

Suicides from the Tasman Bridge

Magistrates Court of Tasmania – Coronial Division

March 2025



The Coronial Division of the Magistrates Court of Tasmania respectfully acknowledges the individuals who have lost their lives to suicide, and their families and communities who have been deeply affected by the loss of their loved ones to suicide.

WARNING

The following report contains information on suicide deaths, which may be confronting and distressing. Reader discretion is advised. Readers are strongly urged to consider their needs carefully when reading the following material. If support is required, contact:

Tasmanian support services

- A Tasmanian Lifeline: 1800 984 434 | <https://atasmanianlifeline.com.au>
- Access Mental Health: 1800 332 338

National support services

- Lifeline: 13 11 14 or text 0477 13 11 14 | <https://www.lifeline.org.au/>
- StandBy Support After Suicide: 1300 727 247 | <https://standbysupport.com.au/>
- Beyond Blue: 1300 224 636 | <https://www.beyondblue.org.au/>
- MensLine Australia: 1300 789 978 | <https://mensline.org.au/>
- Kids Helpline: 1800 55 1800 | <https://kidshelpline.com.au/>

In the case of an emergency, contact Triple Zero (000).

Media guidelines

This report contains information regarding suicide location and method. Media reporting on suicide methods and public locations can increase the frequency of suicides at these sites.

For safe and accurate media reporting, portrayal and communication about suicide and mental health concerns, refer to the Mindframe media guidelines (<https://mindframe.org.au/guidelines#Reporting-suicide-and-mental-ill-health>).

For advice and support on safe media reporting, contact Mindframe on mindframe@health.nsw.gov.au.

Contents

Introduction.....	4
Tasmanian Suicide Register	5
Suicides from the Tasman Bridge	6
1. Sociodemographic profile	6
2. Mental health issues.....	6
2.1. Mental illness diagnosis	6
2.2. Mental illness treatment	7
2.3. Suicidality	9
2.4. Toxicology	10
3. Interpersonal and situational stressors	10
4. Health, legal and other services	12
5. Discussion	14
Risks and prevention	15
6. Contributors to high suicide risk	15
7. Suicide prevention at the Tasman Bridge	18
References	21
Appendix.....	23

Introduction

Constructed in 1964, The Tasman Bridge spans 1.4 km across the Derwent River in Hobart, Tasmania with five lanes for motorised traffic and pathways for pedestrians and cyclists.

The Tasman Bridge is a ‘high-risk suicide location’ because it is easily accessible, it has developed a reputation as a place to suicide, and an unusually high number of suicides have occurred there over time compared to other specific public sites in Hobart (and Tasmania more generally).¹

Between 1 January 2016 and 30 June 2024, there were 22 suicides by jumping or falling reported from the Tasman Bridge. The Tasman Bridge accounted for 56% of suicides by jumping from height and 3% of overall suicides in Tasmania. On average, 2.6 deaths were reported from the Tasman Bridge each year. Over the same period, there was no other specific public location in Tasmania where more than 3 suicides occurred, confirming the Tasman Bridge’s status as Tasmania’s most prominent high-risk location for suicide.

Nationally, the Tasman Bridge was identified as having the sixth highest number of suicides among 17 high-risk suicide locations around Australia between 2001 and 2017.² The remaining locations were situated in New South Wales, Victoria and Queensland. Safety barriers have been installed at bridge sites in other states with noted reductions in suicide deaths (as discussed in section 7).

In November 2016, Chief Coroner Olivia McTaggart made 7 recommendations following an inquest into the suicides of 6 people from the Tasman Bridge. With the aim to prevent further suicides at the location, these include:

“4...that the government continue its commitment as expressed in the Tasmanian Suicide Prevention Strategy to pursue the development of a Tasmania Suicide Register, so as to accurately inform suicide prevention strategies, including strategies for suicide prevention at the Tasman Bridge.”³

¹ A Beautrais, “Suicides by jumping: A review of research and prevention strategies”, *Crisis*, vol 28(Suppl. 1), 2007, 58-63; L Too et al., “High-risk suicide locations in Australia”, *JAMA Network Open*, vol 7(6), e2417770, 2024, 1-11.

² 27 deaths in the 17-year period examined in Too et al., 5. We note that Too et al did not name the Tasman Bridge in this study, however its identity is clear from the description provided in the paper combined with the concordance between Too et al’s reported data and coronial data.

³ O McTaggart, *Deaths from a Public Place*, Magistrates Court of Tasmania 2016 TASCD 385 386 387 388 389 390. https://www.magistratescourt.tas.gov.au/data/assets/pdf_file/0004/362191/Deaths_from_a_Public_Place.pdf, 22, accessed 6 January 2025. See Appendix for list of recommendations.

This report provides an update on suicides at the Tasman Bridge in the period since the coroner's recommendations using data from the Tasmanian Suicide Register (TSR). The report first seeks to describe the characteristics and circumstances of people who recently died by suicide at the Tasman Bridge. It will subsequently examine features that contribute to the Tasman Bridge as a high-risk location for suicide. Lastly, the report will review the progress of suicide prevention measures on the Tasman Bridge as recommended by the coroner, with a focus on safety barrier installation.

The Coronial Division has carefully considered the risks associated with publishing information on suicide at the Tasman Bridge, noting the general guidance that in most cases it is preferable not to publish information on specific suicide means and locations. The decision to identify the Tasman Bridge in this report was heavily influenced by the potential public health benefits of doing so, including the potential for the data to inform suicide prevention strategies and enable authorities to focus their interventions to prevent suicides at this high-risk suicide location. An additional consideration was that the Tasman Bridge has notoriety in the community as a suicide location, so redacting its name would not achieve any purpose related to restricting knowledge about what occurs there.

Tasmanian Suicide Register

Pursuant to the coronial recommendation, the TSR was established in 2017 as a collaboration between the Department of Health (Tasmania) and the Coronial Division of the Magistrates Court of Tasmania. The TSR is a data repository containing suspected and confirmed suicide deaths in Tasmania reported to the coroners. Data on suspected suicides are preliminary based on available initial evidence and are subject to change following coroners' determinations.

This report provides an overview of suicide deaths from the Tasman Bridge reported between 1 January 2016 and 30 June 2024 as extracted from the TSR. The data comprised of both suspected and confirmed suicides reported during the period. At the time of writing, coronial investigations for 8 cases are underway, however the available evidence is consistent with suicide from the Tasman Bridge. For purposes of this report, these suspected suicides are included in the analysis, noting that a final coronial determination has not yet been made.

The information in the TSR is sourced from coronial records gathered from various sources, including police and forensic reports, medical records, and statements from family and friends. Information can therefore vary in depth and quality of evidence. It is important to note that a lack of evidence of a stressor does not guarantee that it was not present. Conversely, the presence of a stressor does not indicate that it was a contributor to the death.

Suicides from the Tasman Bridge

1. Sociodemographic profile

Among the 22 people who died by suicide from the Tasman Bridge:

- The majority were males (91%, 20 people).
- The majority were born in Australia (86%, 19 people).
- The average age was 36 years old, ranging between 18 to 66.
 - A third were aged between 18 to 24 (32%, 7 people), followed by those aged between 35 to 44 (27%, 6 people).
- In terms of employment:
 - Over a third were employed (36%, 8 people), mostly as technicians and trades workers (23%, 5 people).
 - A third were unable to work due to physical and/or mental illness (32%, 7 people), most of whom were disability pension recipients (27%, 6 people).
 - A fifth were students (18%, 4 people).
- Three-quarters were not in a relationship (73%, 16 people).
- All resided in Greater Hobart (SA4) at time of death (100%, 22 people).
 - The highest proportion resided in Clarence City local government area (36%, 8 people), followed by Hobart City (32%, 7 people) and Kingborough (18%, 4 people).

2. Mental health issues

2.1. Mental illness diagnosis

Most people who died by suicide from the Tasman Bridge had at least one mental health diagnosis (86%, 19 people). As shown in Table 1 (over the page), the most prevalent diagnosis was mood (affective) disorders, with more than half of the deceased diagnosed with these conditions (59%, 13 people). The second most prevalent diagnosis was neurotic (anxiety), stress-related and somatoform disorders (55%, 12 people). Nearly half of the deceased were diagnosed with mental and behavioural disorders due to psychoactive substance use (45%, 10 people) and a third of the deceased had a diagnosis of schizophrenia, schizotypal and delusional disorders (32%, 7 people).

Table 1: Number and proportion of deceased with mental illness diagnosis

Mental illness diagnosis	N	%
Any diagnosis	19	86
Mood (affective) disorders	13	59
Neurotic (anxiety), stress-related and somatoform disorders	12	55
Mental and behavioural disorders due to psychoactive substance use	10	45
Schizophrenia, schizotypal and delusional disorders	7	32
Other diagnosis	8	36
No diagnosis	3	14
Total	22	100

Note: An individual may have been diagnosed with more than one mental illness.

2.2. Mental illness treatment

Table 2 shows that over half of the deceased received mental health treatment within 6 weeks prior to death (55%, 12 people), including half of the deceased who were treated as voluntary patients (50%, 11 people).

As shown in Table 3 over the page, most of the deceased received mental health treatment within 12 months prior to death (77%, 17 people), with one in three treated as involuntary patients (32%, 7 people).

Table 2: Number and proportion of deceased receiving mental health treatment within 6 weeks prior to death by patient status

Treatment and patient status	N	%
Treatment within 6 weeks	12	55
Voluntary patient	11	50
Involuntary patient*	3	14
No treatment within 6 weeks	10	45
Total	22	100

Note: An individual may have been treated as both voluntary and involuntary patient within 6 weeks prior to death.

* Involuntary patients were subject to the *Mental Health Act 2013*, whereby individuals were deemed to lack decision-making capacity about their own assessment or treatment.

Table 3: Number and proportion of deceased receiving mental health treatment within 12 months prior to death by patient status

Treatment and patient status	N	%
Treatment within 12 months	18	82
Voluntary patient	18	82
Involuntary patient*	7	32
No treatment within 12 months	4	18
Total	22	100

Note: An individual may have been treated as both voluntary and involuntary patient within 12 months prior to death.

* Involuntary patients were subject to the *Mental Health Act 2013*, whereby individuals were deemed to lack decision-making capacity about their own assessment or treatment.

As shown in Table 4, within the 6 weeks prior to death, half of the deceased received mental health treatment within the community (50%, 11 people). A quarter of the deceased received inpatient treatment (23%, 5 people), including 3 people (14%) who were inpatients at various mental health facilities at time of death.

Table 5 (over the page) shows that within 12 months prior to death, three-quarters of the deceased were treated within the community (77%, 17 people), and nearly half of the deceased were treated within inpatient setting (41%, 9 people).

Table 4: Number and proportion of deceased receiving mental health treatment within 6 weeks prior to death by treatment setting

Treatment status and setting	N	%
Treatment within 6 weeks	12	55
Community setting	11	50
Inpatient setting	5	23
No treatment within 6 weeks	10	45
Total	22	100

Note: An individual may have been treated in both community and inpatient settings within 6 weeks prior to death.

Table 5: Number and proportion of deceased receiving mental health treatment within 12 months prior to death by treatment setting

Treatment status and setting	N	%
Treatment within 12 months	18	82
Community setting	17	77
Inpatient setting	9	41
No treatment within 12 months	4	18
Total	22	100

Note: An individual may have been treated in both community and inpatient settings within 12 months prior to death.

2.3. Suicidality

Table 6 below outlines the prevalence of suicidal thoughts and behaviours among the 22 people prior to death. Most of the deceased expressed suicidal ideation, including to healthcare providers, family and/or friends (82%, 18 people). Nearly half of the deceased made at least one previous suicide attempt (45%, 10 people) and a third of the deceased self-harmed (36%, 8 people).

Table 6: Number and proportion of deceased with evidence of suicidality

Suicidality	N	%
Evidence of suicidality	18	82
Suicidal ideation	18	82
Suicide attempt(s)	10	45
Non-fatal self-harm	8	36
No evidence of suicidality	4	18
Total	22	100

2.4. Toxicology

Results for postmortem toxicological testing were available for 18 of the 22 cases (82%). Table 7 shows that pharmaceutical drugs associated with the treatment of mental illness were detected in over half of the cases (59%, 13 cases). These included anti-depressants and anti-psychotics. Drugs associated with treating physical symptoms, including ibuprofen and paracetamol, were detected in a third of cases (32%, 7 cases). Alcohol or illicit drugs were reported in a quarter of the cases (23%, 5 people).

Table 7: Number and proportion of deceased with substances detected in toxicological testing

Substance detected	N	%
Any substance detected	14	64
Pharmaceutical drugs for mental illness	13	59
Pharmaceutical drugs for physical illness	7	32
Alcohol / illicit drugs	5	23
No substance detected	4	18
Toxicology testing not undertaken	4	18
Total	22	100

3. Interpersonal and situational stressors

Tables 8 and 9 over the page outline the prevalence of interpersonal and situational stressors prior to death. Stressors identified were proximate to death and/or historical where deemed relevant.

The most prevalent interpersonal stressors identified were family conflict (68%, 15 people), conflict with acquaintances (55%, 12 people) and separation with partner (41%, 9 people).

Stressors involving work/employment were evident in three-quarters of the deceased (73%, 16 people), followed by experiences of abuse/violence (68%, 15 people). Evidence of financial stressors, isolation and substance use/misuse were identified in over half of the people (59%, 13 people). All young people in the cohort (i.e. aged between 18 and 24) experienced stressors relating to education (32%, 7 people).

Table 8: Number and proportion of deceased with evidence of interpersonal stressors

Interpersonal stressor	N	%
Evidence of interpersonal stressors	19	86
Family conflict	15	68
Acquaintance conflict	12	55
Partner separation	9	41
Family violence (excluding partner)*	8	36
Death in family	8	36
Partner conflict	7	32
Family health issues	5	23
No evidence of interpersonal stressors	3	14
Total	22	100

Table 9: Number and proportion of deceased with evidence of situational stressors

Situational stressor	N	%
Evidence of situational stressors	22	100
Work / employment	16	73
Abuse / violence*	15	68
Financial	13	59
Isolation	13	59
Substance use / misuse	13	59
Legal	12	55
Education	7	32
No evidence of situational stressors	-	-
Total	22	100

* May refer to physical, verbal, financial, psychological, emotional, neglect, sexual or spiritual/cultural abuse/violence (excludes self-inflicted). The individual may have been the perpetrator, victim, or both.

4. Health, legal and other services

Most of the deceased were engaged with health services prior to death. As shown in Table 10, three-quarters of the deceased were engaged with general practitioners (73%, 16 people). Similar number of people were also engaged with the Tasmanian Government health services, ranging from attendances at the emergency department, inpatient admissions, to community treatments (68%, 15 people).

Table 10: Number and proportion of deceased who engaged with health and social services

Service provider	N	%
Engagement with services	21	95
General practitioners	16	73
Tasmanian Government health services	15	68
Centrelink	7	32
Ambulance Tasmania	5	27
No engagement with services	1	5
Total	22	100

Table 12 (over the page) shows that most of the deceased have interacted with the legal system, including those in contact with police outside the 6 weeks prior to death (64%, 14 people). A third of the deceased interacted with the courts regarding treatment orders or criminal matters outside of the 6 weeks prior to death (36%, 8 people). More recent interactions were reported in a quarter of the deceased who had contact with police within 6 weeks prior to death (23%, 5 people), as shown in Table 11. Interactions with police were typically related to the deceased's mental-health (such as suicidal ideation, suicide attempt, and protective custody) and/or criminal conduct.

Table 11: Number and proportion of deceased who had interactions with the legal system within 6 weeks prior to death

Legal contact	N	%
Contact within 6 weeks	5	23
• Police • Courts	5 1	23 5
No contact within 6 weeks	17	77
Total	22	100

Note: An individual may have had contact with both police and courts within 6 weeks prior to death.

Table 12: Number and proportion of deceased who had interactions with the legal system outside of 6 weeks prior to death

Legal contact	N	%
Contact outside 6 weeks	14	64
• Police • Courts	14 8	64 36
No contact outside 6 weeks	8	36
Total	22	100

Note: An individual may have had contact with both police and courts outside 6 weeks prior to death.

5. Discussion

Most people who died by suicide from the Tasman Bridge were adult males aged between 18 and 44. Consistent with previous findings on people who attempted suicide by jumping,⁴ most of the deceased were diagnosed with at least one psychiatric disorder, including mood, stress and anxiety-related, substance use and/or psychotic disorders. Most of the deceased also experienced ongoing suicidality, with nearly half of the deceased having engaged in suicidal activity in the past.

The prevalence of mental health issues among the deceased was also evident in their contacts with the legal system. While some contacts may have been for criminal matters, interactions with police and courts were typically in relation to the deceased's mental impairment and suicidality. In some cases, interactions with the police involved the deceased being subjected to the *Mental Health Act 2013*, whereby they were placed into protective custody and taken to the Royal Hobart Hospital for assessment. Some had further involvement with the legal system involving the Tasmanian Civil & Administrative Tribunal in relation to their mental health treatment order.

A very high proportion of the deceased experienced both interpersonal and situational stressors in the lead-up to the fatal incident, including conflict with family members and work or employment related stressors. There were intersections between experience of these stressors and experience of mental ill health in many cases, with evidence the two may have exacerbated one another.

Most of the deceased were known to mental health services and received mental health treatment in the year leading up to their death; these included deceased who experienced severe mental impairment, with one in three receiving involuntary treatment within 12 months prior to death. Post-mortem toxicology results showed evidence of having recently taken psychiatric medications in nearly 60% of cases, suggesting a level of compliance with active treatment at time of death. The high level of engagement with mental health services is a positive finding, as it suggests mental health services were reaching those who needed them. These findings highlight the critical role of the mental health system in addressing mental health issues and preventing suicides.

Finally, the role of general practitioners should be recognised. While most deceased were supported by mental health services, their day-to-day health and wellbeing were overseen by general practitioners. Coordination and integration between general practice and specialist mental health services is particularly important for supporting vulnerable people in the community.

⁴ Beautrais, 59; J Joyce and S Fleminger, "Suicide attempts by jumping", *Psychiatric Bulletin*, vol 22, 7, July 1998, 424-427.

Risks and prevention

6. Contributors to high suicide risk

As earlier noted, the Tasman Bridge is a high-risk location for suicide. This section explores some of the main features that contribute to this high-risk status.

Physical accessibility

The primary concern at hand is “the ease of suicide” from the Tasman Bridge with its central location, pedestrian access and inadequate fencing as contributing factors.⁵ Structural issues that allow individuals to physically access a jumping point on the Tasman Bridge were addressed at length during the 2016 coronial inquest (see coronial findings for further details).

Preference

The Tasman Bridge is a major piece of infrastructure connecting Hobart City on the western shore with Clarence City on the eastern shore of the Derwent River. With the deceased mainly residing in either Hobart City or Clarence City at time of death, one in three travelled a relatively short distance of 4 km and less to the Tasman Bridge. High-risk jumping locations are also typically located near psychiatric hospitals or other care facilities.⁶ In this instance, 3 inpatients travelled an average of 2 km from various mental health facilities to the Tasman Bridge to suicide.

Previous studies have found that people were willing to travel substantial distances to suicide at a specific and well-known jump location.⁷ TSR data indicate similar patterns of behaviour with distance travelled from the deceased person’s usual residence to the Tasman Bridge ranging between less than 1 km up to 25 km. Table 13 (over the page) shows that people travelled a further distance to suicide at the Tasman Bridge (a median of 6.2 km) compared to other jumping locations in Tasmania (a median of 3.1 km).

⁵ McTaggart, 17.

⁶ Beautrais, 59.

⁷ J Dwyer et al., “Structural intervention at one bridge decreases the overall jumping suicide rate in Victoria, Australia”, *Epidemiology and Psychiatric Sciences*, vol 32, e58, 2023, 1-7.

Table 13: Distance from deceased's usual residence to jumping locations

Distance (km)	Tasman Bridge		Other locations		All locations	
	N	%	N	%	N	%
0 - 1	1	4.5	5	29.4	6	15.4
1 - 2	2	9.1	3	17.6	5	12.8
2 - 5	6	27.3	4	23.5	10	25.6
5 - 10	7	31.8	1	5.9	8	20.5
10 - 20	4	18.2	3	17.6	7	17.9
> 20	2	9.1	1	5.9	3	7.7
Total	22	100	17	100	39	100
Average (Median)	7.6 (6.2)		5.6 (3.1)		6.8 (4.5)	

Cognitive availability

While ease of physical access is evident for those who lived in surrounding areas, these findings raise the question of why some people travelled a substantial distance to suicide specifically at the Tasman Bridge. A plausible explanation is that the Tasman Bridge have a long-standing notoriety as a suicide location amongst the community. For example, there is a common misperception that at least one suicide death per week occurs at the site.⁸ This can subsequently lead to cognitive availability, that is, the perception that the location is accessible, available and known as a place where people die by suicide.⁹ Cognitive availability about a particular method or location can result from media reporting and interpersonal communication.¹⁰ Evidence from TSR suggests that cognitive availability can influence an individual's choice to suicide specifically at the Tasman Bridge. This includes bypassing other possible means and locations and overcoming physical limitations such as having to travel a substantial distance.

As noted during the inquest, the Tasman Bridge is a high-risk location for impulsive and distressed individuals as "no elaborate plan is required except a short walk to the

⁸ McTaggart, 2.

⁹ J Florentine and C Crane, 1627; L Marzano et al., "Patterns and motivations for method choices in suicidal thoughts and behaviour: Qualitative content analysis of a large online survey", *BJPsych Open*, vol 7, e60, 2021, 1-6.

¹⁰ Beautrais, 59; K Hawton, D Knipe and J Pirkis, "Restriction of access to means used for suicide", *Lancet Public Health*, vol 9, 2024, e796-801.

location”.¹¹ For the purpose of this report, it was important to determine the extent to which other persons might be actively at risk. We therefore sought data from Tasmania Police regarding police attendance on the Tasman Bridge related to welfare concerns, including mental health issues and suicide-related incidents. In addition to the 22 deaths reported, Tasmania Police data shows that police attended an average of 195 ‘concern for welfare’ incidents annually on the Tasman Bridge.¹² The data further underscores the notoriety of the location whereby it is frequented by people in distress or experiencing a crisis, and that the deaths represent the tip of the iceberg of suicidality within the community. This data also highlights the significant police resources required to assist distressed individuals on the Tasman Bridge.

Witness risks

Suicide at public locations impact not only the individual in concern and their loved ones, but also expose witnesses to potential psychological trauma.¹³ The Tasman Bridge has 5 lanes for motorised traffic with a volume of approximately 76,000 vehicles per day. It also has pathways on each side for pedestrians and cyclists. Of the 22 suicides, TSR data indicate that 64% (14 cases) were witnessed by members of the public who were travelling on the Tasman Bridge. The number of witnesses ranged from one to seven people. These figures were based on witness reports to the police, and therefore likely to be an underestimation. Witness exposure to suicide can self-perpetuate the Tasman Bridge’s reputation as a suicide location and increase the risk of further suicides.¹⁴

¹¹ McTaggart, 10.

¹² Provided by Tasmania Police on 27 November 2024. Data sourced from ESCAD/CACS for reports between 1 January 2016 to 30 June 2024.

¹³ Florentine and Crane, 1629.

¹⁴ Too et al., 7.

7. Suicide prevention at the Tasman Bridge

In November 2016, Chief Coroner Olivia McTaggart made 7 recommendations to prevent suicides at the Tasman Bridge following a high number of suicide deaths from the location in 2015. The Tasman Bridge Cross Agency Working Group recently reconvened to review the progress of the coronial recommendations.¹⁵ Responses to the recommendations are outlined in the Appendix. Progress noted included enhanced camera surveillance system, reporting of suicide-related incidents at the Tasman Bridge, establishment of the TSR, monitoring of crisis telephones and signages, and ongoing operations of the working group. Measures such as camera surveillance, police data and the TSR are important for investigation and reporting purposes. As noted in the findings, however, while it may be possible, they are less likely to directly prevent suicide deaths.¹⁶

Findings in this report further emphasise the immediate need for structural intervention through the installation of a safety barrier. Following the inquest, the coroner first recommended that:

“1...the government formulates a plan for the implementation of structural modifications to the Tasman Bridge... having a key aim of eliminating the Tasman Bridge as a method of suicide.”¹⁷

While the recommendation on structural modifications is marked as complete, the Tasmanian Government’s implementation of structural modifications on the Tasman Bridge is ongoing. In June 2022, the government released concept designs for major upgrades on the Tasman Bridge, including providing 3.5 m pathways and heightened safety barriers to enhance cyclist and pedestrian access and safety.¹⁸ The construction work intended to commence in the 2022-2023 financial year, with expected completion by 2025.¹⁹

In September 2024, Tasmanian Premier Jeremy Rockcliff announced changes to the original proposal of the pathway improvements on the Tasman Bridge:

“Detailed engineering reports have found that 3.5 metre-wide pathways cannot

¹⁵ Chaired by the Chief Psychiatrist with members include representatives from the Department of Health, Department of State Growth, Tasmania Police, Lifeline Tasmania and Magistrates Court of Tasmania – Coronial Division.

¹⁶ McTaggart, 15; The effectiveness of crisis telephones on the Tasman Bridge have not been assessed.

¹⁷ McTaggart, 22.

¹⁸ “Designs released for \$130m upgrade of Hobart’s Tasman Bridge”, *ABC News*, 27 June 2022, <https://www.abc.net.au/news/2022-06-27/designs-released-for-130m-upgrade-of-hobarts-tasman-bridge/101186566>, accessed 3 February 2025.

¹⁹ O McTaggart, *Findings and comments into the death of Saeed Hassanloo*, Magistrates Court of Tasmania, 2022 TASCDC 105, https://www.magistratescourt.tas.gov.au/_data/assets/pdf_file/0006/651921/Hassanloo.-Saeed-2022-TASCDC-105.pdf, accessed 20 January 2025.

be installed along the full length of the bridge without significantly modifying its structure, which would cost far more than the project's budget... The Government will proceed with a three metre-high safety barrier on the water side and a 1.4 metre-high roadside barrier over the length of the bridge without compromising its structural integrity.”²⁰

The changes also include an updated timeline:

“The Tasmanian Government will commence consultation on the proposed pathway upgrades by the end of 2024, ahead of pathways connections and higher barriers being installed in 2025.”

The project is currently expected to be completed by late 2026, with an estimated cost of \$130 million as equally funded by the Australian and Tasmanian governments.²¹

Despite the high costs and engineering challenges associated with implementing structural intervention, restricting access to means is an effective public health measure in reducing suicides, particularly when a method is common and accessible.²² Structural interventions such as installing safety barriers is considered best practice to safeguard high-risk locations by limiting a person's physical access to jump from a height. A meta-analysis from various jumping sites around the world found an 86% reduction of suicides following barrier installation.²³ Safety barriers are also commonly implemented with other measures such as camera surveillance, signages and crisis phones. These strategies can eliminate a known and available method for people who are experiencing a crisis and provide opportunity for help-seeking and third-party intervention.²⁴

The effectiveness of safety barriers in reducing suicides have been reported at high-risk bridges across Australia. In Queensland, the number of suicides from the Story Bridge have reduced since barriers were installed in 2015.²⁵ Suicides were also declining at the site since 2012 following the installation of Lifeline phones, signs and

²⁰ J Rockcliff, Premier of Tasmania, *Making the Tasman Bridge Safer*, 23 September 2024, <https://www.premier.tas.gov.au/latest-news/2024/september/making-the-tasman-bridge-safer>, accessed 3 February 2025.

²¹ Tasmanian Government Department of State Growth, *Tasman Bridge Pathways Upgrade*, September 2024, https://www.transport.tas.gov.au/roadworks/current_projects/south_road_projects/tasman_bridge_pathways_upgrade; Australian Government Department of Infrastructure, Transport, Regional Development, Communications and the Arts, *Tasman Bridge Update*, 11 February 2024, <https://investment.infrastructure.gov.au/projects/110461-20tas-np>, accessed 3 February 2025.

²² K Hawton, D Knipe and J Pirkis, e796.

²³ J Pirkis et al., “The effectiveness of structural interventions at suicide hotspots: A meta-analysis”, *International Journal of Epidemiology*, vol 42, 2013, 541-548.

²⁴ K Hawton, D Knipe and J Pirkis, e797.

²⁵ K Kolves, S Leske and D De Leo, “From suicide surveillance to restricting access to means: A time series study of suicide prevention at the Story Bridge”, *Australian & New Zealand Journal of Psychiatry*, vol 57(8), 1184-1186.

surveillance cameras. However, a substitution effect to other surrounding jumping locations was noted as possible.

In Victoria, no suicides have been reported from the West Gate Bridge – once a well-known suicide location – since barriers were installed in 2011.²⁶ The barrier's effectiveness in eliminating suicides was attributed to its characteristics, including being more than 3 metres high and secured across the entire length of the bridge. The barrier also prevents climbing as it is cantilevered, has horizontal mesh, and offers no handholds for climbing. Additionally, there was no evidence of displacement to other similar sites, and there was an overall reduction of suicides from other bridges in the state. It is suggested that the elimination of West Gate Bridge as a suicide location may have reduced the cognitive availability of jumping from height as a suicide method in Victoria.

A recent economic analysis further indicated that barrier installation at high-risk bridge sites across Australia is a cost-effective intervention, saving an estimated US\$145 million in prevented suicides over 5 years and US\$270 million in over 10 years.²⁷

²⁶ J Dwyer et al., 3.

²⁷ P Bandara et al., "Cost-effectiveness of installing barriers and cliff sites for suicide prevention in Australia", *Jama Network Open*, vol 5(4), e226019, 2022, 1-11.

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Appendix

Progress update on 2016 coronial recommendations, Tasman Bridge Cross-Agency Working Group 17 October 2024 & 13 February 2025

Recommendation	Status	Comments
1. I recommend that the government formulates a plan for the implementation of structural modifications to the Tasman Bridge, such structural modifications having a key aim of eliminating the Tasman Bridge as a method of suicide.	Completed	Addressed by the Department of State Growth (DSG) as part of the Tasman Bridge Redevelopment project.
2. I recommend that the Department of State Growth install additional and enhanced camera surveillance on the Tasman Bridge to provide improved quality footage and Completed coverage of all pedestrian areas.	Completed	DSG informed that there is good coverage. DSG is engaged with police and adjustments have been made to ensure that there are no blind spots.
3. I recommend that Tasmania Police continues the operation with respect to the reporting of incidents involving suicide, attempted suicide or persons in crisis on the Tasman Bridge, and further, Tasmania Police review the accuracy of the current reporting and implement any necessary measures to reinforce to police officers the requirement for Completed and accurate reporting of such incidents.	Completed	Tasmania Police advised that the required data has been captured. The Police Academy training continuum is capturing the data in line with this recommendation.

Recommendation	Status	Comments
4. I recommend that the government continue its commitment as expressed in the Tasmanian Suicide Prevention Strategy to pursue the development of a Tasmania Suicide Register, so as to accurately inform suicide prevention strategies, including strategies for suicide prevention at the Tasman Bridge.	Completed	The suicide register is up and running and managed by the Coroner's Office. The committee to continue to receive further updates.
5. I recommend that the Department of Health and Human Services implement a system for the ongoing monitoring of the use of the telephones and signage on the Tasman Bridge, assess the efficacy of those telephones and that signage at regular intervals and report results to the relevant ministers and the cross agency working group.	Completed	The Department of Health confirmed that the funding agreement with Lifeline Australia is in place until 30 June 2025 and will be most likely renewed. As part of the funding agreement, Lifeline Australia does 6 monthly reporting on the data they collect which has been shared with the Office of the Chief Psychiatrist.
6. I recommend that the cross agency working group continues to operate in accordance with its terms of reference as a principle source of advice to government regarding suicide prevention at the Tasman Bridge.	Completed	
7. I recommend that the cross agency working group considers these findings, comments and recommendations in executing its functions in accordance with its terms of reference.	Completed	