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, Simon Cooper, Coroner, having investigated the death of LM

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

a) The identity of the deceased is LM;

b) LM died in the circumstances set out further in this finding as a result of injuries sustained by him when he jumped from the Tasman Bridge, Hobart. I am satisfied on the evidence that his decision to jump from the bridge was made voluntarily and undertaken alone, intentionally and with the express intention of ending his own life;

c) The cause of LM's death was multiple blunt force injuries sustained in a fall from height; and

d) LM died, aged 41 years, on 5 August 2024 in the River Derwent at Hobart, Tasmania.

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

- Police Report of Death for the Coroner;
- Affidavit – Constable Theresa Paterson, Tasmania Police Fingerprint Section, confirming identity;
- Report – Dr Rebecca Irvine, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Medical Records – Tasmanian Health Service – Royal Hobart Hospital;
- Medical Records – Claremont Medical Center [*sic*];
- Affidavit – GT, sworn 7 October 2024;

- Affidavit – Joanne Curran, sworn 5 August 2024;
- Affidavit – Jeremy Phillips, sworn 28 September 2024;
- Affidavit – Davina Kitchener, sworn 23 October 2024;
- Affidavit – Sergeant Evelyn Sterane, sworn 9 December 2024;
- Affidavit – Leighton Beer, police officer (rank not stated), sworn 19 August 2024;
- Affidavit – Constable Philip Vanderwal, sworn 19 August 2024;
- Affidavit – Sergeant Aidan Parkinson, sworn 14 November 2024;
- Affidavit – Constable Mackenzie Winch, sworn 10 December 2024;
- Affidavit – Constable Cheree Stokes, Forensic Services, sworn 10 October 2024 (and photographs); and
- CCTV footage, forensic evidence and police family violence records.

Introduction

LM was born in Hobart on 4 August 1983. He had a lengthy history of alcohol and illicit drug abuse. At the time of his death he was unemployed and reportedly spent his days drinking, consuming methylamphetamine and gambling.

He was in a relationship of sorts with GT, although at the time of his death was facing charges in relation to assaulting her and subject to a Police Family Violence Order protecting GT.

The evidence is he suffered poor mental health, characterised in part by suicidal ideation and attempts. He had been the subject of at least one order under the *Mental Health Act* 2013 in the past but was not subject to any orders at the time of his death.

Circumstances of death

LM and GT spent the last night of his life together consuming a significant amount of alcohol which led to an argument and then a physical attack by LM upon her. She fled his home at about 4.00 am on 5 August 2024.

At about 3.30 pm that day, LM caught a bus from his home at Claremont towards Hobart. GT was on the bus, going she said, to a women's shelter. At 4.25 pm he got off the bus at North Hobart. So did GT. LM told GT that if she was actually going "to the shelter he would go to the bridge and kill himself". The couple parted.

True to his word, LM made his way to the Tasman Bridge, stopping first on his way at a bottle shop in Liverpool Street to steal a bottle of wine.

CCTV footage shows LM walking on the northern footpath of the bridge to its apex. At 6.42 pm he appears to use the 'Lifeline' telephone on the northern side of the bridge. Three minutes later he can be seen jumping over the railing board onto the road before running across five lanes of traffic and climbing onto the footpath on the southern side. CCTV footage shows him picking up the 'Lifeline' phone on the southern side of the bridge before putting it back down, putting down the bottle of wine he was carrying, climbing onto the bridge rail, leaning backwards, and plunging into the water 46 m below directly under the bridge. A passing motorist saw him jump and called 000.

Investigation

Police using both a helicopter and a boat quickly located and recovered LM's body. It was taken to the Cattle Jetty at the Regatta Grounds before being transported to the mortuary at the Royal Hobart Hospital.

At the mortuary, an autopsy was performed on his body by experienced forensic pathologist Dr Rebecca Irvine. Dr Irvine expressed the opinion, which I accept, that the cause of LM's death was multiple blunt force injuries. Samples taken at autopsy were subsequent analyses laboratory of Forensic Science Service Tasmania where elevated levels of alcohol (0.246 g per 100 mL of blood, along with methylamphetamine and THC, the active constituent of cannabis, were also detected in elevated levels. LM was identified by Fingerprint comparison.

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.[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 LM.

Dated: 2 July 2025 at Hobart, in the State of Tasmania.

Simon Cooper
Coroner