



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

**FINDINGS, COMMENTS and RECOMMENDATIONS of
Coroner McTaggart following the holding of an inquest
under the *Coroners Act 1995* into the death of:**

MS

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Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends, youths and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of MS, with an inquest held at Hobart in Tasmania make the following findings.

Hearing dates

I, 2 and 3 August 2023, closing submissions received by 22 February 2024.

Representation

Counsel Assisting the Coroner: L Fox

Counsel for Department for Education, Children and Young People and for David Kilpatrick, Andrew Sweeney, Katherine McKeown and Rebecca Strong: G Chen and C Frankcombe

Introduction

1. MS, aged 13 years, tragically died on the evening of Sunday 16 February 2020 at his home in Mangalore. He died of asphyxia by hanging himself. He was alone when he took this action and there were no suspicious circumstances. At the time of his death, MS had just commenced year 8 in high school. In the weeks and days before his death, MS had expressed to close friends through text messages that he was considering suicide. In the school week before his death, senior staff at his school were advised of a self-harm concern in respect of MS. MS did not have any medical history involving mental health concerns, and his parents were unaware of MS's talk of suicide.
2. I held a public inquest into MS's death in order to understand why MS took the action he did, which resulted in his death; and also to consider whether anyone, including the school, should have reasonably taken any different action to protect him.

Scope

3. The scope of the inquest was as follows:

- a) Findings required to be made under s28 of the *Coroners Act 1995*, with particular consideration given to the question of *how death occurred* as referred to in points b) to h) below;
- b) Whether MS intentionally ended his own life;
- c) MS's state of mind during the weeks and days leading up to his death;
- d) Knowledge regarding MS's state of mind during the weeks and days leading up to his death by his family, his friends, school staff and other adults;
- e) If anyone did have knowledge of MS's state of mind during the weeks and days leading up to his death, what action (if any) was taken by them;
- f) Whether MS had a history of suicidal ideation or other mental health concerns historically and up until his death;
- g) Whether any event or events during the weeks or days leading up to MS's death contributed to his decision to end his life; and
- h) What guidelines were in place at New Town High School and the Department of Education in general in relation to what should be done (by staff) if information is received regarding a student expressing suicidal ideation, thoughts of self-harm or mental instability.

Evidence

4. I am satisfied that a thorough investigation has taken place into MS's death. The documentary evidence comprised Exhibits C1 to C48 itemised in the exhibit list annexed to this finding and marked "Annexure A".
5. Additionally, at inquest, oral evidence was called from the following witnesses in this order:
 - **AO:** mother of MS;
 - **BR:** father of MS;
 - **CE:** brother of MS;
 - **Detective Senior Sergeant Nicholas Evans:** principal investigating officer;
 - **Detective Constable Elise Clark:** attending and investigating officer;
 - **JL:** friend of MS and New Town High School student;
 - **FX:** mother of JL;
 - **David Kilpatrick:** Principal New Town High School;
 - **Andrew Sweeney:** Acting Assistant Principal New Town High School;

- **Katherine McKeown:** Support Teacher at New Town High School;
- **Rebecca Strong:** Senior School Psychologist at New Town High School; and
- **Teresa Pockett:** Student Support Leader with Department for Education, Children and Young People (“DECYP”).

Background

MS

6. MS was born on 24 October 2006. He lived with his parents and older brother CE at Mangalore and had lived there his entire life. He attended Brighton Primary School before moving to New Town High School. At the time he died, he had just commenced grade 8 at New Town High School.
7. MS was described in the evidence as a boy who was very kind to others and quiet and respectful at school. He loved being outdoors and also loved the animals on his family’s property. He was excited about joining the air force cadets. He had a particular interest in military paraphernalia and enjoyed gaming with his friends. MS had good friends, and his friendship group was positive in nature. Shortly before his death, MS had commenced a relationship with a girlfriend, IW, but this was not sexual.
8. MS loved the same recreational activities as his father. He carried knives like his father and spent time fishing and hunting with him. MS enjoyed throwing knives and using a bow and arrow. It appears that such activities also helped him vent stress and frustration.
9. MS was a risk-taker in his physical activities. He enjoyed performing “doughnuts” on quad bikes and riding fast. In this regard, he was very different from his older brother, CE. Despite being younger, MS stood up for CE at school.
10. MS achieved good grades and school reports and had no behavioural issues.
11. MS’s friend, DY, who had been close to MS from primary school, described MS as always being a “normal person”. However, DY said in his affidavit that things began to change in Year 7. He said that MS became negative about himself, stating in his affidavit *“he went from what I would call normal person, to a negative person. He would send me text messages and comments that nobody cared about him. I know his parents, and I would tell him that people did.”*

Health

12. MS was physically healthy and had no recorded history of having mental health issues. He had had an adenoidectomy at about 8 years of age, and had broken his arm (playing football) when he was 11 years of age. MS was known to have a fear of hospitals and needles.
13. The evidence indicates that the onset of puberty impacted MS quite dramatically. MS's mother gave evidence that he went through puberty quite early and at that time she noticed personality and behavioural changes and a significant growth spurt of 20 – 25 centimetres in a year. Understandably, AO attributed MS's moodiness to being a teenager.

Self-Harm

14. At the end of 2019, MS started to engage in self-harm by cutting himself. His friend, DY, stated in his affidavit *"he (MS) would cut both forearms and he used knives. He had quite a collection of knives at home. He bought a few on Ebay and I believe he had at least six or seven, which he kept on his bedside table. He had a fascination with knives and he used to practice throwing them at a tree in his back yard. At one stage he tried to teach me how to throw knives."*
15. DY said that at first, MS would just cut himself occasionally but then after Christmas (2019) the cutting became more frequent. DY stated in his affidavit *"he showed me some of the scars and cuts in his arms, but he normally kept them covered up. He would do this by constantly keeping his arms crossed and at school he always wore a jacket"*.
16. In late January 2020 MS commenced sending text messages to his friend JL regarding the idea of killing himself and said that he had previously tried to kill himself when he was in grade 5. In his affidavit, JL stated *"MS was messaging me and I believe it was on messenger. He started out making a joke referencing killing himself. He was joking to start with and I started questioning him because I thought it was a bit odd as he hadn't talked like that before. He was joking initially about a noose. When I questioned him more he told me that he was depressed and he had tried to kill himself in grade 5. He didn't tell me how he had tried."*
17. In his sworn evidence at inquest, JL confirmed this evidence and also confirmed his initial account that MS had sent him photos of cuts to his arms which he told JL were

made by his own knives. JL gave evidence confirming his original account that MS told him several times that no one could know and made JL promise not to tell anyone.

18. It is clear upon the evidence that MS had been self-harming shortly before his death by cutting his lower arms. The evidence was contained in messages to JL between 2 and 5 February 2020 in which MS sent photos of superficial cuts to JL with accompanying messages. MS's messages to JL were confined to how he did it, describing the sharpness of his knife. When asked by JL why he did it, MS declined to answer the question. JL's replies show that he was discouraging MS from cutting himself.
19. There is little evidence that could assist in determining MS's thought processes or intent. Reasons may have included attention-seeking, experimentation, risk taking or mental angst/illness. His messages to JL do not include content indicating a state of sadness or distress, and seems consistent with experimentation. However, there was evidence in the days and weeks following of MS making repeated comments to friends in messages regarding his wish and intention to end his life.
20. I am satisfied upon the evidence that MS's mother and father had no knowledge at all before MS's death about his self-harm or statements concerning suicide. His communications were confined to his close friendship group. Further, his friends said he wore long-sleeved clothing over the summer, which would have concealed any evidence of self-harm.
21. MS's parents, in fact, had no knowledge or belief that MS was in any form of mental distress that would cause concern. As will be apparent, they had no reason to hold grave fears for MS's well-being or safety.

Bullying

22. Evidence of bullying at school was given by MS's mother, brother and his friends and to a more limited degree by the Assistant Principal, Andrew Sweeney.
23. The bullying was said, by CE, to have occurred regularly but he was not able to describe what was being said or done with any detail. He denied MS tried to protect him, but this was contrary to the balance of the evidence. That MS is likely to have (on some occasions at least) been standing up for his brother is supported by evidence of AO and the evidence regarding MS's personality.

24. JL also gave evidence about bullying and said he had seen MS bullied until he cried by a boy by the name of PH. He said this was in the form of verbal harassment with name calling such as faggot and retard.
25. It seems, however, that most of the bullying was occurring on the bus that MS and his brother caught from school to Brighton (“the Brighton bus”). There was an incident described by Mr Sweeney on 20 August 2019 where food was thrown and threats were made towards MS and three of his friends.
26. AO also described a significant incident in May 2019 associated with the Brighton bus when a number of students attempted to fight CE and MS stepped in. This was not recorded on the school records. However, I accept AO’s evidence that she contacted the school on several occasions about poor behaviour of students on the Brighton bus.
27. During the week of 10 to 14 February 2020, shortly before MS’s death, there was another incident on the Brighton bus involving food throwing which resulted in detentions for students and other measures taken by Mr Sweeney. These measures included: detentions for students engaged in inappropriate bus behaviour, contact made with the parents of students engaging in such behaviour, Mr Sweeney himself often boarding the bus to address behavioural expectations and bus contracts issued for parents and students to sign. Mr Sweeney said that he made persistent requests to Creswells (bus service) for installation of dashcam rear-facing footage to record student behaviours. This did not occur until the end of 2021.
28. Accepting Mr Sweeney’s evidence, the Brighton bus was a very unpleasant environment for a quieter student in Year 8, but there is no actual evidence that MS was significantly affected by it.
29. The incident in February 2020 also resulted in MS being selected (on 11 February 2020) for an upcoming *Strength* program. Mr Sweeney said in his second affidavit for the investigation that MS and boys in his friendship group were selected primarily as recognition for “*great behaviour, quiet demeanour, co-operation in class and supportive positive attitudes and role model friendship groups.*” The *Strength* program focused on wellbeing, mindfulness, leadership, decision-making and development of other positive attributes. The program start date was delayed and commenced in the second school term.

30. MS did not show any signs of being unduly affected by these two recorded incidents on the bus or bus issues generally. I find that the recorded incidents were dealt with appropriately by Mr Sweeney and the school. Those who spoke to MS after the incident in the first week of school indicated that MS was not affected by it immediately before his death and happy with the school's response. AO confirmed this to be the case. I specifically note that Mr Sweeney also spoke to MS at school on 14 February 2020 about the response to the bus incident and he said MS appeared calm and satisfied with the response.
31. None of the incidents relating to the Brighton bus can be associated with causing deterioration in MS's mental well-being to any significant extent. MS did not at any time mention any of these incidents or bullying when he was talking about suicide to his friends in the online messages before his death. Further, none of MS's friends suggested this as a possible issue during these chats.
32. I am satisfied that the issue of bullying did not play a part in MS's death.

Circumstances surrounding death

33. School term at New Town High School commenced on Wednesday 5 February 2020, this being Year 8 for MS. MS attended school on every school day, and therefore was at school for a total of seven days.
34. I now set out, with reference to the commencement of the school year, the circumstances leading up to and surrounding MS's death.
35. The content of MS's messages was not in dispute and I do not refer to them in detail in this finding, except to summarise the contents where necessary.
36. On the first day of school, 5 February 2020, MS sent text messages about suicide to DY but he did not wish to discuss it when DY tried to speak to him about it.
37. Also on this date, JL's mother, FX, saw on JL's phone recent messages and photographs sent by MS indicating self-harm. FX spoke to JL about the messages.
38. At 11.05pm the following evening, 6 February 2020, FX sent an email to the principal of New Town High School, Mr David Kilpatrick, outlining the messages and her concerns for MS. Her email was as follows:

Hello Dave,

I just wanted to let you know about worrying text photos my son got on his phone last night.

My son is JL in 8-3.

He was asleep when the photos were sent so I had a look. I know it's an invasion of his privacy but I think it's a good thing for a parent to check every so often.

The photos were from MS (unsure of the surname). He is also in grade 8. They were of his arms with multiple cut marks. I scrolled back to previous texts and there were similar photos. The wounds were quite superficial looking but concerned me and my husband straight away.

We talked to JL about it tonight and he says he's encouraged MS to talk to the teachers and stop cutting himself. JL also mentioned that MS said he's tried to take his own life previously.

JL was visibly worried about MS as they've become quite good friends and JL had wanted to tell someone. JL said that MS had made him promise he wouldn't say anything.

We thought you'd be the best person to contact as we don't know MS's parents and I'm sure you've had to deal with matters like this before.

Please feel free to contact me if I can help at all. My number is XXXX XXX XXX. I'm at work all day tomorrow but if you don't get me, my husband, VU, is aware of what's going on and can chat to you if needed. His number is XXXX XXX XXX.

Sorry if we seem to be sticking our oar in to what's none of our business and it could be nothing to worry about but we'd feel terrible if something happened to MS that could have been prevented.

Kind regards,

FX

39. FX's email was, most unfortunately, caught in a spam filter and therefore was not seen or read by Mr Kilpatrick before MS's death. I accept upon the evidence that, because the email had been blocked, it was not available for Mr Kilpatrick to access upon searching all of his email folders.

40. The email only came to Mr Kilpatrick's attention when FX resent it to him following MS's death. In a reply email to FX on 19 February 2020, Mr Kilpatrick said:

"...I am concerned that I have not seen this email prior to this message from you below I have a record of receiving an email from you on 17/2/2019 on another matter, to which I replied on the 18/2/2019. With regards this message below I have searched my inbox, drafts, sent box, outbox, delete, trash and a folder where I store email containing parents issues and concern. I have no knowledge of this email prior to this week and cannot find the email in my stored folders. The content of your drafted email is obviously quite serious and if I had read it, would lead me to a number of actions in line with our student support procedure and protocols. I will keep searching for the email..."

41. The issue of this email has been investigated thoroughly and I am satisfied that no criticism of any person or system is warranted. If Mr Kilpatrick had received and read the email, I have no doubt that he would have instigated immediate help for MS, which would necessarily have involved contacting his parents. If he had received the email, perhaps the tragedy of MS's death may have been averted.
42. JL was aware that his mother had sent an email about MS to Mr Kilpatrick. Shortly after it was sent, likely on or about 7 February 2020, JL spoke to Mr Kilpatrick on what was described as "the spiral staircase" at school.
43. Mr Kilpatrick, in his affidavit made only days after MS's death described the conversation with JL as follows:

"This conversation occurred in the hallway near the stairs leading towards the food tech area. I was moving to a pressing event at the time.

The conversation was brief and lasted maybe two or three sentences only. JL raised some concerns with me over the welfare of MS and I asked him to raise this with his grade supervisors or Mr Sweeney. I recall that this conversation with JL (sic) on or about Thursday or Friday in the first week of term 1 2020. I am unsure of the exact time frame and it was only a brief conversation and I did not make a diary note of it.

I have no further information as to whether those concerns by JL were raised any further."

44. I accept the detailed submissions of both counsel that it is unlikely that JL specifically told Mr Kilpatrick that MS was speaking of suicide. It is something that JL may well

have mistakenly assumed that he had told him when making his affidavit four months after MS's death. However, it is quite feasible that JL did mention his mother's email and whether Mr Kilpatrick had received it. I find that JL's evidence in this regard appeared plausible.

45. I also find that JL was mistaken in recalling that he spoke twice to Mr Kilpatrick. Both JL's and Mr Kilpatrick's affidavits (and Mr Kilpatrick's evidence) align with there being only one brief conversation between them whereby JL raised a general concern for MS's wellbeing.
46. JL also stated in his affidavit that he spoke to Mr Sweeney about MS on 7 February 2020, also at the spiral staircase. He said in his affidavit that he told Mr Sweeney that MS was self-harming. In his evidence at inquest, he said he told him that the situation was urgent.
47. Mr Sweeney adamantly denied in his evidence at the inquest, that JL spoke to him about MS on any occasion during the 2020 school year and he made no mention of any conversations at all between himself and JL in either of his affidavits. Mr Sweeney's affidavit was sworn less than two weeks after MS died and detailed other matters regarding MS (as discussed above). I was impressed with Mr Sweeney as a witness. I thought he gave clear and credible evidence which conveyed that he was professional and dedicated in his duties.
48. I cannot find that JL spoke to Mr Sweeney about MS. Mr Sweeney does not mention a conversation in his affidavit, which he would have done if it had occurred.
49. I have no hesitation in finding that JL was well-motivated in his evidence and was a very helpful witness in many respects. However, I cannot find that JL made reference to the serious nature of concerns about MS, specifically self-harm and suicide, to Mr Kilpatrick or that he spoke to Mr Sweeney.
50. Having heard the evidence of Mr Kilpatrick and Mr Sweeney, I am confident in finding that if there had been oral disclosures to them by MS's friends indicating that MS was contemplating suicide, or was self-harming, they would have taken immediate action to escalate and investigate the reports. This is the case notwithstanding the many daily approaches by students to teachers concerning a wide array of matters, including issues relating to student welfare.

51. On or about 10 February 2020 the Brighton bus incident occurred involving MS and was dealt with properly by the school as discussed above.
52. From at least Wednesday 12 February 2020 MS was communicating with his close friends and girlfriend on an instant messaging platform called “Discord” regarding suicide. Earlier messages and chats were not available to police investigators, who could not gain further access to devices. The Discord chats from 12 February to the day of MS’s death contained repeated indications by MS to multiple people (but mainly DY, IW and JL) regarding his wish and intention to end his life.
53. On 13 February 2020 Mr Sweeney called AO to discuss the bus incident and told her that a boy had been given a detention and other ones spoken to. This call was uneventful.
54. The evidence suggests that, despite the concerning nature of the Discord messages, MS’s mood at school on 12 and 13 February 2020 was reasonable.
55. On Friday 14 February 2020 MS attended school and Mr Sweeney spoke to him in the morning. Mr Sweeney said in his affidavit:

“On Friday 14 February 2020 I saw MS in period 1 History between 9:00am and 10:00am. I asked MS and GZ to remain briefly after class to if they were 'Ok' in 8.1 together. MS replied that he was pleased and happy to be in the same class together with GZ. MS did not communicate or disclose any other information with me in relation to his state of mind. This was the last time I saw MS.

Throughout the time I knew MS, other than noted in this and my earlier affidavit, I did not make any other observations or receive any other reported concerns in regards to MS's mental health”.
56. By contrast, throughout that same day MS spoke openly to his friends DY, JL, KN and TQ about his intention to end his life by suicide. DY and JL were trying to calm MS and get him to consider what he was talking about. KN went looking for a teacher to tell them about what was occurring.
57. Ultimately, MS went home early that day after attending the office and having his mother called due to reporting he had a headache. His mother arranged for his father to pick him up sometime between 1.00pm and 2.00pm. Although the evidence is

somewhat uncertain, MS had certainly left the school premises with his father by 2.19pm when an attempt was made to locate him.

58. JL's evidence was that he thought that MS said he was faking his illness and that he had done this before to go home early. However, BR's evidence was that upon picking him up, MS was as white as a sheet. His mother described him as seeming ill later that evening. I agree with the submission of counsel assisting that there is some doubt about whether MS was actually sick; and that alternative explanations for his wanting to leave early might have been simply wanting to get out of school, wanting to game or planning suicide.
59. At about 1.45pm KN told Katherine McKeown, the teacher on lunch duty that day, about MS speaking of suicide and self-harm.
60. A short time later, as a result of KN's disclosure, Ms McKeown tried unsuccessfully to send an email regarding MS to several other staff members. Approximately 10-15 minutes later, at 2.03pm, she successfully sent a second email regarding the matter to two of the same recipients, Mr Sweeney and the school psychologist, Rebecca Strong.
61. The email from Ms McKeown to Mr Sweeney and Ms Strong was as follows:
- "Hi, KN just came to me at lunch time, asking if I can organise an appointment for MS. KN says he doesn't want to see someone. I told him that he can't be made to see someone if he doesn't want to. He then explained that he MS has been talking about suicide and self-harming. Can you follow up, Bec? Kathie"*
62. Ms Strong replied at 2.19pm:
- "Oh my god - dear KN!!! isn't that beautiful of him. How fabulous Kathie that he has that connection with you that he can confide in you and trust you. Will try and get him now."*
63. Mr Sweeney did not respond to the email but indicated in his evidence that he read it as well as Ms Strong's response. He considered that Ms Strong would take the necessary action.
64. Ms Strong attempted to locate MS but discovered that he had already been taken home. She also attempted to speak to KN to gather further information, however the bell had sounded for the end of the school day.
65. There is some discrepancy following this regarding the actions of Ms Strong. Ms Strong indicates that she spoke with Ms McKeown on two occasions that afternoon

verbally, once being to ascertain whether she had further information and the second to get her view on whether MS's parents should be called. Ms Strong's evidence was that they both agreed that MS's parents should not be called.

66. However Ms McKeown indicates that she spoke about this issue to Ms Strong only once on 14 February 2020 and this was in regard to whether she had more detail from KN. Ms McKeown said in evidence she did not speak to Ms Strong about calling MS's parents and there is nothing in either her affidavit from March 2020 or her affidavit from June 2023 indicating she did so. In her evidence in court, she said that it was not her role to enquire about such matters where the psychologist was involved. Having regard to the affidavits and oral evidence of both witnesses, I prefer the evidence of Ms McKeown. Her evidence was solid, coherent and consistent and did not appear reconstructed in any way.
67. I agree with the submission of counsel assisting, Ms Fox, that not a lot turns upon this conflict in evidence. As the psychologist, Ms Strong was required to make the decision concerning the immediate response to receiving the information about MS. She confirmed in her evidence that the decision was hers and she made the decision not to call MS's parents due to lack of information. However, she scheduled MS for the first appointment with her at 9.00am on Monday 17 February 2020.
68. That evening at home, MS told his mother that he was upset because he was unable to give a present to his girlfriend, IW, that morning due to teachers moving them on too quickly. The card and gift were found in his bag by police after his death. His mother did say, however, that MS was settled on the point as his mother said they could get another present to give to IW on Monday. It does not seem this issue in and of itself was likely to have caused ongoing angst for MS over the weekend which contributed to any decision about ending his life.
69. On Friday 14 February and Saturday 15 February 2020, MS described on Discord the act of hanging as a means of suicide and said that he had had failed attempts at hanging on both of those days. The chat to DY and IW on 16 February continued up to minutes before his death with DY attempting to call MS (unanswered) and IW sending a number of messages with no response.
70. From his parent's point of view, during the weekend MS's mood and demeanour were normal. This included speaking to his grandmother who visited on Sunday, 16

February 2020, about cadets and confirming plans to meet his grandmother on Monday after school. AO said that MS had two hamburgers for dinner with the family that Sunday evening before he died.

71. On Sunday 16 February 2020 at 7.05pm MS began speaking to a group of friends on Discord about wanting to commit suicide. DY discouraged MS from killing himself and tried to speak to him on a private chat. DY also tried to call MS who picked up the phone and said “no” before hanging up the call. Nevertheless, DY continued to try to talk to MS via online chat. MS’s last message to IW was at 8.48pm referring to his death. Clearly worried, IW attempted to maintain communication with MS and expressed her love for him.
72. The last response received from MS by DY (or anyone) was at 8.51pm in which MS stated, “*my mics[microphone] muted*”. When MS did not reply to DY, DY contacted CE to check on his welfare. CE commenced looking was unable to find MS in the games room of their house and MS’s father went outside looking for him.
73. BR could not find MS out the front of the house and walked to the side area where MS had a boxing bag attached to a tree and where he would throw knives. There, he found MS hanging by his neck from a tree. He saw that a wooden pallet was underneath MS on the ground and at least one of his feet was on the pallet. He was able to easily reach the tree limb and lower MS to the ground. He called out to CE and AO for help and commenced CPR. MS was unresponsive when found by his father, although BR said in his affidavit that, in conducting CPR, he thought he could hear a heartbeat.
74. Police and Ambulance were called at 9.31pm.
75. At 9.44pm two uniform police officers arrived at the scene and assisted with CPR until Ambulance Tasmania paramedics arrived a short time later.
76. MS was pronounced dead at the scene at approximately 10.35pm.
77. There is no evidence to suggest that the responses by ambulance and police were anything other than appropriate or that any change in this would have prevented MS’s death.

78. Further police officers arrived at the scene, including detectives and forensics officers. They observed that the branch above the branch which was the hanging point had missing limbs, with some limbs and foliage laying on the ground near MS. The branch above MS also had a number of “hack” style marks in it and there was an axe (or block splitter) laying a short distance away from MS. There were also a number of wooden pallets strewn around on the ground. Also near MS was a pair of black gaming style headphones with a microphone and cable. There was also a light-coloured dog leash which had its handle looped through itself to create an easily adjustable loop. The headphones were threaded through the loop created in the dog leash. Although MS’s clothing had been cut from him during resuscitation attempts, it was evident that he had been wearing track pants and a belt with two knives in sheaths. At the time of his death, MS had an iPhone in his trouser pocket, and this was taken by attending officers for further investigation. Its battery went flat just after access was gained.
79. Forensics Services officer, Constable Ben Farquett photographed the scene. Constable Farquett, in his affidavit, expressed the view that the cuts in the tree branches were fresh and believed that MS had used the log splitter to remove weaker and obstructing branches until he was left with a stump of a branch capable of taking his weight. He then tied the dog leash to the tree and around his neck and allowed it to take his weight. The evidence does not permit me to determine whether MS had configured the dog lead to a length where he was still able to stand on the pallet. From the evidence of BR, this may have been the case.
80. The investigating police officers searched the residence for evidence regarding MS’s death. They located his backpack hanging on a hook in the laundry and recorded that it contained a gift box of chocolates with a gift tag and card to IW.
81. The attending officers located the Discord chats discussed above on an iPad located in the bedroom next to MS’s. It was apparent to the officers upon viewing the messages that MS was in communication with a number of people in the days leading up to his death and was open about his wish to die and his intention to effect suicide. He had described methods of suicide and had sent photographs of a tree with a dog leash around the branch. He had described that he had attempted suicide but had fallen as the branch had broken and included a photograph of the broken branch. The officers viewing the messages assessed that it appeared that MS had made three attempts to suicide in the previous five days by hanging himself from the tree.

82. An autopsy upon MS was conducted by Dr Donald Ritchey, who had regard to the circumstances outlined in the initial Police Report of Death for the Coroner. Dr Ritchey examined the ligature marks and compression of the underlying subcutaneous tissue scene upon MS's neck. He formed the opinion that the broad strap-like ligature abrasion seen on MS's neck and angled upwards, was consistent with the accompanying dog leash ligature. He concluded that MS died due to asphyxia due to hanging. Dr Ritchey also concluded, as a result of a full autopsy, that MS had no physical abnormalities or illnesses. Toxicology testing of his blood revealed that he had no alcohol or drugs in his system. I accept the conclusion of Dr Ritchey regarding cause of death.
83. Early in the morning on Monday 17 February 2020, police officers attended the residence of Mr Kilpatrick to advise of MS's death. Mr Kilpatrick said in his affidavit that he then instigated the system of critical support in relation to such events. He telephoned the director of Student Support at the Department of Education, Teresa Pockett. He said that by 9.00am that morning a team of social workers and psychologists were present at the school, the team members comprising a combination of internal and external resources. He said that Headspace was also involved in this process.
84. Mr Kilpatrick further described conducting a staff briefing, allocating space for a student support centre and contacting MS's parents on two occasions. He organised a "scripted briefing" for students to occur at 11.00am that morning. The responsible staff also commenced identifying students who were particularly affected to provide them with support services in the short term and also into the weeks ahead. He then undertook a review of MS's school file and commenced to collect relevant information as part of the process of reviewing the school's actions.
85. I have also received evidence from Ms Pockett regarding activation of the critical response at the school. Ms Pockett described in her affidavit the activation of Professional Support teams and the use of the *Be You Suicide Postvention Toolkit*. She provided considerable detail of the immediate and short-term response, the mid-term response, the Covid-19 response and the longer-term response and recovery plan. Within each of these response phases, it is clear that comprehensive measures were taken in respect of matters such as the following: appropriate communication with the students, parents and school community; mitigation of the risk of contagion; monitoring of student and staff well-being, ensuring adequate professional counselling

and support staff; liaising with external agencies, such as CAMHS (Child and Adult Mental Health Service).

86. I find that the response by New Town High School following MS's death was of a very good standard. The school was able to implement a full response and support system in a logical and structured manner within a short time and continued to provide and support in accordance with a carefully documented plan. For this reason, the scope of the coronial inquest did not include consideration of the school's response to MS's death.

MS's intention

87. There remains uncertainty as to whether MS actually intended to die or whether his death was ultimately unintended and therefore accidental.
88. The Discord chats are unambiguous in terms of MS communicating an intention to die. However, these could well have been attention seeking, for show or an attempt to get help. It is unclear whether MS, given his age, even understood death and its finality or saw it as disconnected from the actual consequence of his actions. However, the evidence indicates that MS functioned intellectually at a good level.
89. Another possibility is that MS was acting or showing off and when he hung himself from the tree, he did not intend to follow through but intended to release himself. The knives being on MS are not however, of themselves indicative of him preparing to release himself as wearing knives was normal for MS. It is noted he chose a branch close to the ground and also that the lead was able to be easily released by his father without cutting which may indicated he didn't fully intend to die.
90. AO is of the view that MS did not intend to end his life and that his death was accidental. I agree that it is plausible that MS was speaking about suicide as a game, as attention-seeking, or to relieve anxiety. It is possible that he was showing off and risk-taking for the benefit of his friends. However, his persistent communications about suicidal intent are perhaps inconsistent with this view.
91. MS may well have suffered an underlying mental health condition, as he spoke of "depression" and believed that ending his life was a genuine solution to his suffering. I also cannot discount that the onset of puberty and dramatic hormonal changes may have affected and distorted his thought processes. This might have been a temporary

situation which, if he had lived, may have passed over the following years. It does not appear that trauma, bullying or events in his life featured significantly or at all in his decision. However, it is not possible to say with certainty what was impacting upon his mental state.

92. Unfortunately, I am left to speculate about MS's reasons and intentions, and I am not able to reconcile the evidence pointing in apparently disparate directions. In conclusion, therefore, I cannot determine definitively whether or not MS appreciated the significance of his suicidal statements and his actions leading to his death. I also cannot determine whether or not he intended to die or whether he had a true appreciation of the finality of death.

Comments and Recommendations

93. In many deaths reported to the coroner, the investigation will reveal potential opportunities to have prevented a death if different actions had been taken beforehand by one or more individuals.
94. The investigation into MS's death is a case where I have been required to consider whether there were any actions or inaction by individuals that could be found to have contributed to it. Further, my function under the *Coroners Act 1995* requires me to consider whether to make comments and/or recommendations on matters *connected* to MS's death, but not necessarily *causative* of it.
95. I emphasise that, in assessing causation or contribution for any death, it is critical that a coroner makes findings and comments bearing in mind the considerable advantage of a hindsight perspective, with knowledge that a death has occurred and the availability of comprehensive evidence. The coroner's independent and investigatory function is critical for the purpose of analysis in making the required findings. However, it is crucial that the coroner has an understanding of the actions, situations and decision-making faced by various witnesses *at the time* the events occurred and to avoid attributing to them a duty to act in a different way than was reasonable in the circumstances with the information available. Conversely, a coroner should not avoid making critical comment, where satisfied upon the requisite standard of proof, if it is connected to death and for the purpose of public health and safety.
96. I have found upon the evidence that MS brought about his death by his own actions. He did so following signalling his intention to his close friends. He was alone at the

time and no other persons encouraged his actions. Even if he did not mean to end his life, he took a great risk with his actions, knowing that death could result.

97. I make comment below upon the specific issues discussed in this finding which were identified within the scope of the inquest as matters forming part of the wider circumstances surrounding MS's death; and which may have represented opportunities to have changed the outcome.
98. MS's friends cannot be criticised. Those receiving his communications tried to dissuade him and encourage him to seek help within the limits of the group chat. Additionally, JL and KN expressed concerns to teachers shortly before MS's death. It would appear that MS's good friends did not think he would actually carry out his intentions. However, just before his death, MS's definitive and persistent statements had become alarming to his friends, and one made contact with MS's brother. I also bear in mind that they were also very young people who cared greatly for MS and felt a reluctance to disclose his communications against his wishes.
99. I do not make adverse comment concerning the actions or decision-making of David Kilpatrick, Principal of New Town High School.
100. There was a focus at inquest upon whether Mr Kilpatrick did enough to investigate or follow up upon the information provided by JL. Counsel assisting submitted that Mr Kilpatrick at the very least should have checked to ensure that JL had raised the matter with the class teacher or Assistant Principal as he was advised to do. Counsel's submission is reasonable, and one which I may have accepted had I not had the benefit of the persuasive evidence at inquest.
101. Mr Kilpatrick, a very experienced teacher and school principal, gave evidence that school principals are approached multiple times per day (up to 30 occasions) by students raising a range of issues. He said that it was common to be approached by students relating to the well-being of other students.
102. He gave evidence of the formal student support structure in place at New Town High School. This comprised various teachers, a school psychologist, social workers and a nurse. He said that a student's first point of contact for pastoral issues was the assigned homeroom teacher, and then the grade supervisor or Assistant Principal. It appeared from his evidence that this support structure and contact points were well-established and known to teachers and students.

103. Further, I heard persuasive and knowledgeable evidence from Ms Pockett, herself a very experienced former school principal. Ms Pockett reinforced the evidence of Mr Kilpatrick that as a principal, students would informally approach her multiple times every day, ranging from 5 to 45 instances, specifically about concerns for other students.
104. Ms Pockett described the need to prioritise action and responses to these approaches based upon the individual reports and the time available. She said that she would respond to reports of concerns for another student's wellbeing by directing the reporting student to correct personnel, such as the psychologist or social worker, if she judged them as having confidence to do so.
105. Having heard the evidence concerning the context and frequency with which school principals receive such information from students, I find that Mr Kilpatrick did not act unreasonably in directing JL to school personnel who were better placed to receive and assess the information. I have already determined that Mr Kilpatrick would not have simply relied upon a student to make a further report if suicide or self-harm was referred to. However, in respect of general reports of a less concerning nature, I agree with counsel for Mr Kilpatrick that it would be impractical and unworkable for a school principal to personally follow-up every matter raised with them by a student during the course of a school day; particularly when they are moving between commitments and have many other functions to perform.
106. I do not make adverse comment concerning the actions or decision making of Andrew Sweeney, Assistant Principal of New Town High School. He appropriately managed the bus incident including making follow-up contact with MS and his mother. I further find that Mr Sweeney acted reasonably in deliberately leaving Ms Strong, as the appropriate professional, to deal with the matters contained in Ms McKeown's email. Apart from that email, I find that Mr Sweeney had no knowledge or communication regarding MS being suicidal or at serious risk at any material time.
107. The issue relating to Rebecca Strong, school psychologist, is whether she should have contacted MS's parents upon receiving information which potentially indicated a concern for MS's welfare. A call to MS's parents on Friday afternoon would have alerted them to the concerning issue. If they had received the information, they would likely have supervised and supported him so that the outcome might have been different.

108. In deciding this issue, I have had the benefit of Ms Strong's evidence at inquest, her two affidavits and the comprehensive submissions of both counsel.
109. Ms Strong is an experienced, dedicated and hard-working senior school psychologist. Her workload can be described as overwhelming. At the time of giving her evidence she was responsible for the higher-level needs of 93 schools. She also had a case load of 120 students, all of whom she was actively managing at New Town High School in her allocated two days per week.
110. She described spending the school hours at New Town High School in session with her students and, after school hours, making safety plans with parents and organising external supports to mitigate the risk. She described dramatically increasing levels of mental illness, suicidal distress, risk and vulnerability in school student populations. She said that she worked with actively suicidal students every day she was at the school and would have been providing support and planning for them at the time she received the email about MS.
111. I acknowledge that it was somewhat fortuitous that Ms Strong was able to reply to the email from Ms McKeown at all. She was not scheduled to work at the school that day but in her supervisory role elsewhere.
112. Nevertheless, Ms Strong became responsible for dealing with the matter that afternoon and took steps to investigate MS's risk. As discussed, the steps involved attempting to find MS and KN and generally to seek more information about MS. Although she was unsuccessful in speaking to MS or KN, she asked the First Aid Officer about MS's emotional state when he left school. Ms Strong was advised that MS appeared calm and well supported. I accept that Ms Strong did take this step and did receive what she considered to be reassuring information.
113. Ms Strong had had no prior contact with MS and it is clear from her evidence that she also considered it reassuring that MS was not a student on her caseload and was not known to have had previous referrals for well-being concerns or recorded behavioural issues. Further, she was aware that suicide in a 13-year-old was a particularly rare occurrence.
114. Ms Strong conceded that there was much information that was unknown and that she did not have the opportunity to interview MS, which was a necessary element of a risk assessment. However, she judged that it was safe in the circumstances to delay

contacting MS's parents and/or embarking upon further enquiries until she had spoken to MS on Monday morning.

115. Ms Strong, in her court evidence, explained her decision and her regret in not contacting Mr and AO:

“Just because I made the assessment on the basis of the information that I had access to at the time, that MS’s level or risk was very low. I made a commitment to follow up with MS, to gain further insight into his challenges, into any kind of suicidal distress on the Monday, and it was just incredibly unfortunate and tragic that that happened. I mean I would have loved – I would love to take back time and make that call to AO and BR.”

116. It was clear from Ms Strong's evidence that without her large and pressing workload that afternoon, which included managing actively suicidal children, she would have embarked upon further enquiries about the extent of the risk to MS. These would necessarily have involved contacting his parents together with Mr Sweeney and others. I am in little doubt that, if she thought she had the capacity, she would have done so.
117. Counsel for Ms Strong submitted that criticism of her actions would be unfair and unreasonable as she was working in “*imperfect conditions and with incomplete information*”. There is force in this submission. There is also a particular need to avoid judging the issue with the benefit of hindsight, knowing that a devastating event has occurred and assuming that it should have been prevented. Finally, I also bear in mind that the higher *Briginshaw* standard of proof applies to the making of any adverse comment concerning Ms Strong.
118. For these reasons, I am not satisfied to the requisite standard that criticism of Ms Strong is warranted. Her decision not to call MS's parents was based upon her long experience as a school psychologist together with as much information as she was able to obtain within her limited capacity and large workload. Despite significant gaps in the information, it was not unreasonable to have assessed MS as being at low risk of suicide.
119. The evidence in the inquest as a whole did not leave me with concerns that New Town High School was generally lacking in its processes for dealing with reports about student well-being.

120. Counsel assisting submitted that recommendations should be made regarding the need for processes to ensure that parents are notified at the earliest time about concerns for their child's welfare. Secondly, she submitted that there is a need for robust processes to be in place for dealing effectively with informal reports by students about their own or another student's well-being.
121. I do not have sufficient evidence to make formal recommendations to DECYP which would likely apply any policy to all state schools in Tasmania. However, I would hope that this inquest and finding highlights the need for DECYP to ensure that these areas are reviewed in its ongoing policy development.
122. Ms Pockett and Ms Strong provided evidence about positive developments since MS's death. These have included ongoing development of policies and procedures in response to student wellbeing concerns, including reports of self-harm and suicidal ideation. Of note is the following:
- Student Support and Wellbeing Teams (SSWT) were introduced in all state schools in 2021. The SSWT are mandated in every school and are required to meet at least twice a term to identify vulnerable students in terms of mental health and/or engagement, determine actions and activate appropriate supports.
 - Interagency Communication Protocols were implemented in 2021 between DECYP and the Child and Adolescent Mental Health Service (CAMHS) to create communication protocols around young people presenting to hospital with suicidal distress or after suicide attempts, to mitigate risk, minimise exposure and prevent contagion on discharge.
 - In September 2022 the Managing Self-Harm and Suicidal Distress Working Party was established. This is a State-wide, multi-disciplinary working party to develop DECYP guidelines and procedures to respond to and manage self-harm and suicidal distress in schools.
 - Student Support Leaders within DECYP support ongoing development, implementation of strategies and education around vulnerable students in terms of expressing suicidal ideation, thoughts of self-harm or poor mental health.

- Ongoing Professional Support Staff Resourcing and Staff Development has occurred. There has been an approximate 30% increase in the quota of professional support staff within DECYP since 2017.
- All new social work and school psychology employees are provided with induction that includes procedures for managing suicidal distress, duty of care requirements and risk management practices.
- Part of the response provides for contacting families and the necessary steps to address prior to contact.

123. The efforts of DECYP are to be commended. Ongoing intensive efforts and resourcing are required to meet the need presented by the dramatic increase in students experiencing psychological distress and mental illness.

Findings Required by s28(1) of the Coroners Act 1995

124. I make the following formal findings pursuant to section 28(1) of the *Coroners Act 1995*:

- a) The identity of the deceased is MS, date of birth 24 October 2006;
- b) MS died in the circumstances set out in this finding;
- c) The cause of MS's death was asphyxia as a result of his own action of hanging himself; and
- d) MS died on 16 February 2020 at Mangalore in Tasmania.

I convey my sincere condolences to MS's family, loved ones and all those affected by his death.

Dated: 5 February 2025 at Hobart in the State of Tasmania

Olivia McTaggart

Coroner



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

ANNEXURE 'A'

LIST OF EXHIBITS

Record of investigation into the death of MS

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	REPORT OF DEATH FOR THE CORONER	CONSTABLE AARON WOOLEN Tasmania Police
C2	LIFE EXTINCT AFFIDAVIT	DR DAVID TITCHEN Royal Hobart Hospital
C3	AFFIDAVIT OF IDENTIFICATION	ACTING SERGEANT BENJAMIN HARRISS Tasmania Police
C4	AFFIDAVIT OF IDENTIFICATION	ANTHONY CORDWELL Mortuary Ambulance
C5	POST MORTEM AFFIDAVIT & INTERIM PM	DR DONALD RITCHEY Office of the State Pathologist
C6	TOXICOLOGY REPORT	NEIL MCLACHLAN-TROUP Forensic Science Service Tasmania
C7	AFFIDAVIT	BR Father of MS
C8a	AFFIDAVIT – 30 April 2020	AO Mother of MS
C8b	AFFIDVAIT – 9 February 2023	AO Mother of MS
C9	AFFIDAVIT	CE Brother of MS
C10	AFFIDAVIT	DY Friend of MS
C11	AFFIDAVIT	FX Mother of JL
C12	AFFIDAVIT	JL Friend of MS
C13	AFFIDAVIT	IW

		Friend of MS
C14	AFFIDAVIT	DAVID KILPATRICK Principal – New Town High School
C15	AFFIDAVIT	ANDREW SWEENEY Acting Principal of New Town High School
C16	AFFIDAVIT	KATHERINE MCKEOWN Support Teacher – New Town High School
C17	AFFIDAVIT	REBECCA LEE STRONG School Psychologist – New Town High School
C18	AFFIDAVIT	ACTING SERGEANT BENJAMIN HARRISS Tasmania Police
C19	AFFIDAVIT	CONSTABLE AARON WOOLEN Tasmania Police
C20	AFFIDAVIT	DETECTIVE CONSTABLE ELISE CLARK Tasmania Police
C21	AFFIDAVIT	CONSTABLE AMBER THORLEY-SMITH Tasmania Police
C22	AFFIDAVIT	SENIOR CONSTABLE PAUL HYLAND Tasmania Police
C23	AFFIDAVIT	CONSTABLE ANTOINE MEIJER Tasmania Police
C24	AFFIDAVIT	SENIOR CONSTABLE LUKE GRIFFITHS Tasmania Police
C25	AFFIDAVIT	DETECTIVE SENIOR CONSTABLE NICHOLS EVANS Tasmania Police
C26	AFFIDAVIT & PHOTOGRAPHS	SENIOR CONSTABLE BEN FARQUETT Tasmania Police
C27	TEXT/PHOTO MESSAGES	JL Friend of MS
C28	EMAIL EXCERPTS	REBECCA STRONG School Psychologist – New Town High School KATHERINE MCKEOWN Support Teacher – New Town High School
C29	'DISCORD' CHAT PHOTOS	DY Friend of MS
C30	'DISCORD' CHAT PHOTOS	IW Friend of MS

C31	'DISCORD' CHAT PHOTOS	#LADS GROUP CHAT
C32 a-j	RECORDS – MS	DEPARTMENT OF EDUCATION
C33	RECORDS - CE	DEPARTMENT OF EDUCATION
C34 a-h	NEW TOWN HIGH SCHOOL STAFF EMAIL RECORDS	DEPARTMENT OF EDUCATION
C35 a-k	POLICIES & PROCEDURES	DEPARTMENT OF EDUCATION
C36 a-e	NEW TOWN HIGH SCHOOL RESPONSE	DEPARTMENT OF EDUCATION
C37	MEDICAL RECORDS – GP	BRIGHTON DOCTORS SURGERY
C38	MEDICAL RECORDS – TASMANIAN HEALTH SERVICE	ROYAL HOBART HOSPITAL CHILD HEALTH AND PARENTING SERVICE
C39	AMBULANCE TASMASNIA RECORDS	AMBULANCE TASMANIA
C40	CHILD SAFETY SERVICES RESPONSE	DEPARTMENT OF COMMUNITIES TASMANIA
C41	INCIDENT REPORT	TASMANIA POLICE
C42 a-b	PROPERTY RECEIPTS	TASMANIA POLICE
C43	SUPPLEMENTARY AFFIDAVIT – 8 June 2023	KATHERINE MCKEOWN Support Teacher – New Town High School
C44	SUPPLEMENTARY AFFIDAVIT – 15 June 2023	DAVID KILPATRICK Principal – New Town High School
C45 a-g	AFFIDAVIT & ANNEXURES	TERESA POCKETT Student Support Leader – New Town High School
C46	SUPPLEMENTARY AFFIDAVIT – 7 July 2023	ANDREW SWEENEY Acting Assistant Principal – New Town High School
C47	SUPPLEMENTARY AFFIDAVIT – 9 July 2023	REBECCA STRONG School Psychologist – New Town High School
C48	EMAIL EXTRACT FROM C34d	FX Mother of JL DAVID KILPATRICK Principal – New Town High School