



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 PD

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

- a) The identity of the deceased is PD, date of birth 26 April 1982.
- b) PD was 41 years of age. He was born and raised in Tasmania. PD had never married and did not have children. Since 2019, he had been in a relationship with RT, although he did not reside permanently with her. PD was unemployed and was a recipient of the disability support pension. In his working life, he had held various forms of employment.

In or about 2010, PD moved to Perth, Western Australia to join his then partner. Whilst living in Perth, PD worked for a mining company and began using methamphetamine. After 12 months, PD lost his job with the mining company upon failing multiple mandatory drug tests. He remained in Western Australia for a short time and continued using methamphetamine on a regular basis. PD's relationship with his partner broke down during this time. PD had, for a long time, suffered poor mental health in the form of depression and post-traumatic stress disorder. Further, medical records indicate that in 2014, he suffered his first psychotic episode, which was linked to intravenous methamphetamine use. At about this time, he returned to Tasmania and lived with his mother, OY, in Midway Point.

PD began consuming alcohol heavily upon returning to Tasmania and remained using illicit drugs. He continued to experience regular episodes of psychosis with delusional behaviour and aggressive outbursts that necessitated hospital presentation. By about 2016, he had been diagnosed with schizophrenia. In his multiple presentations to the Royal Hobart Hospital, he underwent mental health

assessment and was often placed on short-term involuntary orders. He was treated with medication and his discharge plans included subsequent engagement with the Crisis Assessment and Treatment Team (CATT). He also received depot medication and was under the care of community mental health services until about May 2023. It appears that PD's mental health was declining in the months before his death, and he was discharged from community mental health services as a result of disengagement. He told RT that he did not intend to continue engagement with community mental health because they were unable to do anything for him. The evidence indicates that RT was a source of great support for him, as were his parents. Sadly, PD experienced significant suicidal ideation which particularly involved thoughts of jumping from the Tasman Bridge. It does not appear that he had made any previous attempts at suicide.

On 19 August 2023, PD spent the day and the preceding week with his father, QI, at his home. During that week, PD gave his father his special belongings, such as framed photos, and also asked his father what heaven would be like. In hindsight, QI (Senior) realised that his son was planning his suicide during that time.

At 10.40am on 22 August 2023, PD, believed to be alone, sent a text message to RT seeking forgiveness and requested that she ring him. RT rang PD and assured him that he had not done anything that required forgiveness. PD's movements over the next several hours cannot be ascertained on the evidence.

At about 2.50pm, a motorist travelling on the Tasman Bridge observed a male pedestrian use both hands to push himself up onto the railing of the bridge and hoist himself over the railing. The motorist described his position as being close to the apex of the bridge (on the northern side). Tasman Bridge CCTV, which was later obtained for this investigation, showed the male who was later identified as PD walking over the bridge from the eastern shore towards the city. The CCTV also depicted him climbing the rail, as witnessed by the motorist, and standing on the outer side of the rail for a short period of time. It depicted him then jumping from the bridge and landing directly on the surface of the water under the bridge.

The motorist called emergency services and police officers arrived at the scene. A mayday call was also broadcast to vessels. At 3.14pm a Pennicott Wilderness vessel receiving the mayday call made its way towards the bridge. The police officers on the bridge directed the Pennicott crew to PD's exact location in the

water. The Pennicott vessel crew located PD unresponsive and brought him onto the boat. The police search and rescue vessel arrived, with officers deploying the defibrillator. However, PD could not be revived and was formally pronounced deceased by ambulance personnel upon arrival at the nearby Cattle Yard Jetty.

- c) PD died of chest and limb injuries resulting as a result of deliberately jumping from the Tasman Bridge with the intention of ending his life. Toxicology testing revealed the presence of methamphetamine in his system. PD's further decline in mental health and the influence of an illicit drug likely played a significant role in his decision.
- d) PD died on 22 August 2023 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Opinion of the State Forensic Pathologist regarding cause of death;
- Toxicology report of Forensic Science Service Tasmania;
- Medical records for PD;
- Affidavit of QI, father of PD;
- Affidavit of RT, partner of PD;
- Affidavits of attending, rescuing and investigating police officers;
- Affidavits of Mia Pennicott and Andrew Hennessy, Pennicott vessel crew members;
- Affidavit of the motorist who last saw PD on the Tasman Bridge;
- CCTV footage Tasman Bridge; and
- Forensic photographs and police body worn camera footage.

I extend my appreciation to investigating officer Constable Jacob Viney for his investigation and report. I also acknowledge the efforts of Pennicott Wilderness crew members in the search and rescue process.

I have considered the views of RT and the parents of PD regarding deficiencies in his mental health treatment. I am satisfied that PD's death could not have been reasonably prevented due to the severity of his condition and use of illicit substances. As such, further comment in this regard is beyond the scope of my investigation.

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.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.

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

¹ [Deaths from a Public Place.pdf](#)

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.

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 PD.

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

Olivia McTaggart
Coroner

² Department of State Growth, *Tasman Bridge Upgrade Project: Project Briefing*, 5 May 2025. Provided to the Coroner’s Office on 3 June 2025.