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, Robert Webster, Coroner, having investigated the death of XA

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

a) The identity of the deceased is XA

b) XA died in the circumstances set out below;

c) XA's cause of death was head and chest injuries; and

d) XA died on 24 December 2022 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Affidavit of the forensic pathologist Dr Andrew Reid;
- Affidavits of TA
- Affidavit of the forensic scientist Mr Neil McLachlan-Troup of Forensic Science Service Tasmania;
- Medical records obtained from the Royal Hobart Hospital (RHH);
- Medical records obtained from the Churchill Avenue Medical Centre;
- Medical records obtained from GP2U;
- Affidavit of a Senior Constable Richard Keygan;
- Affidavit of Constable Barry Schrader;
- Affidavit of First-Class Constable Nikki Mackintosh;
- Affidavit of Constable Zoe Fisher;

- Affidavit of Charlotte Pond;
- Affidavit of Jessica McEldowney;
- Affidavit of Maria-Rosa Genovese;
- Affidavit of Kate Hill;
- Affidavit of Constable Carly Medhurst; and
- CCTV footage, photographs and forensic evidence.

Background

XA was born on 12 June 1981, in Melbourne Victoria, to TA and GF. He had an older brother who is a marine engineer and a younger brother who is an electrical engineer. His mother says when he was between three and six months old, he suffered a very serious bout of meningitis which she thinks has always affected his health. Before TA moved to Tasmania in 2012, the family lived on a hobby farm on the Mornington Peninsula in Victoria. Her three boys loved growing up on the farm.

XA attended primary and high school and completed his matriculation. He went on to successfully complete an electrician's apprenticeship. He enjoyed playing football and tennis throughout his school years and he won multiple sporting awards.

XA had a large group of friends until he was about 14 years of age, but from that point on TA says *"he started to hang around with the wrong sort of people"*. He came to the notice of local police and was taken into custody on a couple of occasions. At one stage, TA went into the back yard where XA was building something and she found a noose which was ready for use. TA discussed that issue with her son extensively.

XA commenced his own business as an electrician in about 2001. In addition he kept studying in order to advance his skills. However in about 2008 or 2009, a couple of large clients stopped paying XA for his services and he struggled financially from this point on. He attended his general practitioner and was diagnosed with bipolar disorder which is characterised by emotional highs, also known as mania or hypomania, and lows, also known as depression. He was prescribed medication for this condition, however, TA believes her son was never the same after this point.

TA said they lived on their farm until about 2010 when she found out her husband had a gambling and drinking problem, and this resulted in the loss of the farm to the bank. It had to be sold and TA moved into her own apartment and left XA's father in 2012. She then moved back to Tasmania to look after her sick mother while XA stayed in Victoria with his father for a short time.

Because of some mental health difficulties, which are outlined below, XA was taken to hospital in Geelong in 2010. In 2011 he started to travel around Australia for a couple of months and stayed with one of his brothers in Darwin for a period, but he again became unwell. TA thinks that this was because he was not regularly taking his medication and was seeing multiple doctors. He then moved to Western Australia during 2012 to work and save money. Thereafter, he went to South Australia and while there he contacted his mother and indicated he needed help. One of his brothers travelled to South Australia to bring XA to Tasmania.

TA rented a flat for her son in Sandy Bay so that he was near her for a while until about 2017. It was during that year he had some further mental health difficulties and made attempts on his life. After being treated at the RHH, he was able to get himself a job and then he moved into an apartment and was having regular injections to control his mental illness, which by that stage had been diagnosed as schizophrenia. The housing was provided by what was called the Choices Program, which is delivered by Baptcare in partnership with the Department of Health. His mother says he lived there for a couple of months before moving to Montrose, at which point he started having his injections in Glenorchy. She says his life was *"very routine"* until 2019 when he ceased working because his mental health started to decline. After initially refusing government benefits, by 2022, he had commenced receiving a disability support pension due to his mental health.

At the date of his death XA was single and he had no children.

Involuntary mental health treatment in Tasmania

Involuntary mental health treatment in Tasmania is governed by the provisions of the *Mental Health Act* 2013. Section 15A of that Act enshrines the rights of patients which include the right to have any restriction on, or interference with, the person's dignity, rights and freedoms to be limited as much is possible and the right to promote, and make prominent, the person's decision-making capacity and to respect his or her wishes to the maximum extent possible. There are also a number of statutory rights given to involuntary patients which include the right to ask for leave of absence from the relevant approved facility, the right to seek legal advice, the right to be provided with adequate food, light and ventilation, and the like.

Section 17 permits the temporary detention of a person if it is reasonably believed that person has a mental illness and they should be assessed against the assessment criteria[1] and his/her safety or the safety of others is likely to be at risk if the person is not detained.

[1] The assessment criteria are provided for in section 25 which provides:

By section 24 a medical practitioner may make an assessment order in respect of a person which authorises that person's admission to and, if necessary, detention in the approved hospital. The RHH is an approved hospital for the purposes of that provision. Once that order has taken effect, section 30 provides the patient must be independently assessed within 24 hours unless the order is discharged before the expiration of that time. The assessment must be conducted by an approved medical practitioner,[2] other than the medical practitioner who applied for or made the assessment order. By section 32, the medical practitioner conducting the assessment must affirm or discharge the assessment order, and if affirmed, that medical practitioner can extend its operation, once, by a period not exceeding 72 hours. Section 35 enables an assessment order to be discharged at any time for sufficient cause by the medical practitioner who made it or any approved medical practitioner or the Tasmanian Civil and Administrative Tribunal (TASCAT).[3] Section 37 authorises an approved medical practitioner to apply to TASCAT for a treatment order and sections 38 and 39 enabled TASCAT to make interim treatment orders and treatment orders. By section 44, if not renewed or sooner discharged, a treatment order continues in effect for a period not exceeding six months and section 49 enables an approved medical practitioner or TASCAT to discharge a treatment order. An approved medical practitioner must discharge a treatment order if he or she is satisfied, after assessing the patient while the order is in effect, that the patient does not meet the treatment criteria which are defined in section 40.[4] Section 55 permits the provision of medical treatment to an involuntary patient without that patient's informed consent in certain circumstances.

Health

"The assessment criteria are –
(a) the person has, or appears to have, a mental illness that requires or is likely to require treatment for –
(i) the person's health or safety; or
(ii) the safety of other persons; and
(b) the person cannot be properly assessed with regard to the mental illness or the making of a treatment order except under the authority of the assessment order; and
(c) the person does not have decision-making capacity."

[2] By section 138 the Chief Psychiatrist may, by instrument in writing, approve individuals as medical practitioners for the purposes of the *Mental Health Act* 2013. To be approved as a medical practitioner the person must be a psychiatrist or a medical practitioner who is otherwise qualified or experienced in the diagnosis or treatment of mental illness.

[3] Prior to 5 November 2021 this power was vested in the Mental Health Tribunal.

[4] "The treatment criteria in relation to a person are –
(a) the person has a mental illness; and
(b) without treatment, the mental illness will, or is likely to, seriously harm –
(i) the person's health or safety; or
(ii) the safety of other persons; and
(c) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1) ; and
(d) the treatment cannot be adequately given except under a treatment order; and
(e) the person does not have decision-making capacity."

XA's general practitioner records cover the period from 28 February 2014 until 25 February 2022. He therefore had not been to see his general practitioner for approximately 10 months prior to his death. His medications are listed as Effexor XR 75 mg one capsule daily and a 75 mg injection of paliperidone once per month. Effexor XR, also known as venlafaxine, is used to treat adults with major depressive disorder, generalised anxiety disorder, social anxiety disorder or panic disorder. Paliperidone is prescribed to treat the symptoms of psychotic disorders including schizophrenia. The last script of Effexor XR was provided to XA on 1 August 2019. He was provided with five repeats so the total number of tablets, assuming all the repeats were used, amounted to 168. Assuming he took one tablet per day XA would have exhausted his supply by 15 January 2020.

XA's next consultation after 1 August 2019 took place on 5 October 2020. He presented on that occasion with a physical ailment. At the next appointment on 4 November 2020, he indicated to the general practitioner he wished to start exercising and change to a healthier diet. He therefore requested a general screening as had been suggested to him by the mental health nurse. Pathology tests were therefore organised. At the next visit a week later, a cardiovascular risk assessment was conducted. At that time, XA mentioned he was keen to cease smoking. He indicated he would rather attempt dietary change than be prescribed a statin. The next and final appointment took place on 25 February 2022, at which time XA presented with a sore left foot. XA's mental health was discussed at consultations on 20 December 2018, 19 June 2019, 26 June 2019 and 1 August 2019. At the appointment on 26 June 2019, XA advised his general practitioner he was feeling very unwell due to the side-effects of his medications which he had been taking for the last four to five months. He felt sluggish and fatigued but conceded it might take additional time for those symptoms to settle.

In 2016, the general practitioner referred XA to the psychiatrist Dr Lane on two occasions, however at an appointment on 13 October 2016, the notes record XA was *"still v[ery] resistant to seeing Jon Lane"*. It appears XA never saw Dr Lane.

Additional general practitioner records were obtained from the practice known as GP2U. XA saw doctors at that practice between the 2013 and 2017. At the first attendance on 21 August 2013, he indicated he did not wish to take advantage of government funded telehealth psychology sessions as he felt he did not need that assistance. He was prescribed Lexapro which is used to treat depression and anxiety. Of the nine appointments over that period six were for treatment of his mental health symptoms. There was a referral to a psychiatrist by the name of Dr Hyde whom XA saw on 9 May 2017 with his mother. At that time, XA was living with his mother and her partner. It was noted there was no family history of mental illness or suicide and that XA's medical history was unremarkable, apart

from meningitis and seizures when he was in infant. His drug use and forensic history were noted. There was no history of abuse or difficulties at school. After considering all of the history and after conducting a mental state examination, Dr Hyde concluded XA was a low to medium risk of harm to himself or others and he diagnosed schizophrenia of the paranoid type with a differential diagnoses of schizoaffective disorder. Treatment recommendations were made and lifestyle modification and regular exercise were recommended. Dr Hyde says, *"XA is aware that resolution of his symptoms are largely dependent on adherence to medication and the additional psychosocial support."* Dr Hyde was to review XA in four weeks, however there appears to have been no further contact with Dr Hyde or GP2U after 14 June 2017.

The hospital records indicate that in 2007 XA was admitted to Frankston Hospital in Victoria and he had further follow-ups which were conducted by the Peninsula Health Mental Health Service in January and April 2011. Between 13 December 2010 and 6 January 2011, XA was treated at the Geelong Clinic in Victoria. He had been referred by his mother and his general practitioner and he was a voluntary patient. He presented with a three year history of paranoid ideation regarding banks, other organisations and people, and a three month history of marked mood irritability, four to five hours a night of poor sleep and poor appetite. In September and October 2010, he consumed alcohol and smoked marijuana at night and renovated his house during the day. He gave a history of depressed periods with interspersed elevated mood since the age of 23 and he had been prescribed sertraline for the last five years. He had overdosed on that medication five years ago which resulted in an overnight admission to the psychiatric ward in Frankston. He was declared bankrupt in 2007. He was assessed, diagnosed and treated. During his admission, he became mildly hostile in manner and was concerned that the Geelong Clinic's electrician was from Frankston and was observing him. There was a possible diagnosis of schizophrenia/schizoaffective disorder. He could not be detained as he did not meet the statutory criteria for involuntary detention in Victoria and he discharged himself against medical advice.

Between 8 and 12 April 2011, XA was treated at the Peninsula Health Psychiatric Service. He had ceased his medication two weeks previously and presented as paranoid with depressive symptoms. He had low mood and motivation, lacked enjoyment and had suicidal ideation. His history of illicit substance use was noted. Again, he did not fit the statutory criteria in Victoria for detention and he declined admission choosing to go to Tasmania on a planned holiday with his mother. He agreed to an admission upon his return however that does not seem to have occurred. He was commenced on risperidone. At that time he was residing with his parents, he was unemployed and he had recently sold his house. He had a limited social network and reduced attention to activities of daily living. These notes reveal that the admission in January 2007 was for a period of two days and was the result of a

relationship breakup three months earlier. At that time he denied suicidal intent or any suicidal thoughts but then told emergency department staff he did intend to suicide.

Between 31 August 2017 and 18 October 2017, XA was an inpatient in the Department of Psychiatry at the RHH. He was diagnosed with schizophrenia with a secondary diagnosis of cannabis use disorder which was in remission. He was admitted after being brought in by ambulance in the context of experiencing persecutory delusions of being stalked and ASIO (Australian Security Intelligence Organisation) conspiring against him. It was noted he had a 10 year history of similar symptoms and he had been previously treated in Victoria. He had been itinerant with marked deterioration in social and occupational functioning, and therefore he had been living with his parents. He was not complying with his paliperidone which was being administered by the Crisis Assessment and Treatment Team. A history of suicide attempts in the past, by way of hanging 12 months prior to the admission and a near drowning in April 2017 where he reportedly swam into open sea in freezing cold weather, were noted. These records indicate that urgent circumstances treatment was provided, XA was assessed under the provisions of the *Mental Health Act* 2013 and an interim treatment order was made, which was followed by a treatment order which was valid for the period 5 September 2017 until 4 February 2018. It appears once XA was well enough to be discharged, he was discharged to Karingal on a program that was delivered by Baptcare in partnership with the Department of Health. The program was designed to assist people who could not be discharged from inpatient settings due to homelessness or who required intensive support to prevent readmission. The Karingal facility has five bedrooms and shared living areas.

On 8 November 2017, TASCAT reviewed and continued the treatment order. The order was then reviewed by a psychiatrist on 23 January 2018 and was discharged because XA no longer met the treatment criteria. Although discharged from the treatment order, follow-up mental health treatment was provided by Hobart and Southern Districts Adult Community Mental Health Service, but because XA subsequently moved to the northern suburbs of Hobart, the provision of his treatment was transferred to the Glenorchy and Northern Adult Community Mental Health Service (G & NACMHS). The notes record that although treatment continued, XA was unreliable; that is he would not always turn up to scheduled appointments and he was difficult to contact. By 31 May 2018, he wanted an exit plan from his treatment. He indicated he would continue with the depot injections at the moment but that was *"against my will"*. On 15 June 2018, he indicated he would prefer to be medication free, however, he was encouraged to remain on his medication for another 12 months. By that stage he had only been receiving his treatment in the community for approximately six months. Despite this, it seems treatment continued as XA was still attending appointments in late 2021, and by letter dated 29 October 2021, his care coordinator and registered nurse

and his psychiatrist wrote a letter in support of XA being granted the disability support pension. A letter to him of 11 May 2022 noted he had failed to attend his appointment with a psychiatrist in the previous month and he had failed to attend the clinic to receive his long acting injection. The letter also noted XA had not contacted the service in several weeks and nor had he answered numerous phone calls which had been made to his mobile. He was advised if he wished to continue to engage the G & NACMHS then he needed to make contact on the number provided. He was advised if the service did not hear from him by 24 May 2022, *"we will acknowledge this and respect your decision to discharge from our service in the care of your GP. You can always be rereferred by yourself, a GP or others via the mental health helpline"* the details of which were provided. There was no further contact with G & NACMHS or with his general practitioner.

Circumstances leading to death

On Thursday 22 December 2022, XA last saw her son at his address. She attended for a period of about four hours. She says it was a very intense visit. Although TA describes her son as really calm, he told her that *"they were after him and had him cornered and didn't know where he could go"*. She suggested he was off his medication and she offered to assist him to rectify that situation. He sat down and he talked about his whole life from start to finish and that he had been living in hell for the last 13 years. He also indicated he had written his life story but asked what he should do now. She suggested to him he needed help and she suggested admission to the Hobart Private Hospital. At the end he said he was right, but then asked *"what now"*. She again suggested he go back onto his medication and seek further help and support whether it was from doctors or some other support like religion. He indicated he had written his whole life story on his computer which he had just finished but decided to delete it. TA told her son they both ought take the time to reflect on the discussion. He advised her he had spoken to one of his brothers and they discussed when XA would be visiting her over Christmas. He was invited to stay with his mother on Christmas eve and he indicated he would let her know what his plans were.

What he did from that point until he passed away is unknown. However, on Saturday 24 December 2022 at approximately 7:49pm, he is seen walking on the southern footpath of the Tasman Bridge from west to east. He is carrying a plastic bottle of what appears to be water in his right hand and he appears to be showing no signs of distress. He takes a drink from the bottle and looks behind him. By this stage he is carrying the bottle in his left hand, and shortly thereafter, he reaches the apex of the bridge where he placed the bottle on the roadside or northern edge of the footpath. He then attempts to climb the railing on the southern side of the bridge. On his first attempt to climb over he slipped, but without

hesitation, he tried again and then stood with both feet on the top of the railing. He then propelled himself off the bridge headfirst.

Investigation

At 7:48pm multiple police officers responded to calls from members of the public that a male was walking in traffic on the bridge. On arrival, police reported there was no person walking in traffic and nor was anybody observed to be in stress or in a crisis. Shortly thereafter, Police Radio Dispatch Services advised police on duty multiple calls had been received that a male had jumped from the bridge. Multiple officers made their way to the bridge and at 7:59pm Constables Schrader and Fisher observed a water bottle which had been placed on the footpath of the bridge.

At 8:00pm, the Hobart Duty Inspector authorised the use of a helicopter to assist the four police officers who were searching for the male person. Two minutes later, one officer observed a male in the water and at 8:14pm the helicopter with an intensive care flight paramedic on board commenced its journey towards the Tasman Bridge. A Tasmania Police marine unit was also dispatched. At 8:19pm, a body was recovered by the helicopter from the Derwent River at which time the male person was declared to be deceased. The helicopter flew to the Hobart Cenotaph and a police officer from forensic services attended after which the body was taken to the Hobart mortuary. On 29 December 2022, the body was formally identified as XA by his mother.

The forensic pathologist Dr Andrew Reid conducted a post-mortem examination on 29 December 2022. After conducting that examination and after considering the results of a post-mortem CT scan and the results of microbiology and toxicology, Dr Reid came to the conclusion that XA died of head and chest injuries. The autopsy revealed a significant head injury with bilateral basal skull fractures and associated haemorrhage from both the ears. Signs of water immersion were also present. Dr Reid says the injuries were consistent with a blunt force trauma typically associated with a fall from height. He says the nature and degree of the basal skull fractures were such that death would have been instantaneous. There is no evidence to suggest the injuries caused a loss of consciousness and subsequent drowning. There was no circumstantial evidence of features consistent with drowning. He says the medication found on toxicology did not cause or contribute to death.

Mr McLachlan-Troup says the antidepressant venlafaxine was detected at less than 0.02 mg/L (milligrams per litre) and paliperidone, which is a major metabolite of risperidone, is used to treat acute and chronic psychoses including schizophrenia was detected at less than 0.01 mg/L. One mg/L is equivalent to 1 part per million (ppm). In this case, the measurements were less than 200th of 1 mg/L and 100th of 1 mg/L respectively. The latter figure is

equivalent to 0.010011423 ppm. The readings confirm XA had not taken his prescribed medication for a significant period of time and history shows that when this occurred his mental health declined significantly. No alcohol or illicit drugs were detected.

XA's electronic devices were seized and forensically examined. A number of suicide sites had been visited between 2016 and 2022.

I am satisfied there are no suspicious circumstances surrounding XA's death. I find that he took the action of jumping off the Tasman Bridge alone and with the intention of ending his life. XA had coped with his mental illness when he complied with the recommendations of his treatment providers in so far as taking his medication was concerned. When he did not comply, his mental health deteriorated and he became a danger to himself. Unless he was so unwell that he was taken into protective custody, and then detained and treated in accordance with a treatment order, there was no power for anyone to force XA to take his medication. Consistent with his wish to take no medication, it appears he has disengaged with the health system and therefore any statutory power to force him to take his medication could not be exercised. Given XA's history of attempting suicide, his choice not to take his medication and disengage from the health system and his worsening mental health, the decision he took on 24 December 2022 to end his life was, very sadly, inevitable. I make this comment in hindsight with all of the information available to me. His family, particularly his mother who in my view did everything she possibly could for her son, was not armed with all the information that I have been able to review. This of course is not her fault. It is a product of our laws which prevents medical professionals from disclosing sensitive medical information with respect to a patient to family members without the patient's permission. In this case and on the assumption XA had given permission, all that could have been disclosed by his doctors was that XA had disengaged from treatment. Even then there is nothing TA could have done unless XA became extremely unwell to the extent that he required immediate involuntary patient treatment. It does not appear from the evidence before me he had reached that point when he spoke to his mother at length on 22 December 2022.

I extend my appreciation to investigating officer Constable Zoe Fisher for her 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.[5] 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 early stage", with further assessments and tendering process still to take place.[6] 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

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

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 XA.

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

Magistrate Robert Webster
Coroner