MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Rod Chandler, Coroner, having investigated the death of Braiden Tyler Dick

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

a) The identity of the deceased is Braiden Tyler Dick;
b) Braiden was born in Latrobe on 20 March 1999 and was aged 18 years;
c) Braiden died on 17 July 2017 at Miandetta, Tasmania; and
d) The cause of Braiden's death was asphyxia due to hanging.

Background

Braiden lived alone in a unit at Miandetta. His girlfriend of 12 months was Melody Vassalo. He had an extensive mental health history extending back to his primary school days when he was noted to draw images of death and was referred to Child and Adolescent Mental Health Services. There were incidents of self-harming in his early high school years and in 2011 he was diagnosed with depression. In 2013 there were instances of bizarre behaviour, mood swings, insomnia and disengagement from others. Near the end of that year he was diagnosed with schizophrenia and bipolar disorder. There was an incident in August 2015 involving an attempted assault upon his mother which led to his admission to Spencer Clinic, the psychiatric unit at the North West Regional Hospital. The following year he was taken to the same hospital by police after threatening to hang himself at home.

In around mid-2016 Braiden met Melody and shortly afterwards they began dating. In the months following, Braiden's mother considered that her son was *"happier and enjoying life"* although *"he still had his moments."*

Circumstances Surrounding the Death

Between 5.00 and 6.00pm on 16 July 2017 Melody was at Braiden's unit when he informed her that he was ending their relationship. Melody left but later that evening attempted to make contact with Braiden via Facebook Messenger. He did not respond. She also tried to phone him on the land line but he did not pick up.

The next morning Melody had concerns for Braiden when he had not contacted her. Her mother drove her to Braiden's unit. He was not inside the residence. She then

entered the garage and observed Braiden suspended on a rope from a beam. He was clearly deceased.

Officers of Tasmania Police attended. They were satisfied that no suspicious circumstances attached to the death.

Post-Mortem Examination

This was carried out by pathologist, Dr Ruchira Fernando. An associated toxicology test revealed the presence of MDMA (also known as ecstasy) and benzoylecgonine, a major metabolite of cocaine. Dr Fernando confirmed the cause of death to be asphyxia by hanging.

Findings, Comments and Recommendations

Sadly, Braiden's death is another instance where a young person has prematurely ended his own life. I am not able to identify with certainty the factor or factors which induced Braiden to intentionally take this step. However, it is clear that his death occurred upon a background of mental health difficulties which may have adversely impacted upon his good judgement.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Braiden's family and loved ones.

Dated: 7th day of September 2018 at Hobart in the State of Tasmania.

Rod Chandler
Coroner