MAGISTRATES COURT TASMANIA

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 KT

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

a) The identity of the deceased is KT, date of birth 12 May 1997.

b) KT was 26 years of age, was single and lived in Battery Point with his father. KT grew up in New Norfolk and attended local primary schools. His family moved to Cairns where he attended a local Christian College. KT graduated from year 10 and did not continue schooling. Having an interest in graphic design, he pursued a career in photography where he worked for approximately three months prior to starting his own business with a friend. The family returned to Tasmania in June 2018 but KT remained in Cairns until returning in November that year. Subsequently, he returned to live in Cairns for a further periods of time.

In 2021 KT was diagnosed with attention deficit hyperactivity disorder (ADHD) and came under the care of Queensland psychiatrist, Dr Alice Chang, who commenced KT on appropriate medication. She also diagnosed him with generalised anxiety disorder and sleep wake disorder. Dr Chang managed KT's conditions and medication regime until about November 2022.

In late 2022 KT travelled to Canberra and experienced a psychotic episode. He contacted his aunty, AC, for help, and she organised accommodation at a local hotel and a flight home the following day. KT did not travel as expected on that flight. He made his way to Sydney and was unable to be contacted. RO filed a missing person's report. When he was located by police, AC's two daughters collected him and ensured that he returned safely to Hobart. AC contacted

emergency services, including the PACER team.[1] KT was taken by the Hobart PACER team to the hospital for a mental health assessment.

In March 2023, KT travelled to Cairns and presented to the emergency department at Cairns Hospital in relation to a medical complaint. He described experiencing persecutory and grandiose delusions and was held on an involuntary order under the Queensland *Mental Health Act* 2016 from 13 March 2023 to 27 March 2023. Following an assessment, he was diagnosed with psychosis and acute schizophrenia.

In June 2023, following his return to Hobart, the PACER team went to check on KT at his home. At this visit, KT stated to PACER team members that the Australian Security Intelligence Organisation (ASIO) had hacked into his phone and laptop in Canberra, threatened him and gave him $10,000 to stay quiet. He had been unable to use his phone or laptop and felt overwhelmed. KT was again taken to the Royal Hobart Hospital (RHH) where he was again held for 2–3 days on a mental health order.

An application was made to the Tasmanian Civil and Administrative Tribunal for KT to be placed on a mental health order on 30 June 2023. KT was discharged from the Interim Treatment Order on 3 July 2023 and the hearing was cancelled.

At about 1.30pm on Wednesday 16 August 2023, KT told his father he loved him and was going for a walk. At around 3.05pm, he walked up the north facing side of the Tasman Bridge heading towards the Eastern shore. A witness observed KT and phoned police advising there was a man on the bridge "*looking like he is not doing well*". KT was also observed walking on the Tasman Bridge by his cousin who was driving over the bridge. Upon seeing him "looking lost" she called KT's father and started to make her way back to his location on the bridge.

Off-duty police officer Constable Bradley Somers was driving over the Tasman Bridge when he observed KT climbing over the rail. He stopped and talked to KT, discouraging him from jumping. KT told Constable Somers that he couldn't help him. At this time, KT was holding onto the outside railing with one hand. Detective First Class Constable Thomas Gordon, a police officer on duty, also attended the scene in response to a radio call. He joined Constable Somers in trying to engage with KT. A third person, civillian Danny Fry, was also present

[1] The PACER team is a mental health emergency response team comprising mental health clinicians, paramedics and police officers.

and tried to engage with KT. Within a short time, KT did not further interact or make eye contact with those present. From the outside of the bridge railings, KT then jumped into the water below. KT's cousin arrived at the scene after he had jumped.

The police officers then maintained observations of KT, coordinating with the police helicopter and police vessel to recover KT. Once recovered, KT was taken to the cattle jetty near the cenotaph. Once docked, PACER team members and paramedics from Ambulance Tasmania boarded the vessel. Despite all resuscitation measures, KT was unable to be revived and was pronounced deceased at the scene.

c) KT died as a result of multiple injuries, primarily severe chest trauma, due to jumping from the Tasman Bridge. Toxicological analysis only revealed low levels of his prescribed medications, paliperidone and amiodarone, in his blood. I am satisfied that KT jumped from the bridge with the intention of ending his life. He was determined to take this action, despite the best efforts of the two police officers and Mr Fry to stop him doing so. Just prior to his death, his mental state appeared to his father to be stable. He did not indicate his intentions to any other person. He did not leave any note regarding his suicide.

d) KT died on 16 August 2023 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Opinions of the forensic pathologist regarding cause of death;
- Toxicology report of Forensic Science Service Tasmania;
- Records of Ambulance Tasmania;
- Tasmanian Health Service records;
- Medical records from Edge Hill Clinic, Queensland;
- Affidavit of FR, father of KT;
- Affidavit of PL, partner of KT's brother;
- Affidavit of BI, mother of KT;
- Affidavit of WE, brother of KT;
- Affidavit of QY, cousin of KT;

- Affidavits of Constable Bradley Somers and Detective First Class Constable Thomas Gordon;
- Affidavits of attending and investigating police officers, including photographs and body worn camera footage;
- CCTV footage from the Tasman Bridge; and
- Review of KT's psychiatric treatment by the Coronial Nurse, Kevin Egan.

Most unfortunately, KT suffered worsening mental health issues, involving psychosis, before his death. I am satisfied that he was provided with appropriate medical assessment and treatment for his serious condition, including the imposition of involuntary mental health orders where appropriate. He fluctuated in his decision-making capacity and his level of paranoia and delusional thinking. He was non-compliant with medication regimes and withdrew from mental health support services. The evidence also suggests that his use of cannabis caused a worsening of his condition. Family members, and particularly his father, were very supportive of KT.

In his review, the Coronial Nurse expressed the opinion that the PACER team was an excellent service in responding to KT in episodes of crisis. I agree with this assessment and comment that the PACER team is a most valuable service in assisting those in need of assessment and timely mental health support.

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.[2] 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.

[2] 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.[3] 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.

[3] 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 KT.

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

Olivia McTaggart
Coroner