



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 GD

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

- a) The identity of the deceased is GD, date of birth 6 January 1987;
- b) GD died in the circumstances set out in this finding;
- c) GD died as a result of multiple injuries due to being accidentally run over by a train; and
- d) GD died on 26 June 2023 at Burnie, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits regarding identity;
- Opinion of the forensic pathologist as to cause of death;
- Toxicology report of Forensic Science Service Tasmania;
- Affidavit of AB, father of GD;
- Affidavits of TasRail workers at the scene of death;
- Affidavit of the witness who found GD's bag and belongings unattended;
- Affidavits of attending and investigating police officers, including forensics officers and a crash investigation officer;
- CCTV footage of TasRail yard showing the movements of GD before his death;
- Worksafe Investigation and report dated 10 September 2024;
- Correspondence from TasRail to the Coroner's Office;
- Chronology of treatment prepared by the Coronial Nurse;

- Report from Dr Christopher Robinson, Senior Consultant Psychiatrist, Mental Health Service North West;
- Correspondence from Executive Director of Medical Services North West; and
- Report of Dr Stephane Auchincloss, independent consultant psychiatrist, regarding GD's care and treatment following his presentations to the North West Regional Hospital on 11 and 12 June 2023.

Background

GD was 36 years of age and single. Just before his death, he was transient with no fixed place of abode as a result of drug and mental health issues. His parents are AB and UY, long term residents of Strahan, who provided a great deal of support to their son up until his death.

After finishing high school in Queenstown, GD undertook an apprenticeship as a boilermaker welder and subsequently worked locally in fabrication until 2016, at which time he moved to Victoria for further employment opportunities.

GD began using cannabis from around 16 years of age. However, following his move to Victoria, he commenced using other illicit drugs. At the age of 17 years, GD began suffering seizures and was subsequently diagnosed with epilepsy. GD was compliant with his anti-convulsant medication and was not recorded as having suffered any seizures in the ten years before his death.

GD remained in Victoria until about two months before his death. During his time in Victoria, his life unfortunately went into a downward spiral. He accumulated a record of criminal convictions relating to illicit drugs, public disorder, violence and property damage. He was also recorded in Victoria as an intravenous drug user, a carrier of concealed weapons and as a person exhibiting violence towards emergency service workers and police. He served prison time in Victoria for his offences.

On 5 April 2023, GD was released from a period of imprisonment in Victoria and returned to Tasmania on 24 April 2023. He immediately moved in with his parents in Strahan. Initially, GD did not appear to be using illicit substances and his father said that he was his normal self. However, after about a month, GD's mental state deteriorated dramatically, likely coinciding with the resumption of drug use. GD became paranoid, expressing to his father that people were able to spy on him through the television, that his father was spying on him through Facebook and that there were cameras in the bathroom. His parents were not able to convince him otherwise.

Events prior to death

On 11 June 2023, GD threatened to stab and kill his father. His parents were then forced to lock themselves in a rear shed for their own safety and to call for police. Attending police officers then conveyed GD under a protective custody order to the North-West Regional Hospital for a mental health assessment. However, following assessment, GD was not admitted as an inpatient and police officers returned him home to Strahan that evening. The medical practitioner assessing GD prior to discharge recorded, amongst other things, that he did not exhibit signs of intoxication, was not hallucinating, and his thought processes were normal with no thoughts of harming himself or others.

The following day, 12 June 2023, GD's mental state worsened with ongoing paranoia, volatility and threats to kill his parents. AB and UY, fearing for their safety, sought the assistance of police again. GD was again conveyed under a protective custody order by the attending police officers to the North West Regional Hospital. AB and UY and GD also travelled to the hospital and spoke to a treating doctor, describing their son's unstable mental state and their own fears for their safety. They left to go home, understanding that he would remain as an inpatient. GD was then admitted to the Spencer Clinic, the mental health inpatient unit in the hospital.

The following day, 13 June 2023, GD was discharged from the Spencer Clinic. Although it was noted that he may have an emerging psychotic disorder, the psychiatry team assessing him formed the view that he did not meet the criteria for detention under the *Mental Health Act*. AB and UY, upon discovering that he had been released, expressed their frustration and concern that he would not receive the assistance he needed. GD's parents had previously arranged a room for him at Wellers Inn in Burnie in the event of discharge, instead of returning him to their place of residence. He therefore went to the accommodation at Wellers Inn.

Ten days later, on or about 23 June 2023, GD was ejected from Wellers Inn due to behavioural issues.

GD's parents were not aware of their son's movements after leaving Wellers Inn. However, he remained in contact by telephone with his father in the week before his death. GD's father last spoke to his son the night before his death in a phone call that lasted about half an hour. AB (Senior) described the conversation as pleasant, with GD expressing his love for his parents. AB (Senior) deposited money into his son's account to pay for his accommodation, although GD did not provide the receipt for the

accommodation as his father requested. It would appear likely from the evidence that GD did not book into any accommodation.

Circumstances of death

At 3.52am on Monday 26 June 2023, two weeks after his release from the Spencer Clinic, GD was walking on the public pedestrian footbridge over the Burnie Rail Terminal at Marine Terrace adjoining the wharf facility. There is no evidence of his previous movements. His movements on the footbridge, with accurate timing, were captured by TasRail CCTV footage. The footbridge is managed by the Burnie City Council. The rail terminal ("the rail yard") is operated by TasRail and is a secure facility, utilising high wire fences, locked gates and signage indicating that there is no public access.

Within the next five minutes, GD moved around the footbridge. He then climbed over the low rail (1.3 metres high) and dropped a distance of 1.8 metres onto a container on a train wagon (or carriage) before climbing down between two wagons. The wagons were easily accessible from the footbridge.

At around 4.02am, GD moved around the rail yard without coming to the attention of staff members on site. At 4.37am, he moved between two wagons and out of sight. The evidence suggests that GD may have crouched between the wagons to hide from staff members in the area.

Normal operations were being undertaken in the rail yard during the evening of 25 June 2023 and morning of 26 June 2023. All usual protocols and safety procedures were followed. GD was not seen by any member of TasRail staff. I am satisfied that staff members present could not have reasonably detected GD secreting himself in various parts of the yard or even anticipated that there would be a member of the public in the yard.

From about 4.00am onwards, TasRail staff commencing their shift proceeded to undertake the task of moving and splitting the train wagons. This included "shunting forward" six wagons a short distance¹ using a locomotive, preparatory to the unloading process.

At 4.56am, the wagons were shunted forward on the tracks, again in accordance with usual protocols. Shortly after the completion of this process, at 5.07am, staff members

¹ The evidence suggests the distance was equivalent to the length of six wagons, each wagon being 14.5 m in length.

located the body of a deceased person on the tracks with catastrophic traumatic injuries. The deceased person was subsequently identified as GD.

At 5.15am, police officers arrived at the scene. A full investigation, including by specialist crash and forensics officers, took place.

I find that at the time the wagons were shunted forward GD was crouched and hiding between two of the end wagons in the loading area. Upon the train shunting, GD fell or was trapped under the wagons and dragged for a distance of approximately 20 metres. He died immediately. Toxicological testing revealed that, at the time of his death, he had his anticonvulsant medication in his system, as well as the illicit drug methamphetamine.

Upon all of the evidence, the most probable motive for GD being in the rail yard was to steal. His backpack was subsequently recovered from a nearby concealed location, suggesting that he had positioned it with a view to returning to collect it.

I am satisfied that GD did not die as a result of suicide or foul play. I find that GD's death was as a result of misadventure. He entered the depot as a trespasser and unbeknownst to staff members on site. Unfortunately, he placed himself at risk by entering into an operational rail yard and concealing himself on the tracks between two wagons. Because of the lack of evidence of GD's last days, I cannot determine the extent to which his mental illness, including persecutory delusions, contributed to his actions. Regardless, his behaviour was likely influenced by the effects of methamphetamine.

Comments and Recommendations

As part of the investigation, I have considered the circumstances surrounding GD's presentations to the NWRH prior to his death. GD's parents have expressed concerns about the quality of his treatment for his mental illness and his discharge without apparently adequate assessment.

As the two hospital presentations were shortly before his death, it was appropriate for me to consider whether there were any deficiencies in the care or treatment that might be seen as lost opportunities to improve GD's condition and possibly prevent his death. I therefore sought the opinion, by way of a written report, from highly respected consultant psychiatrist Dr Stephane Auchincloss.

For her report, Dr Auchincloss reviewed the medical records in detail and provided various comments upon the issues surrounding GD's treatment. Dr Auchincloss, in summary, made the following comments regarding deficiencies in his care:

- (a) GD lacked decision-making capacity as that phrase is defined under the *Mental Health Act* on both occasions of his discharge, such that an application for an involuntary order for assessment and care should have been made.
- (b) There is little evidence of a comprehensive psychiatric assessment during either stay in the emergency department. There was an incorrect notation that GD did not have delusions or hallucinations, and insufficient exploration of his persecutory delusions, his recent aggression and violence, his history of offending and the extent of his substance use. There was an under-appreciation of the relevance of his parents fearing for their lives and expressing that they might themselves need to harm their son for self-protection.
- (c) GD clearly had persecutory delusions, which are amongst the most concerning of psychiatric phenomena. They are associated with a high degree of risk, particularly to the individuals seem to be perpetrating the persecution – in GD's case, principally his father. The presence of persecutory delusions is not ever identified in the hospital records and the risks to GD and others from these delusions was not fully appreciated. Regardless of the underlying cause of the delusions (even if due to drug induced psychosis) it is very likely they would have been significantly ameliorated by appropriate treatment.
- (d) Prior to his discharge on 13 June 2023, GD was treated with an antipsychotic, olanzapine, as well as a sedating benzodiazepine with anti-anxiety effects. Therefore, for the pre-discharge assessment, GD was likely to have been sedated, less anxious and less disturbed by persecutory delusions; and this did not reflect his untreated mental state. It was inappropriate to discharge him at this stage simply because his immediate symptoms had been successfully controlled, without providing more lengthy observation, assessment and community follow-up.

- (e) GD's main diagnosis on the hospital record after each of the two emergency department presentations was "*behavioural disorders due to other stimulants*." His psychotic symptoms were therefore not adequately reflected in the diagnosis which was recorded and communicated to others. The omission of psychosis from the discharge diagnoses occurred despite psychosis been discussed within the hospital notes.
- (f) A more assertive approach to community follow-up was warranted in light of his history of aggression and actual violence arising from persecutory delusions.

The conclusions expressed by Dr Auchincloss in her report are persuasive.

I have also received correspondence from the Executive Director of Medical Services North-West accepting that Dr Auchincloss's conclusions are reasonable and that there were opportunities to have provided GD with better assessment and treatment. These included the escalation to a senior emergency department medical practitioner and a more rigorous assessment of capacity with corresponding notations in the records. The Executive Director did not consider, however, that GD lacked capacity and required an involuntary order under the *Mental Health Act*.

Another report on GD's treatment was provided helpfully by Dr Christopher Robinson, Senior Consultant Psychiatrist for Mental Health Service North West. Dr Robinson was consulted in GD's mental health assessment prior to his discharge on 13 June 2023. He also did not consider that GD lacked capacity regarding mental health decision-making. He reasoned at the time of that assessment that there was no indication of suicidal ideation, disorganised thought or cognitive impairment to suggest discharge was too high a risk. Further, GD was barred from returning to the Strahan area where his parents resided by bail conditions.

Ultimately, I have decided not to hold a public inquest into the death of GD to further examine and make positive findings regarding any issues in his assessment and treatment.

Upon all of the evidence, including GD's history of criminal offending, mental health issues and drug use, I cannot find a direct connection between any deficits in his treatment two weeks before his death and his presence in the rail depot.

As stated by Dr Auchincloss, GD may have been responding to untreated persecutory delusions, which are known to greatly increase the risk of misadventure. However, this

cannot be known to the requisite standard to properly enable further exploration of deficiencies in his treatment.

I therefore do not make adverse comment about any mental health professional, but comment upon the critical importance of thorough and accurate assessment and treatment of psychotic patients with persecutory delusions.

As a final matter, I observe that an incident of this type in the Burnie rail and port area is an extremely rare event. I am not aware that a death has previously occurred in a similar manner. There is also no evidence that the rail yard has issues with trespassers.

Since GD's death, further lighting and fencing improvements have been made in the rail yard.² Although it is unnecessary to make any formal recommendations in this case, I comment that it may nevertheless be reasonable for TasRail and Burnie City Council to jointly assess whether any further restrictions, railings or other measures are warranted to prevent members of the public accessing the yard from the footbridge.

I extend my appreciation to investigating officer Detective Sergeant Richard Chugg for his very thorough investigation and report.

I convey my sincere condolences to the family and loved ones of GD.

Dated: 9 October 2026 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner

² Not as a direct result of the death of GD.