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, family, friends, and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of BK

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

a) The identity of the deceased is BK.

b) BK was born on 17 July 2003 and was aged 18 years at his death. He was one of four children of ER and JN. He lived with his parents in Hobart, was a grade 12 college student and was employed part-time in a bakery. He was single at the time of his death and was in good health physically. He was loved by his family and many others, and was described in the evidence as caring, intelligent and funny. He was artistic and had several hobbies and interests. In May 2021, BK attended his general practitioner reporting that, for a period of about two months, he had been feeling down, lacking in energy and had difficulty concentrating. He said he did not have suicidal thoughts, although the doctor provided him with advice for "safety net" contact with Lifeline, friends, family, teachers and return to the doctor in the event that he did have such thoughts. At that time, the doctor prescribed him anti-depressant medication. When BK returned to the doctor on 20 July 2021, a mental health plan was developed for him. The dose of his medication was increased and he was referred to a psychologist. The psychologist's appointment did not eventuate before his death. On 7 September 2021, BK returned to his doctor and said that he felt more awake and more focused, although still low in mood and irritable. He did not have thoughts of self-harm and his doctor noted that he was significantly improved. It appears that the study load and pressure of grade 12 caused BK's stress and triggered his low mood. The school staff were concerned about his disengagement from school and helped him to re-engage. BK was a social

drinker and smoker. There is no evidence to suggest that he used illicit substances.

On the evening of 10 September 2021, the day before his death, BK attended a party at which he consumed a high quantity of alcohol. He had become particularly fond of the woman hosting the party and he made some advances towards her in his intoxicated state. The woman repeatedly indicated that she did not consent to his advances. Later in the evening, he was found by the mother of that woman to be passed out in the laundry in an intoxicated state. She drove him home and was able to converse with him on the journey.

The following day, being Saturday 11 September 2021, BK awoke at about 10.00am and was reported by his mother to be alert and happy. He went to work at the bakery and then to eat at McDonald's with family members in the afternoon. He spent time in his bedroom in the late afternoon and messaged the female from the party to apologise for his behaviour. It seems upon the evidence that BK considered that he had sexually assaulted the woman and became extremely upset that he had conducted himself in this manner. At 7.44pm BK called another friend and was irrational, crying and hyperventilating. He said that he was upset because he believed he had sexually assaulted someone. It is unclear where BK was when this discussion occurred but, at an unknown time, he left the house in his car without his family members knowing.

At 8.01pm BK drove to the crest of the Tasman Bridge where he stopped his vehicle and alighted from the driver's door. He then climbed both sets of rails (inner and outer rails) and launched himself off the bridge into the water. Four eyewitnesses saw him jump but they were unable to reach BK in time. BK's body was recovered by police and a full police investigation into the circumstances of his death took place. No suicide note was located and there were no suspicious circumstances. I am satisfied that BK suffered from depression and his decision to end his life was likely triggered by his guilt over his actions at the party. The consumption of a large amount of alcohol the previous evening may have exacerbated his depressed state of mind.

c) The cause of death was blunt trauma and drowning.

d) BK died on 11 September 2021 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- An opinion of the forensic pathologist regarding cause of death;
- Toxicology report of Forensic Science Service Tasmania;
- Affidavits confirming life extinct and identification;
- Medical records from Hopkins Street Medical and the Lindisfarne Clinic;
- Affidavits of ER and JN father and mother of BK;
- Affidavit of FG, who spoke to BK before his death;
- Affidavit of OU, the host of the party and friend of BK;
- Affidavit of AX, mother of OU;
- Affidavits of CJ, TD, HM and VW – witnesses on the Tasman Bridge;
- Affidavits of six attending and investigating police officers, including photographs;
- Medical review by Dr Anthony Bell, coronial medical consultant; and
- CCTV footage from the Tasman Bridge.

Comments and Recommendations

Most tragically, BK decided to end his life by jumping from the Tasman Bridge. There was no warning to those close to him that he intended to do so. I am satisfied, based upon the medical review by the independent coronial medical consultant, that he was treated and monitored appropriately by his doctor for his emerging depressive condition. At the time of his last consultation, the indications were that his mental health had improved. Further, BK did not reveal to any staff members at his school the nature or extent of his mental health issues and did not mention that he had suicidal thoughts. BK did not see the school counsellor, although school staff had had many discussions with him during the year to help him to re-engage in his schooling. The school staff did not have information about BK's condition that would have alerted them to his potential risk. BK maintained to his doctor in the months before his death that he did not have suicidal thoughts. It is quite plausible that this was correct and that he only decided to end his life in the day or hours before his death.

In November 2016, I handed down findings in *Deaths from a Public Place* 2016 TASCD 385-390 involving six suicides from the Tasman Bridge. In those findings, I observed that the current outer railing of the bridge is 1.59 metres in height. This is relatively easy to scale and provides a direct drop into the river at a height that will almost always cause death. BK was able to scale the railing quickly and without great difficulty. He did so despite a well-intentioned motorist alighting from his car, pleading with him not to jump and trying to catch up with him to restrain him.

It is difficult to say whether, had BK not been able to end his life on the Tasman Bridge, he would have done so using other means. Research indicates that, on many occasions, there is

no substitution of means of suicide. In BK's case, it appears that his decision was impulsive and the product of a distressed and irrational state of mind. If he had not had easy access to the bridge as a means of suicide, there may have been a chance of him receiving support or assistance to reducing or eliminate his suicide risk at that time.

In my 2016 findings, I recommended that the government formulate 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.

In my finding of *Hassanloo, Saeed 2022 TASCD 105,* I commented that both state and federal funding had been allocated to commence the project of widening the pathways and increasing the height of the barriers on the Tasman Bridge. The project has now undergone community consultation, the results reinforcing the community's desire that there be non-climbable barriers on the bridge. The full project is expected to be complete by late 2025. [1]

The circumstances of BK's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

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

Dated: 31 July 2023 at Hobart in the State of Tasmania.

Olivia McTaggart

Coroner

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[1] https://www.transport.tas.gov.au/projectsplanning/road_projects/south_road_projects/tasman_bridge_pathways_upgrade

https://www.transport.tas.gov.au/__data/assets/pdf_file/0009/406647/Tasman_Bridge_Pathways_Upgrade_Consultation_Summary_Report.pdf