



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **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 VY

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

- a) The identity of the deceased is VY, date of birth 25 October 1990.
- b) VY was 33 years of age, was not in a significant relationship and had two children. She lived in George Town. VY had a significant history of mental health issues (including depression and anxiety), alcohol and drug addiction, suicidal ideation and suicide attempts. She also engaged in self-harm by cutting and overdosing on medications, resulting in multiple hospital admissions.

From the early evening of 5 April 2024, VY was consuming alcohol, including later attending a party at which her boyfriend was present. At the party, she had an argument with her boyfriend, before leaving the party address at about 1.30am to walk home. She had walked several hundred metres before stopping outside 168 Agnes Street (the local school) at a power utility pole number 24A which had attached to it a length of telecom rope within reach. She attached the rope to her neck and lowered herself towards the ground causing asphyxiation. In this position, her feet were resting on the ground. She remained hanging for 23 minutes until she was discovered by a group of partygoers. A nearby school security guard cut her down and commenced CPR. Police officers who had been called also undertook CPR. When paramedics attended, she had no signs of life and was declared deceased.

- c) VY's cause of death was hanging. Toxicological testing revealed that she had a very high level of alcohol in her system (0.183g/100mL). I find that, in a highly intoxicated state, VY took the action of hanging

herself alone and with the intention of ending her life. I am satisfied that there are no suspicious circumstances surrounding her death.

d) VY died on 6 April 2024 at George Town, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Toxicology report from Forensic Science Service Tasmania;
- General practitioner records; Tasmanian Health Service
- Affidavit of MN, mother of deceased;
- Affidavit of RB, father of deceased;
- Affidavit of Shane Crawford, security guard who attended the scene;
- Affidavit of KT, boyfriend of VY;
- Affidavit, body worn camera footage and photographs of two attending and investigating police officers;
- CCTV footage of the scene and VY's actions; and
- Information from Vision stream Australia Pty Ltd regarding works on utility pole 24A.

### **Comments and Recommendations**

From 2023 onwards, including at the time of VY's death, ongoing telecommunications works were being conducted by NBN's contractors on and around power pole 24A in Agnes Street, George Town. The work involved cutting through existing concrete footpaths to the base of the power pole, placing a plastic conduit pole riser against the power pole and running draw rope from the telecommunications pit up through the pole riser. A length of remaining rope was left outside the riser and tied against the pole to prevent it from swinging loosely. This remaining rope was tied to the pole at a height of approximately 1.00-1.30 metres and was left in this position to be drawn through the riser and pit into dwellings at 168 Agnes Street at a later date.

NBN's principal contractor responsible for the works reported that it is common practice within the telecommunications civil construction industry for draw or haul rope to be left in situ for later use in situations such as pits and pole risers.

NBN reported that there are no specific rules or regulations relating to leaving such rope tied to a pole for later use. It stated that applicable legislation and code of practice require such works to be inspected and maintained, carried out in a way that minimises damage, complies with good engineering practice, and avoids creating risk. Specifically, reasonable steps are required to be taken to protect the safety of persons and property.

Given VY's poor mental health and history of suicide attempts, the chances of her death by suicide were high. However, the presence of an accessible length of rope was a factor in providing VY the means for suicide at that time. I am not aware that any such event has occurred previously. However, it is foreseeable that lengths of rope at a low height left on power poles, particularly for long periods of time, may pose safety hazards in various ways to persons in the vicinity. I consider that further assessment of these risks and alternative safety measures warrant further consideration by NBN and its contractors.

I **recommend** that NBN and/or its relevant contractors undertake a review of the practice of leaving lengths of rope on utility poles during works; such review to include an assessment of risks to the health and safety of members of the public and whether changes to the practice are reasonably warranted or practicable.

I **recommend** that, following the review, NBN and/or its relevant contractors implement any appropriate measures to protect the health and safety of members of the public.

I extend my appreciation to investigating officer Constable Jayden Monaghan for his investigation and report.

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

**Dated:** 23 February 2026 at Hobart, in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**