) had for over 50 years been resident and treated in State run facilities due to her severe mental illness. The issue arose as to whether she was a person "*held in care*" under the Act given she was not under an order at the time of her death. After a consideration of the provisions of the *Mental Health Act* 1996 Coroner McTaggart observed:

> *"I have examined the use of the expression 'liable to be detained' in the Mental Health Acts 1963, 1996 and 2013. The expression is used in provisions dealing with persons already subject to a formal order or direction in respect of involuntary admission but, for the time being, are not situated within an approved hospital. For example, in the Mental Health Act 1963, section 3 (2) provides; 'references in this Act to a person liable to be detained shall be construed as references to a person who, in pursuance of any application, order, or direction, is liable under this Act to be detained in a hospital, whether or not he is for the time being absent from that hospital with leave or otherwise'. This concept carries through to the subsequent Acts; for example, section 205 of the Mental Health Act 2013, dealing with involuntary patients at large."*

In the case of Molly Smith consideration of the circumstances in which there is a liability to be detained did not extend to circumstances, such as exist here, of community based care. As I have found the textual, contextual and purposive approaches to the interpretation of the phrase "*liable to be detained*" support the proposition that a liability to be detained arises only when a person is under an order or being assessed for an order requiring them to be at an approved hospital. Where further is required, such as those matters in sections 47 and 47A of the *Mental Health Act* 2013 before a person can be taken and detained at an approved hospital they cannot be said at that time to be liable to be detained.

IB had been compliant with his Treatment Order, interim, final and as varied. His discharge from the RHH and transfer of care to Mistral Place occurred in the context of his improvement and compliance. There is no evidence that it was, immediately prior to his death, necessary for him to be detained in an approved hospital. The order to which he was subject had been varied to reflect the change in treatment settings from that of the approved facility to the community. The extent of the State's exercise of its powers of compulsion and its impact on the freedoms of IB were limited to his residency in a non-approved setting, Mistral Place, and the supervision of his treatment.

IB had been transitioned on his Treatment Order, albeit still a compulsory order, to live and be treated outside of an approved hospital and as such, he was not at that time detained nor liable to be detained at an approved hospital without further order from TASCAT if non-compliant[32] or without the treating medical practitioner being satisfied of those matters required to invoke section 42 of the *Mental Health Act* 2013.[33] IB was compliant, no treating medical practitioner held a concern regarding his health or those of others. I find that he was not liable to be detained at the time of his death and the holding of an inquest is not mandated by the Act.

Whilst the holding of an inquest is not mandated by the Act one may be held if it is considered desirable.[34] This involves a consideration of whether an inquest will assist to make the findings, comments or recommendations required under section 28 of the Act. IB's death has been the subject of significant investigation traversing the events at the time of his fall but also his medical care and treatment both at the RHH and at Mistral Place. The matters about which I am required to make findings have been sufficiently elucidated by that investigation. I do not require the powers of compulsion and examination that are available at inquest to discharge or better inform my functions under the Act

The decision to transfer IB to Mistral Place

As I have noted earlier in these findings, the *Mental Health Act* 2013, to which IB was subject by virtue of the Treatment Order, established principles including that he be treated in the least restrictive way whilst still protecting him and others. Over the time of IB's stay at the RHH his auditory hallucinations resolved in response to the increase in his medication. Indeed, up until he left Mistral Place on 1 June 2019, his condition remained stable.

Prior to IB's transfer from the RHH to Mistral Place, Dr Thavarajah reviewed him on 27 May 2019 and considered that at that time he was functioning well, he was sleeping and eating well, he was visiting the gym daily, was using unaccompanied leave and denied suicidal ideation or intent. He was positive about the future. A mental state examination was conducted and Dr Thavarajah determined there was improvement in mental state. The doctor's notes indicate he contacted DR and updated her on IB's progress and the ongoing plan.

On 29 May 2019 at 10.00am, a clinical risk assessment was conducted and on a scale of 0 to 4, where 0 is equivalent to no risk and a score of 4 is equivalent to a very severe risk. IB was assessed at 0 for intentional self-harm, unintentional self harm and at risk from others. He

[32] *Mental Health Act* s 47.
[33] *Mental Health Act* ss47 and 47A.
[34] *Coroners Act* 1995 s24.

was given a rating on the border between 0 and 1 (mild risk) with respect to being a risk to others. In so far as his needs and disabilities were concerned he was rated a 1 for survival and psychological and 2 (a moderate risk) with respect to his needs and disabilities from a social point of view. Apart from 10 May 2019 this assessment was conducted on one or two occasions each day from 9 to 29 May 2019.

The medical records of the RHH and that of Mistral Place have been reviewed by Dr Anthony Bell MB MD BS FRACP FCICM, medical advisor to the Coroner. Dr Bell's opinion is that IB's management was sound with decisions being made concerning his treatment at a consultant psychiatric level.

A Root and Cause Analysis (RCA) was conducted by the Tasmanian Health Service regarding IB's care whilst an inpatient at the RHH and resident at Mistral Place. Whilst the RCA did not identify any factors that led directly to IB's death the RCA did identify areas for system improvements. These improvements included:

1. Educational information relating to the ill effect of illicit drug abuse on mental health should be provided by clinical staff to patients suffering an acute relapse of their diagnosed psychotic illness and significant others.
2. A review and/or development of protocols should occur around the management of leave for transferred clients from acute inpatient units who are under a treatment order.
3. Mental state examinations and risk assessments should be documented as part of a comprehensive assessment completed by treating clinicians in the 24 hours prior to transfer/discharge from the inpatient setting.
4. All clients admitted to Mistral Place should have a mental state examination and risk assessment completed at each clinical review and/or at least once during a 24 hour nursing shift.

I agree with the above recommendations and view the implementation of them as likely to positively contribute to the quality of care for patients.

I have also considered the report of Dr Elijah, Executive Director of Medical Services for Statewide Mental Health Services, concerning IB's treatment and care whilst at Mistral Place. He has reviewed the decision making underlying his transfer to Mistral Place and concluded that the decision to transfer was clinically sound in light of the following:

a. IB was managed in the least restrictive way which aligns with the principles of service delivery described in the *Mental Health Act* 2013;

b. IB had demonstrated a desire and ability in the past to seek and obtain help for worsening symptoms;
c. IB's condition had steadily improved over the period of his care and his trajectory suggested further improvements were likely over time;
d. He was future focused with no evident suicidal ideation at the time; and
e. He had requested to go to Mistral Place.[35]

Dr Elijah notes that leading up to his transfer to Mistral Place records from the RHH record observations of IB as exhibiting settled behaviours. He notes that there was no:

> "*event or illness process that I am aware of which would alter his trajectory including of risk given that he was keen to move to a less intrusive environment and had expressed a wish to stay in Hobart before moving back to his mother in Canberra*".[36]

IB was regularly reviewed by health practitioners at Mistral Place. As noted by Dr Elijah, he was seen by a medical officer and a consultant who noted ongoing paranoia and anxiety and responded by increasing his dose of antipsychotic medication. I find that IB's transfer to and care whilst at Mistral Place was appropriate and congruent with how he was presenting at that time. Whilst the records at Mistral Place include observations of IB as guarded, pre-occupied, distracted, paranoid and at times isolative, Dr Elijah considers these behaviours did not necessarily indicate active illness and were in keeping with his personality style.

The principles of service delivery espoused in the *Mental Health Act* 2013, as I have noted earlier in these findings, reflect the tension between an individual's treatment needs as informed by the risk they present to themselves and others, and respecting and enhancing their independence, social engagement and autonomy. The fact that IB was transitioned to a less restrictive treatment environment was in Dr Elijah's opinion reasonable given the matters I have previously referred to.

IB was able to access a jumping off point on the northern side walkway of the Tasman Bridge with ease. Had the barrier at the external edge of the walkway on the bridge been at a height that was inaccessible by jumping up and over the railing the capacity for IB to have done as he did would have been reduced. IB's actions of jumping up and over the bridge railing have the hallmarks of a spontaneous, unplanned act. He did not leave a message, appeared as normal on departing Mistral Place and gave no indication to his companion of his intentions until it was too late. On a past occasion when IB had thoughts of jumping to his death, he was self-protective and accessed treatment. The absence of any sufficient

[35] Report of Dr Elijah dated16 September 2024 p2.
[36] Report of Dr Elijah dated16 September 2024.

deterrent or preventative measures on the bridge may have denied IB the time and space to have made a different decision or, as he had done previously, sought medical intervention.

I extend my appreciation to investigating officer Constable Auker 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, 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.[37] 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.

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,

[37] Deaths_from_a_Public_Place.pdf

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.[38] 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.

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 IB.

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

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

Leigh Mackey
Coroner