JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	BRENDYN DEAN NELSON, CORONER
HEARD	**:**	22 AND 23 APRIL 2026
DELIVERED	**:**	27 MAY 2026
FILE NO/S	**:**	CORC 23 of 2024
DECEASED	**:**	QUITERIO, MARTIN CARL

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)

Mental Health Act 2014 (WA)

Counsel Appearing:

Ms E Lynch and Mr G Chin assisted the Coroner

Ms P Femia, instructed by Ms J Tower and Ms J Symons (State Solicitor's Office) appeared on behalf of the Department of Health, the East Metropolitan Health Service and the North Metropolitan Health Service

Ms K Reynolds, instructed by Ms E Dobson (Gilchrist Connell) appeared on behalf of St John of God Health Care

Mr E Panetta (Panetta McGrath) appeared on behalf of Dr Zaven Boyadjian

Mr P Mariotto (Barry Nilsson) appeared on behalf of Mr Trent Langer

Cases referred to in decision:

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Brendyn Dean Nelson, Coroner, having investigated the death of ***Martin Carl QUITERIO*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 22 and 23 April 2026, find that the identity of the deceased person was* ***Martin Carl QUITERIO*** *and that death occurred* ***on 3 January 2024*** *at* ***16 Mayfair Street, West Perth****, from* ***multiple injuries*** *in the following circumstances:*

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Introduction

1 Martin Carl Quiterio died on 3 January 2024 from injuries he sustained after jumping from a car park building in West Perth. He was 59 years old.

2 Martin[1] had a long history of treatment for his mental health, including multiple hospital admissions as an involuntary patient.

3 His last inpatient admission prior to his death was at Sir Charles Gairdner Hospital (**SCGH**), in the Mental Health Unit (**MHU**). He was discharged from SCGH on 28 December 2023.

4 At discharge, Martin was made the subject of a community treatment order (**CTO**) under the *Mental Health Act 2014* (WA), to be managed by the City East Community Mental Health Service (**CECMHS**).

5 The CTO was an involuntary treatment order[2] which remained in place as at the date of Martin's death, and as a consequence:

(a) Martin was an involuntary patient under the *Mental Health Act* immediately prior to his death;[3]

(b) Martin was therefore a 'person held in care' within the definition of that term in the *Coroners Act 1996* (WA);[4] and

(c) an inquest was required to be held to investigate his death.[5]

6 I held the mandatory inquest on 22 and 23 April 2026.

7 In addition to making findings as to Martin's cause and manner of death, if possible,[6] I am required to comment on the quality of the supervision, treatment, and care that Martin received whilst subject to the CTO.[7]

8 I may also comment on any matter connected with Martin's death, including public health or safety or the administration of justice.[8]

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[1] Martin's family requested that he be referred to by his first name at the inquest, and in these findings.
[2] *Mental Health Act* s 21(2)(b).
[3] *Mental Health Act* s 21(1).
[4] *Coroners Act* s 3.
[5] *Coroners Act* s 22(1)(a).
[6] *Coroners Act* s 25.
[7] *Coroners Act* s 25(3).
[8] *Coroners Act* s 25(2).

Involvement of Martin's family

9 It was clear from the evidence that Martin enjoyed the consistent support of his family in relation to his health and treatment.

10 The death of Martin's father in 2021 impacted him significantly, and there is ample evidence that Martin's mother and his brother sought to assist clinicians to provide Martin with the best care possible. It is a credit to his family that they continued those efforts during periods of time when Martin's illness and behaviour posed risks to their safety, and they were required to take measures to protect themselves accordingly. Martin's family explained that when he was well, he showed a gentle and caring side, especially to his mother. He had humour and warmth, and was a much-loved son and brother, who mattered deeply to his family.

11 The involvement of Martin's family in his treatment was reflected in their engagement with the coronial process.

12 I express my gratitude to Martin's brother for providing, prior to the inquest, a detailed and balanced statement of his recollections of Martin's treatment, particularly in 2023. Provision of this statement enabled the inquest to proceed in a fully informed and orderly way.

13 In his statement, Martin's brother acknowledged the efforts of mental health nurses particularly throughout 2023, including their support, communication, and professionalism. It may bring some comfort to Martin's family to know that every witness who appeared at the inquest expressed their condolences to Martin's family in relation to his death. It appeared to me that these expressions were, in part, the result of the regard in which Martin was held by those who treated and supported him.

Issues raised at the inquest

14 The inquest focused on the quality of the mental health care and other supports provided to Martin, particularly during 2023 and 2024, including:

(a) whether Martin was ever assessed for suspected autism spectrum disorder (**ASD**), including where formal assessment had been recommended upon Martin's discharge from St John of God Midland Hospital (**SJOG Midland**) in September 2023;

(b) whether any changes to the management of Martin's health should have occurred to address the suspected ASD, including the prospect that he had that condition in addition to a long-standing (and more recently, doubted) diagnosis of schizophrenia;

(c) whether there was any inconsistency in the approaches of the health services who treated Martin that materially impacted his treatment;

(d) whether Martin's treatment would have been improved by the continuity afforded by an admission to a transitional care unit;

(e) whether Martin's treatment would have benefited by clinicians having the ability to access a consultation and liaison service for treatment of existing patients who are suspected to also have ASD;

(f) the appropriateness of the decision to discharge Martin on the CTO in December 2023, including the quality of the discharge planning;

(g) the quality of CECMHS's management of Martin's mental health in December 2023 and January 2024;

(h) the quality of the services provided by Anchorpoint Support Coordination (**Anchorpoint**), Martin's support coordinator under his National Disability Insurance Scheme (**NDIS**) plan; and

(i) whether any of Martin's interactions with various people in the morning of 3 January 2024 (including his care coordinator at CECMHS, his support coordinator at Anchorpoint, and by telephone with the Mental Health Advocacy Service (**MHAS**)) warranted immediate escalation of his management.

15 In addition, the inquest also heard evidence about why the East Metropolitan Health Service (**EMHS**), did not undertake a Severity Assessment Code (**SAC**) 1 investigation into Martin's unexpected death, including where Martin had been seen by his CECMHS care coordinator earlier on the day of his death.

Materials received at the inquest

16 To address those matters, I received the documentary evidence in the coronial brief, two additional exhibits tendered during the inquest, and the following witnesses gave evidence:

(a) Dr Adam Stevens, a consultant psychiatrist who treated Martin at SJOG Midland and diagnosed Martin with ASD;

(b) Dr Zaven Boyadjian, a psychiatric registrar who treated Martin at SCGH and conducted Martin's medical review prior to his discharge;

(c) Mr Trent Langer, Martin's support coordinator at Anchorpoint in 2023 and 2024, who visited him on the morning of 3 January 2024;

(d) Mr Stevin Boban Joseph, Martin's care coordinator at CECMHS and case manager under his CTO, who also visited him on 3 January;

(e) Dr Adam Brett, an independent expert consultant psychiatrist who prepared a report to the Court in relation to Martin's mental health care, and gave his opinion about issues arising from his review;

(f) Dr Vinesh Gupta, the Acting Area Medical Director, Mental Health, for EMHS, who addressed questions concerning Martin's treatment by clinicians at Royal Perth Hospital (**RPH**) and CECMHS; and

(g) Dr Salam Hussain, the Acting Head of Clinical Service at SCGH's Mental Health Service, who addressed questions concerning Martin's treatment at SCGH and gave evidence in relation to matters concerning the North Metropolitan Health Service (**NMHS**).

Materials received after the inquest

17 On 1 May 2025, following the inquest, the Court provided proposed recommendations in draft form to the solicitors acting for EMHS, NMHS and the Department of Health, inviting any submissions. Responses were received from the solicitors for the Department of Health and EMHS.

18 The Court also received additional materials from the State Solicitor's Office on behalf of NMHS and EMHS in response to the Court's request at the conclusion of the oral evidence, relating to the SAC 1 investigation issue referred to at par [15] above. Those materials were made exhibits 5 to 11, inclusive.

Factual findings

19 In this part, I make factual findings about the circumstances leading up to and including Martin's death, including any findings necessary to make comment on the matters identified at par [14].

Martin's personal background

20 Martin was born in Kolkata, India, in 1964 before emigrating with his family to Australia in 1975.[9]

[9] Exhibit 1, tab 9, p 9.

21 As a child, he lived with his parents and his brother, although he did travel overseas to India with extended family for a period of time.

22 Issues with Martin's mental health were observable from childhood, and became progressively worse despite his parents' efforts.[10]

23 Martin experienced bullying in high school which caused him to, first, transfer to a new high school and then, withdraw from school entirely.[11]

24 After leaving school, he worked in a variety of roles, but was unable to maintain long-term employment due to frequently experiencing interpersonal issues with colleagues.

25 Before his death, Martin lived by himself in a unit in West Perth.

Initial diagnosis, previous hospitalisations, and GP treatment

26 Martin was first diagnosed with schizophrenia in Australia in around 1987/88, having received a diagnosis of paranoid schizophrenia while in India in about 1983.[12] He was first admitted to Royal Perth Hospital and then to the Heathcote Mental Health Hospital.

27 Martin's brother's recollection is that Martin remained at the latter hospital for a significant period of time following a major breakdown and after Martin had made threats directed towards their mother.[13]

28 Martin was again admitted to hospitals on a number of occasions in 1991 and 1992 after instances of violent outbursts and threats by Martin.[14]

29 Martin's general practitioner at the time of his death, Dr Jennifer Yeoman, first had contact with Martin in December 2008, having taken over his care from his previous, retiring GP.[15]

30 Dr Yeoman noted that Martin was seen regularly in the surgery, at home and in the community by a mental health nurse employed by the practice from 2011 to 2017 as part of the Mental Health Nurse Incentive Program, subsidised by the Commonwealth Government.[16]

[10] Exhibit 1, tab 9.3.
[11] Exhibit 1, tab 10.2, p 67.
[12] Exhibit 1, tab 9.3; tab 19.1.
[13] Exhibit 1, tab 19.1.
[14] Exhibit 1, tab 19.1.
[15] Exhibit 1, tab 9.11.
[16] Exhibit 1, tab 9.11.

31 When that program ceased, Martin was referred by his GP to a replacement service, before being referred to Inner City Mental Health Services, and otherwise maintaining regular GP review.[17]

32 Dr Yeoman considers that the therapeutic relationship between Martin and her practice deteriorated from about January 2023, after safety concerns expressed by Dr Yeoman to a clinician at RPH became known to Martin.

33 Martin was upset by those comments, and Dr Yeoman considered that from that time, Martin no longer trusted her or her GP practice.[18]

34 It is clear on the evidence that the death of Martin's father in September 2021 had a profound and lasting impact on him. It would appear that his father's death preceded a marked deterioration in Martin's health, and multiple hospital admissions and presentations to emergency departments.

35 It is unnecessary to set out a chronology of all of those treatment events.

36 These findings will, instead, focus on his healthcare from the beginning of 2023, including the following four, lengthy inpatient hospital admissions:

(a) a 50-day admission to RPH from 24 January to 14 March 2023;[19]

(b) a 57-day admission to RPH from 1 May to 26 June 2023;[20]

(c) a 20-day admission to SJOG Midland from 28 August to 14 September 2023; [21] and

(d) a 45-day admission to SCGH from 14 November to 28 December 2023.

37 As can be seen from the above, Martin spent over 170 days – almost half of the 2023 calendar year – in hospital, between mental health units.

First admission to RPH MHU in 2023

38 Martin was admitted to RPH on 24 January 2023.

[17] Exhibit 1, tab 9.11.
[18] Exhibit 1, tab 9.11.
[19] Exhibit 1, tab 10.1, p 10.
[20] Exhibit 1, tab 10.1, p 1.
[21] Exhibit 1, tab 9.12.

39 He was brought into hospital by ambulance after approaching police and expressing a sense of guilt in relation to information he believed he had that was relevant to high-profile criminal matters.[22]

40 He was accepting of admission for the purposes of assessment, diagnostic clarification, and support.[23]

41 Upon admission, Martin presented as over-inclusive and tangential, but not grossly thought-disordered or floridly psychotic.[24]

42 The clinical impression at intake included the possibilities of:

(a) atypical schizophrenia in relapse;

(b) underlying mood disorder with psychotic features; and

(c) a neurodevelopmental disorder such as ASD.[25]

43 Clinicians engaged at an early stage with Dr Yeoman, and Martin's family. His medication was reviewed and titrated from olanzapine to aripiprazole, which he tolerated well.[26]

44 His discharge plan involved continuation of his medication, and follow up with his GP and community mental health.

45 His discharge involved communication with his family,[27] as well as consultation with occupational therapy, social work, and physiotherapy.[28]

46 Upon discharge, his medications included 400mg of aripiprazole to be administered intramuscularly monthly.[29]

47 He was referred to the CECMHS's Assessment and Treatment Team (**ATT**), including for follow up regarding his depot injection.[30]

48 His discharge plan also included follow up with his GP.[31]

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[22] Exhibit 2, tab 4, par [22(c)].
[23] Exhibit 1, tab 10.1, p 11.
[24] Exhibit 1, tab 10.1, p 11.
[25] Exhibit 1, tab 10.1, p 12.
[26] Exhibit 1, tab 10.1, pp 12-13.
[27] Exhibit 2, tab 4, par [22(g)].
[28] Exhibit 1, tab 10.1, p 13.
[29] Exhibit 1, tab 10.1, p 14.
[30] Exhibit 1, tab 10.2, p 16.
[31] Exhibit 2, tab 4, par [22(h)].

Management by CECMHS ATT

49 The CECMHS ATT is the first point of contact for all referrals to that service. The team provides triage, assessment and short-term coordination and treatment for up to 10 weeks.[32]

50 Martin was triaged by a registered mental health nurse on 16 March 2023, at which time he expressed that he was in good spirits and willing to attend and engage with the clinic.[33]

51 During his assessment by the psychiatric registrar, Martin's fixation, and obsessiveness lead to querying his having neurocognitive spectrum disorder.[34]

52 The assessment expressly noted that it had been suggested that he had ASD or another neurodevelopmental disorder.[35]

53 The psychiatric registrar noted that Martin was very fixated on subjects and showed traits of ASD, and noted the impression '*?Schizophrenia vs ?Autism*.'[36]

54 The initial management plan involved continuation of his depot medication.[37]

55 The psychiatric registrar's notes also indicate that some consideration was given to the introduction of risperidone.[38]

56 It is unclear if this was raised as a possibility in order to treat the diagnosed schizophrenia or the symptoms of suspected ASD (or both).

57 In any event, there is no indication that consideration was given to progressing any form of assessment of Martin for ASD, or if it was considered, why it was not recommended at this time.

58 Although Martin was regularly followed up by the ATT, he was unhappy with the depot injection and its side effects and was expressing feelings of guilt about past behaviours.

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[32] Exhibit 2, tab 2, par [5(a)].
[33] Exhibit 1, tab 10.2, p 59.
[34] Exhibit 1, tab 10.2, p 63.
[35] Exhibit 1, tab 10.2, p 67.
[36] Exhibit 1, tab 10.2, p 69.
[37] Exhibit 1, tab 10.2, p 69.
[38] Exhibit 1, tab 10.2, p 69.

59 His distress and obsessive ruminations continued to escalate, and his family came to express their belief that he required hospitalisation again.[39]

Second admission to RPH MHU in 2023

60 Martin was admitted to RPH again on 1 May 2023.

61 He was brought to the hospital by staff from CECMHS due to concerns about his declining mental state.[40]

62 A care transfer summary refers to '*possible autism spectrum*' and Martin displaying '*autistic traits*' including fixation on certain subjects.[41]

63 During assessment, his long-established diagnosis of paranoid schizophrenia was noted as now being in question, and he exhibited depression and, possibly, ASD. He was assessed to be ruminating on thoughts and expressing paranoid and persecutory thoughts.[42]

64 Martin was assessed as being delusional, but not seen to be responding to unseen stimuli and was considered 'chronically elevated.'[43]

65 Again, there is no evidence that consideration was given to how any suspected diagnosis of ASD might be formalised, including following discharge, or why pursuing such a diagnosis may not be of assistance.

66 During the admission, social workers had meetings with Martin's mother and brother, during which they explained that on Mother's Day, Martin had a day of leave from hospital and had become physical with both of them at his mother's home and at one point, had grabbed a knife.[44]

67 According to his brother, Martin became distressed and abusive to a level they had not previously experienced, and they were unable to calm him. Martin's brother called the hospital ward, and at the recommendation of the nurse, called police, who attended.[45]

[39] Exhibit 1, tab 10.2, p 54.
[40] Exhibit 2, tab 4, par [24(b)].
[41] Exhibit 1, tab 10.1, p 8.
[42] Exhibit 1, tab 10.2, p 57.
[43] Exhibit 2, tab 4, par [24(c)].
[44] Exhibit 1, tab 10.2, p 10.
[45] Exhibit 1, tab 19, p 2.

68 Following this incident, health staff liaised with police to ensure that alerts was placed with police to ensure Martin's mother's and brother's safety.[46]

69 The plan on discharge included referral back to the CECMHS and engagement with a recovery coach to assist in Martin's engagement with his family.[47]

70 Martin was discharged on various medications including oral paliperidone and olanzapine, with an expectation that he would attend for a monthly depot injection.[48]

71 At discharge, Martin's brother expressed concern that Martin was speaking in a manner similar to the way he was speaking prior to his admission. Clinicians advised Martin's brother that this was his baseline.[49]

72 The discharge planning also included a safety plan by which Martin was not to attend his family home but could meet with his mother in public with a support worker present.[50]

73 According to his brother, this arrangement with Martin did not last.[51] Mr Boban Joseph corroborates this.[52]

Approval of new NDIS Plan

74 On 28 June 2023, Martin was advised that his new NDIS plan had been approved, starting on that date.[53]

75 The plan involved funding for core supports totalling approximately $80,000 over two years, and $24,000 for capacity building.

76 Martin was referred to Anchorpoint for support coordination in July 2023.[54]

77 The role of a support coordinator is to assist participants to understand and implement the supports funded within their NDIS plan. Support coordinators do not provide clinical treatment or crisis response services.

[46] Exhibit 1, tab 10.2, pp 10-11.
[47] Exhibit 1, tab 10.1, p 3.
[48] Exhibit 2, tab 4, par [25(f)].
[49] Exhibit 1, tab 10.1, p 4.
[50] Exhibit 2, tab 4 par [25(b)].
[51] Exhibit 1, tab 19.1, p 2.
[52] Exhibit 2, tab 2, par [27].
[53] Exhibit 1, tab 15.
[54] Exhibit 1, tab 18, p 3.

78 In Martin's case, support coordination involved communicating with the National Disability Insurance Agency (**NDIA**) and health providers including CECMHS.[55]

79 Given the complexity and risk profile identified by Anchorpoint, Mr Langer was allocated to manage and coordinate Martin's supports.[56]

80 Mr Langer's extensive work experience included social work and disability services, including specialist support coordination.[57]

81 I interpose that in around October and November 2023, Mr Langer formed the view (based on Martin's diagnosis and complexities) that the funds in Martin's existing NDIS plan were 'dramatically insufficient'.[58]

82 To address that concern, Mr Langer initially sought a 'Section 100 review'[59] and, following discussion with the NDIA, a change of circumstance review was requested instead.

83 A plan reassessment meeting was scheduled for 12 January 2024 to review Martin's needs.[60]

84 The intent of the 'Section 100 review' request had been to seek additional coordination and supports that would better reflect the complexity of Martin's circumstances and level of coordination required across services.

85 The change of circumstance application sought, amongst others, to provide an opportunity for Martin and those involved in his care to discuss and plan support to, amongst others, pursue reemployment and set goals for participation in the community.[61]

Management by CECMHS CTT

86 Martin was transferred by the ATT to the CECMHS's Clinical Treatment Team (**CTT**) in May, during his second admission at RPH.[62]

[55] Exhibit 1, tab 18, p 2.
[56] Exhibit 1, tab 18, p 3.
[57] Exhibit 2, tab 7, par [5].
[58] Exhibit 2, tab 7, par [15].
[59] See exhibit 1, tab 18.3.
[60] Exhibit 1, tab 18, p 3.
[61] Exhibit 1, tab 18, p 5.
[62] Exhibit 2, tab 2, pars [16], [19].

87 The CTT provides mental health assessment and care coordination for clients who require specialist care and treatment for more than 10 weeks.[63]

88 The CTT is a multidisciplinary team that includes psychiatrists, nurses, social workers, occupational therapists, and psychologists.[64]

89 Mr Boban Joseph, a registered mental health nurse, was Martin's allocated care coordinator within the CTT.

90 His role involved:

(a) coordinating supports;

(b) maintaining contact with Martin to monitor his mental state;

(c) liaising with other services involved in Martin's care;

(d) liaising with Martin's family; and

(e) prompting Martin's engagement with the clinic including for psychiatric review.[65]

91 Mr Boban Joseph first had contact with Martin on 1 June 2023 while he remained an in-patient at RPH, in order to conduct an assessment.[66]

92 At that time, consideration was being given to a transfer of Martin to a Rehabilitation and Recovery Unit.[67]

93 This did not progress further due to concerns about Martin's level of risk at such a unit, particularly given the incident on Mother's Day.[68]

94 Following his discharge from hospital, Mr Boban Joseph coordinated Martin's care including while he was in the community.

95 Mr Boban Joseph liaised with Mr Langer to establish and maintain a support structure, and sought to ensure that Martin was medically managed and assessed. He also visited Martin and had family meetings with his brother and mother.[69]

[63] Exhibit 2, tab 2, par [5(b)].
[64] Exhibit 2, tab 2, par [10].
[65] Exhibit 2, tab 2, par [18].
[66] Exhibit 2, tab 2, par [20].
[67] Exhibit 2, tab 2, par [21].
[68] Exhibit 1, tab 10.2, pp 12-13.
[69] Exhibit 2, tab 2, pars [23]-[24].

96 Mr Boban Joseph stated that during this time, he held increasing concerns about Martin's impulsivity, and was concerned that he was at risk of harming himself due to misadventure or due to an impulsive decision.[70]

97 Mr Boban Joseph conducted face-to-face home visits during this time, during which Martin reported that he was compliant with medications, including by producing Webster packs.[71]

98 Mr Boban Joseph also liaised with Dr Yeoman about Martin's care.[72]

99 Dr Gahan, of CECMHS, reviewed Martin on 16 August 2023. Martin reported good adherence to medication and denied missing any doses.

100 Dr Gahan's plan was for the medication regime to continue, with follow up by Mr Boban Joseph (in addition to some other routine testing).[73]

101 Mr Boban Joseph visited Martin on 21 August 2023, and noted what he considered to be indications of relapse.[74]

102 On 24 August 2023, Martin was referred by WA Police to RPH for an assessment of possible psychosis. He admitted to having suicidal thoughts but no current suicidal ideation.

103 He was offered an admission to hospital but declined, saying that he felt safe to go home.[75]

Admission to SJOG Midland MHU

104 Martin was assessed by CECMHS the following day, during which he expressed feelings of guilt, hopelessness, and entrapment.

105 He reported plans to self-harm, and intention to act on the same.

106 He became agreeable to attending the RPH Emergency Department for a psychiatric assessment.[76]

[70] Exhibit 2, tab 2, par [25]-[26].
[71] See, e.g., exhibit 1, tab 10.2, p 93.
[72] Exhibit 2, tab 10.2, p 94.
[73] Exhibit, 1 tab 10.2, pp 96-97.
[74] Exhibit 1, tab 10.2, p 98.
[75] Exhibit 1, tab 10.2, pp 47-48.
[76] Exhibit 11.2, p 1; tab 10.2, pp 106-107.

107 He was referred to SJOG Midland due to a shortage of beds in RPH's MHU.[77]

108 Martin was assessed at SJOG Midland on 25 August 2023, with acute risk to his self, and suicidal planning and intent. He was reviewed by a consultant on 26 August 2023, who queried if Martin's behaviours were psychotically driven.[78]

109 It was noted at that time that Martin's presentation continued to appear like a relapse of schizophrenia, including expression of a range of paranoid thoughts regarding his phone and laptop. It was noted that his misreading of multiple social cues and the level of rigidity in his thinking raised the possibility of his thoughts and behaviours being consistent with an undiagnosed neurodevelopment disorder.[79]

110 Dr Stevens, having returned to work during the course of Martin's admission at SJOG Midland, took carriage of Martin's care, and following review, formed the opinion that Martin's diagnosis was ASD and not schizophrenia.[80]

111 In his report, Dr Brett expressed some doubt about the ASD diagnosis.[81]

112 As I identified during the course of the inquest, it is unnecessary for me to reach any concluded view (even if I were capable of doing so) of the comparative 'correctness' of Dr Stevens' diagnosis of ASD as against the diagnoses of schizophrenia by other clinicians, including subsequently during Martin's admission at SCGH.

113 The reason I reach that conclusion is that I accept that the change in diagnosis from schizophrenia to ASD by SJOG Midland, and back to schizophrenia at SCGH, did not materially alter Martin's treatment particularly in terms of medication and managing psychosis.[82]

114 The changes may have informed Martin's care in the community.

[77] Exhibit 3, p 1.
[78] Exhibit 1, tab 11.1, p 3.
[79] Exhibit 1, tab 11.1, p 3.
[80] Ts 94.
[81] Exhibit 1, tab 16, p 11, pars [4]-[5].
[82] Exhibit 3, p 2; exhibit 2, tab 4, pars [66], [75].

115 I will return, below, to the question as to whether formal confirmation of the ASD diagnosis might have enabled Martin to access greater supports through any revised NDIS Plan.

116 In any event, there is insufficient evidence to persuade me that either diagnosis is necessarily correct to the exclusion of the other, or to exclude the possibility that Martin had both schizophrenia and ASD.

117 As noted by Dr Brett, the conditions may co-occur, and commonly do.[83]

118 I do, however, accept Dr Brett's opinion that any change to Martin's long-standing diagnosis of schizophrenia must have been a source of some stress and potential confusion to Martin.[84]

119 During a review at SJOG Midland on 6 September, Martin was informed of his diagnosis of ASD. Martin was dismissive of the diagnosis on that occasion.

120 During a meeting with Mr Boban Joseph on 7 September, he was indifferent about the ASD diagnosis.[85]

121 However, during a review with a consultant on 14 September, Martin was accepting of the explanation that his presentation appeared to be in the context of ASD rather than schizophrenia.

122 In terms of treatment, his olanzapine was ceased and cross-titration with intramuscular haloperidol was commenced.[86] A haloperidol depot was considered to be efficacious for the behavioural symptoms of ASD,[87] and is also effective for treating the positive symptoms of schizophrenia.

123 At discharge, Martin was to continue on the haloperidol depot injection, and it was suggested that in the absence of robust evidence, the historical diagnosis of schizophrenia could be redacted.[88]

124 During the inquest, it became apparent that there was an issue, and potentially a lack of shared understanding at the time of discharge, about how a recommendation by SJOG Midland regarding a formal neuropsychologist assessment for ASD should be actioned.

[83] Exhibit 1, tab 16, par [14].
[84] Exhibit 1, tab 16, par [8].
[85] Exhibit 1, tab 10.2, p 119.
[86] Exhibit 1, tab 11, p 4.
[87] Exhibit 1, tab 11, p 5.
[88] Exhibit 1, tab 11, p 6.

125 The SJOG discharge summary contains a clear recommendation that Martin be the subject of a formal neuropsychological assessment to confirm a diagnosis of ASD, including for the purposes of an application for additional support through the NDIS.[89]

126 At the inquest, Dr Stevens explained that a referral was made on 1 September 2023 to an inpatient service at SJOG Midland for such an assessment to occur,[90] but that this had not been able to be undertaken by the time Martin was ready for discharge from hospital.[91]

127 Martin was encouraged to remain in hospital for the purpose of the assessment, but was unwilling to stay in hospital and wanted to go home. Dr Stevens considered that there was no basis, at that time, to detain Martin at the hospital on the grounds of his mental health where he was actively seeking to be discharged.[92]

128 There was a discussion with Martin's family about a neuropsychology assessment to further assess the ASD diagnosis,[93] and Mr Boban Joseph[94] and Mr Langer[95] both have some recollection of an assessment being discussed prior to Martin's discharge.

129 However, the evidence suggests that there was no clear, shared understanding about who would take carriage of ensuring such a referral was made, given the inpatient referral was going to lapse upon Martin's discharge (including where he was from outside the catchment).[96]

130 Mr Boban Joseph's file notes record such an assessment being raised with him on 1 September 2023.[97] Given the timing, it is clear that this file note relates to the inpatient neuropsychological assessment.

131 As such, it would have been reasonable for Mr Boban Joseph to infer, at least at that time, that the referral was in hand and no further action was required. I have been unable to identify any file note concerning any specific discussion about a referral as an outpatient at a later date.

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[89] Exhibit 1, tab 11.1, p 6.
[90] Exhibit 1, tab 11.1., p 28; ts 103.
[91] Ts 104.
[92] Ts 106-107.
[93] Exhibit 1, tab 11, pp 4-5.
[94] Ts 59, 64.
[95] Ts 32, 36-37.
[96] Ts 104.
[97] Exhibit 1, tab 10.2, p 116.

132 I note that while the lack of a clear understanding was unfortunate, it is potentially symptomatic of the issue raised by Dr Brett, to which I will return, about the gaps in the availability of public health services for diagnosis and treatment of ASD.[98]

133 Further, it cannot be said with certainty that had a referral to an outpatient service been made (potentially by a clinician at CECMHS), that Martin would have attended and undergone such an assessment, given it is apparent that he came to doubt the ASD diagnosis,[99] and such an assessment would necessarily have had to be undertaken in the private health sector, at some cost.

134 Finally, even had a referral been made and an assessment undertaken and an ASD diagnosis confirmed, it is likely that, at most, the diagnosis would have formed part of the attempts by Anchorpoint to obtain additional supports for Martin under his NDIS plan.

135 I am not in a position to reach any concluded view about whether those attempts would have been successful.

136 Some of the clinicians who gave evidence at the inquest doubted the extent that the levels of support may have been increased,[100] although Dr Brett considers that it was likely.[101]

137 I note Dr Brett's opinion that the safety planning between the SJOG Midland social worker and family was excellent.[102] It was also clear from the evidence that Martin's discharge planning from SJOG Midland was cross-disciplinary and involved both his in-patient treating team and members of CECMHS, as well as others involved in Martin's care and support in the community, including Mr Langer.

Management by CECMH from September

138 Upon Martin's discharge from SJOG, Mr Boban Joseph had developed a comprehensive treatment support and discharge plan.[103]

139 Dr Gahan reviewed Martin on 3 October 2023, during which the plan discharge plan from SJOG Midland was noted.

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[98] Exhibit 1, tab 16, p 14, par [25].
[99] See, e.g. exhibit 1, tab 13, p 9.
[100] Exhibit 2, tab 4, par [74].
[101] Ts 76.
[102] Exhibit 1, tab 16, par [45].
[103] Exhibit 1, tab 10.2, pp 70-76.

140 Dr Gahan noted that Martin had several features consistent with a picture of neurocognitive disorder.[104]

141 Martin reported that his 'main issue' at the time was his recent commencement of haloperidol by depot and impression of ASD.

142 He was agreeable to taking oral haloperidol while remaining with the clinic, but was resistant to the information provided concerning ASD.[105]

143 Dr Gahan switched Martin from the depot to oral haloperidol, with a follow up in a months' time, and for Mr Boban Joseph to continue to monitor his mental state in the meantime.[106]

144 At the inquest, it was explained that the switch from the depot to the oral medication was, in effect, a trial of a less restrictive option in order to attempt to maintain Martin's engagement with the community service.[107]

145 Again, there is no evidence that consideration was given to any formal assessment for the purposes of confirming any ASD diagnosis.

146 I infer, given the deterioration in his mental state that ensued, that Martin's compliance with his oral medication was poor.

147 This was also Mr Boban Joseph's and Dr Gupta's impression.[108]

148 The deterioration included at least two occasions where Martin was taken to hospital in emergency circumstances.

149 On 19 September, CECMHS called WA Police after Martin attended a shop in the Perth CBD and expressed an intention to self-harm.

150 Mr Langer also contacted CECMHS and WA Police at this time to raise concerns about Martin's welfare, and to request a welfare check on the basis of statements that had been made to him by Martin.[109]

151 Martin was detained under the *Mental Health Act* and referred to RPH for examination on the basis of his distress and refusal to go to hospital.[110]

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[104] Exhibit 1, tab 13, p 10.
[105] Exhibit 1, tab 13, p 9.
[106] Exhibit 1, tab 13 p 10.
[107] Ts 51.
[108] Exhibit 2, tab 2, par [31]; tab 4, par [77].
[109] Exhibit 1, tab 10.2, p 1.
[110] Exhibit 1, tab 10.2, p 1.

152 On 1 November 2023, Martin presented to SCGH ED at 1.50 pm, having called WA Police advising that he was having thoughts of self-harm.

153 He denied the same at triage, although he did say his life was over.

154 He had a consultation with the psychiatric liaison nurse, and was discharged at 4.53 pm on 2 November 2023.[111]

Admission to SCGH MHU

Circumstances giving rise to the admission

155 On 13 November 2023, WA Police received a call from ambulance officers requesting assistance as Martin was armed with a knife and threatening self-harm. He had called emergency services earlier.

156 When police officers arrived, they observed Martin with a blood-drenched shirt, covering his abdomen. He was conveyed to hospital.[112]

157 Upon presentation to the SCGH ED, it was apparent that Martin had stabbed himself with a kitchen knife. The wounds were able to be sutured without further surgical intervention.

158 Martin advised that he was motivated by voices of his deceased father calling him worthless and telling him to stab himself.[113]

159 While in the ED, he jumped up and down on the bed, screaming that he was '*Muhammed Ali*,' before attempting to 'shadow box' a consultant.

160 This behaviour resulted in a code black, and Martin had to be restrained and sedated.[114]

161 He was subsequently admitted to the MHU.[115]

Management by treating team

162 Dr Boyadjian believes that Martin was referred to the MHU at SCGH as there were no beds available at SJOG Midland, and RPH's MHU was closed temporarily for refurbishment at the time.[116]

[111] Exhibit 1, tab 12.1, p 28.
[112] Exhibit 1, tab 9, p 9; tab 12.1, p 29.
[113] Exhibit 1, tab 12.1, p 6.
[114] Exhibit 1, tab 12.2, p 1.
[115] Exhibit 1, tab 12.1, p 29.
[116] Exhibit 2, tab 6, par [9], ts 10-11.

163 On his admission to the MHU at SCGH, Martin came under the management of Dr Ahmed Munib as the consulting psychiatrist in the MHU's Red Team.

164 The Red Team also included Dr Boyadjian, as well as an RMO.[117]

165 Dr Boyadjian noted that the reported auditory hallucinations telling Martin to self-harm were consistent with an exacerbation of his schizophrenia.[118]

166 Martin was closely supervised by nursing staff upon admission to the MHU, although the nursing ratio was reduced over time as Martin became more redirectable, which Dr Boyadjian attributed to the dosage of haloperidol on which he had been commenced in hospital (in both depot and oral form) reaching a therapeutic level.[119]

167 Between 16 November and 28 December 2023, the treating team reviewed Martin on at least 17 occasions.[120]

168 According to Dr Munib, Martin demonstrated compromised insight for decision-making about his mental health condition and the need for ongoing treatment.[121]

169 It is apparent that Dr Munib engaged with Martin about Martin's desire to cease haloperidol, with an agreement being reached to reduce the dosage of the depot medication.[122]

Family safety

170 During this admission, Martin expressed a desire to clinicians to return to live with his mother, but also an understanding that this was not a possibility, which he found upsetting.[123]

171 On 4 December 2023, Martin's brother, at the advice of clinicians and as recommended by Mr Boban Joseph,[124] took certain steps in order to protect the safety of Martin's mother and himself.[125]

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[117] Exhibit 2, tab 3, par [17].
[118] Exhibit 2, tab 6, par [12], ts 22.
[119] Exhibit 2, tab 6, par [13].
[120] Exhibit 2, tab 3, par [18].
[121] Exhibit 2, tab 3, par [27].
[122] Exhibit 1, tab 9.12.
[123] Exhibit 1, tab 9.12.
[124] Exhibit 1, tab 9.1, par [4].
[125] Exhibit 1, tab 9, pp 7 and 10.

172 Martin's brother felt badly about having to do so but, understandably, felt the need to preserve his safety and the safety of his and Martin's mother.[126]

173 Mr Boban Joseph placed significant emphasis on the safety of Martin's family in his dealings with Martin and with his mother and brother, and considered the steps taken by Martin's brother to be an important intervention to mitigate any risk.[127]

174 Mr Boban Joseph also, appropriately, escalated concerns to Martin's in-patient treating team when Martin made statements that indicated he might not abide by steps taken by others to mitigate risk.[128]

Involvement of CECMHS

175 As is evident from the above, Mr Boban Joseph maintained regular involvement with Martin's care and treatment during this in-patient admission. Mr Boban Joseph's involvement included multiple face-to-face meetings with Martin and with his inpatient treating team, and communicating with Martin's family.[129]

176 Mr Boban Jospeh participated in Martin's care planning and, in particular, advocated for the imposition of the CTO to support Martin's adherence to treatment following discharge, given his limited insight and demonstrated reluctance to engage in treatment voluntarily.[130]

Discharge planning

177 Martin's discharge from SCGH was considered at a multidisciplinary team meeting for the first time on 13 December 2023.

178 The meeting was attended by Dr Munib and other allied health workers, as well as Mr Boban Joseph and Mr Langer.

179 The team noted a significant improvement in Martin's mental state, with greater insight and increased awareness about possible risk-taking behaviour.[131]

[126] Exhibit 1, tab 9.3, p 3.
[127] Exhibit 2, tab 2, par [33].
[128] Exhibit 2, tab 2, par [43].
[129] Exhibit 12, tab 2, par [32].
[130] Exhibit 2, tab 2, p 4.
[131] Exhibit 2, tab 2, par [56].

180 A provisional discharge date of 22 December 2023 was proposed, with a plan for the CTO to be implemented upon discharge.[132]

181 Mr Boban Joseph raised concerns expressed to him by Martin's brother regarding discharge close to, and prior to, Christmas.[133] The basis for these concerns included the reduced availability of supports in the community during that time of the year.

182 The team agreed to liaise with Martin's family about these concerns.[134]

183 Following Mr Boban Joseph's advocacy on behalf of Martin's brother, the treating team revised the discharge plan, and extended Martin's discharge date to 28 December 2023.[135]

184 A social worker attempted to contact Martin's brother to communicate the change in discharge date, but was not successful.[136]

185 It is not apparent that anyone in the in-patient treating team spoke directly with Martin's brother about the change in date.[137]

186 Martin's brother was made aware of the date change by Mr Boban Joseph by phone on 20 December 2023, after Martin's brother had contacted him seeking an update.[138]

187 On 18 December, Martin's brother contacted the SCGH MHU reception and reported that Martin had said to him that he would kill himself upon discharge.[139]

188 Martin was expressly asked about the report from his brother and denied making the statement.[140]

[132] Exhibit 2, tab 2, par [53]-[54].
[133] Exhibit 2, tab 2, pars [63]-[64].
[134] Exhibit 2, tab 2, par [55].
[135] Exhibit 2, tab 2, par [65].
[136] Exhibit 2, tab 6, par [25].
[137] Ts 15, 19.
[138] Exhibit 1, tab 10.1, p 202.
[139] Exhibit 2, tab 6, par [24].
[140] Exhibit 2, tab 3, par [36].

189 Martin's brother's concerns were escalated to the clinical team and were discussed at the multidisciplinary team meeting on 18 December[141] and at the Red Team meeting on 20 December 2023.[142]

190 Dr Boyadjian conducted a medical review for discharge on 27 December 2023.

191 Martin was focused and appeared optimistic. He explicitly stated that he wanted to go back to work, and asked for a fitness to work certificate.[143]

192 Martin was discharged from SCGH on 28 December 2023.[144]

193 He was discharged under the CTO with Mr Boban Joseph as his case manager, with his next haloperidol depot due 16 January 2024.[145]

194 He was discharged in the company of a social worker, and a social worker was organised to take him grocery shopping that day.[146]

195 There is no evidence that Martin's brother was contacted by any of the in-patient treating team to advise that discharge had taken place.

Management by CECMH from 28 December 2023 onward

196 Martin was seen at home by Mr Boban Joseph on 29 December 2023, the day after his discharge from hospital.

197 He presented as pleasant and polite, with euthymic affect. He did not express any risk to himself,[147] and appeared to be future focused.[148]

198 Mr Boban Joseph had formulated a plan to follow up with Martin on a twice weekly basis, on Mondays and Fridays to ensure ongoing assessment of his mental state and risk.[149]

199 Mr Boban Joseph's assessment at that time was that Martin was continuing to improve.

[141] Exhibit 2, tab 1, par [39].
[142] Exhibit 2, tab 6, par [24].
[143] Exhibit 2, tab 6, par [30].
[144] Exhibit 1, tab 10.2, p 201.
[145] Exhibit 1, tab 12, p 10.
[146] Exhibit 2, tab 3, par [51]; tab 6, par [31].
[147] Exhibit 1, tab 10.2, p 201.
[148] Exhibit 2, tab 2, par [74].
[149] Exhibit 2, tab 2, par [73].

200 Mr Boban Joseph considered it positive that discharge had occurred shortly after Martin had received his last depot, and that Martin was engaging with other care providers.[150]

201 I interpose that Mr Langer spoke with Martin on two occasions by phone on 31 December 2023 and 2 January 2024.

202 Although Mr Langer considers that Martin jumped around topics, there is no evidence that he expressed any thoughts of self-harm or suicidal ideation on either occasion.[151]

Martin's contact with the MHAS on 3 January 2024

203 Martin had contact with the MHAS at about 9 am on 3 January 2024.[152]

204 The substance of the conversation was recorded in a contemporaneous file note by the person with whom Martin spoke at the MHAS.[153]

205 The file note was entered into MHAS's system on 5 January, but was based on handwritten notes taken by the MHAS operator on the day.[154]

206 The file note is in evidence and, given the contemporaneity of its contents, as well as its comprehensive nature, I find that the conversation occurred in the terms outlined in the file note.

207 During the phone call, Martin had a lengthy conversation with the representative of the MHAS, including in relation to a hearing before the Mental Health Tribunal scheduled for 9 January.

208 During the conversation, the representative twice asked Martin if he felt safe in himself, and he advised that he "[was] *safe, just overwhelmed*."

209 According to the representative, Martin sounded calm, and she confirmed that Martin had her contact details.

210 Following the conversation, the representative debriefed with her senior colleague, and it was concluded that in the absence of Martin raising any safety concerns and on the basis of his assurances that he was safe, she would not contact his CECMHS case manager.

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[150] Exhibit 2, tab 2, par [76].
[151] Exhibit 2, tab 7, pars [20]-[21].
[152] Exhibit 1, tab 13, p 1.
[153] Exhibit 1, tab 9.12, pp 13-14.
[154] Exhibit 1, tab 9.13.

Mr Langer's home visit on 3 January 2024

211 Mr Langer visited Martin at his home on the morning of 3 January 2024.

212 Mr Langer appeared – both by virtue of the detail in his witness statement, and the clarity of his oral evidence at the inquest – to have a strong independent recollection of the home visit on 3 January 2024.

213 I have no basis to doubt the accuracy of any of Mr Langer's evidence about the home visit, including where his notes of the meeting were completed later that day, and before he became aware of Martin's death.[155]

214 I accept Mr Langer's evidence in its entirety.

215 Mr Langer visited Martin at his home at about 11 am to discuss supports and have Martin sign paperwork concerning his desire to return to employment and regarding transport.[156]

216 Significantly, Martin disclosed that earlier in the day, he had received a call from SCGH to inform him of the upcoming CTO review, and that following that call he had gone to the car park in his street and contemplated jumping from the top floor of the building.[157]

217 Martin told Mr Langer that he had not carried this out as he felt he did not want to kill himself, and he also said that he would not do this due to the hurt it would cause others.[158]

218 Martin stated to Mr Langer that he was not suicidal, and following their discussion about employment and access to supports, Martin said that he felt positive about the future. Mr Langer reinforced the 'after hours' services that were available to Martin if he needed them.[159]

219 During their meeting, Mr Boban Joseph arrived.

220 Mr Langer advised Mr Boban Joseph, in Martin's presence, about Martin's statement that he had gone to the top floor of the car park in his street earlier that day, contemplating suicide.

[155] Exhibit 2, tab 7, pars [24], [26].
[156] Exhibit 2, tab 7, par [22].
[157] Exhibit 2, tab 7, par [22.2].
[158] Exhibit 2, tab 7, par [22.2].
[159] Exhibit 2, tab 7, par [22.2].

221 Martin confirmed this to Mr Boban Joseph, and Martin expressed similar comments to Mr Boban Joseph about his not wanting to kill himself, and that he was feeling positive about recommencing employment.[160]

222 Mr Langer observed Mr Boban Joseph discuss a safety plan with Martin, which Martin said he would initiate if required.[161]

223 Mr Langer's impression when he left Martin at the end of their meeting was that Martin was calm, and clear in his statements and comments.[162]

224 After the meeting, Mr Boban Joseph and Mr Langer spoke outside and debriefed including as to Martin's expression of suicidal ideation.

225 Mr Langer's view was that the safety plan discussed with Martin was adequate and appropriate.[163]

CECMH's home visit on 3 January 2024

226 Mr Boban Joseph created a file note relating to his home visit on 3 January 2023 and his assessment of Martin, which is evidence.[164]

227 At the inquest, Mr Boban Joseph explained that he created a word document containing his notes later on 3 January 2024 and that he was not aware that Martin had died when he wrote the notes.[165]

228 Mr Boban Joseph then uploaded the document to the Psychiatric Services On-Line Information System (**PSOLIS**) on 4 January 2024.[166]

229 He was aware of Martin's death at that time, although not the manner in which Martin had died.[167]

230 At the inquest, Mr Boban Joseph confirmed that he did not make any changes to his notes before they were uploaded to PSOLIS.[168]

231 I find that Mr Boban Joseph was an honest and reliable witness, and that his evidence in this particular regard was truthful.

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[160] Exhibit 2, tab 7, par [22.8].
[161] Exhibit 2, tab 7, par [22.8].
[162] Exhibit 2, tab 7, par [25.3].
[163] Exhibit 2, tab 7, par [23].
[164] Exhibit 1, tab 2, par [88].
[165] Ts 57.
[166] Exhibit 1, tab 2, par [88].
[167] Ts 57.
[168] Ts 57.

232 I find, accordingly, that Mr Boban Joseph's file note represents his recollection of events of 3 January 2024 as recorded later that day, at a time when he was unaware of Martin's death.

233 I note that Mr Boban Joseph's recollection of the home visit appeared to be heavily reliant on his file note. It was clear that his independent recollection was not as strong as Mr Langer's.

234 There is no direct conflict between the evidence as contained in Mr Boban Joseph's file note and Mr Langer's records and independent recollection. However, as will become apparent, Mr Langer's independent recollection included matters that do not feature in Mr Boban Joseph's file note.

235 According to his file note, upon Mr Boban Joseph's arrival, Martin was meeting with Mr Langer. They were discussing Martin's NDIS package, and plans going forward. Martin was pleasant and polite, with euthymic affect. He was at his stable baseline.[169]

236 Martin made a note of the upcoming appointment with the psychiatrist for medical review.

237 Martin expressed an eagerness to return to work, and did not express any risk of harm to himself or others, including when explicitly asked.[170]

238 Martin did not raise any concerns and was aware of crisis pathways. He appeared future focused, and reported that she was going to the barber later that day to get a haircut.[171]

239 Martin was aware of crisis pathways and indicated that he would contact CECMHS, Mr Boban Joseph, or emergency services if the need arose.[172]

240 Mr Boban Joseph's file note does not refer to the information provided to him by Mr Langer regarding what Mr Langer had been told by Martin about going to the nearby carpark.

241 At the inquest, Mr Boban Joseph did not dispute that he had been told that information by Mr Langer.[173]

[169] Exhibit 2, tab 2, par [78]; exhibit 1, tab 13, p 19.
[170] Exhibit 2, tab 2, par [81].
[171] Exhibit 1, tab 10.2, pp 203-204.
[172] Exhibit 1, tab 2, par [84].
[173] Ts 56.

242 He also said that he would often include information given to him by someone other than the client in a different part of PSOLIS, rather than in the record of his own assessment.[174]

243 Mr Boban Joseph agreed with my observation that such information, even if received from a third party, would be relevant to his assessment of the client, and therefore would be usefully included in the body of his assessment notes (including to ensure that all of the context was readily ascertainable by any clinician needing to review the notes in future).

244 In any event, none of Mr Boban Joseph's written or oral evidence causes me to doubt the accuracy of Mr Langer's account.

245 That account includes what he observed Mr Boban Joseph do as part of his apparent risk assessment of Martin, including after being provided with the additional information that Martin had disclosed to Mr Langer before Mr Boban Joseph's arrival.

Critical incident

246 According to Mr Langer, he spoke with Martin for about 45 minutes, before Mr Boban Joseph arrived.[175]

247 If Mr Boban Joseph's subsequent consultation with Martin was about 30 minutes as he estimates,[176] then this would have resulted in Mr Langer and Mr Boban Joseph leaving the unit about 12.30pm, followed by a debrief of about 15 minutes outside.[177]

248 I find, based on that conclusion and the available CCTV footage, and in the absence of any eyewitnesses, that sometime after 12.45 pm and before 1.19 pm, Martin left his unit on foot. By 1.19 pm, he had walked to the car park on Mayfair Street in West Perth, about 100 metres from his home.

249 When he arrived at the car park, he walked up the vehicle ramp, eventually stopping on the 14th floor of the building.

250 At about 1.28 pm, he stepped over the edge of the 14th floor.[178]

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[174] Ts 58.
[175] Ts 42.
[176] Ts 55.
[177] Ts 42.
[178] Exhibit 1, tab 9, pp 3 and 6.

251 It is not apparent that Martin spoke or engaged with any other person during the nine minutes he was in the car park.[179]

252 I find that Martin fell from the 14th floor and landed on the bitumen roadway below, suffering significant injuries.

Emergency response

253 A registered nurse working in a nearby office heard a noise which caused him to go outside with a colleague, and upon observing Martin lying on the roadway unresponsive, they immediately began performing CPR.[180]

254 Emergency services were called at 1.31 pm.[181]

255 Police officers attended and took over resuscitation before ambulance officers arrived at 1.38 pm[182] and assumed responsibility.[183]

256 Despite best attempts, first aid was ceased at 1.47 pm, and Martin was certified life extinct by an ambulance officer.[184]

Police investigation

257 In addition to investigating at the scene, police officers attended Martin's home and found a two-page handwritten letter from Martin, dated 8 December 2023.[185]

258 Some investigative materials from police refer to the seizure from Martin's home of what was believed may have been a suicide note.[186]

259 Although the letter is not entirely legible, it is clear (not least from the date) that the letter is not a note documenting Martin's intention to self-harm immediately prior to his death.

260 Instead, the letter relates to Martin's views about his medical treatment at that time, and refers to his hope that his future will 'brighten up.'[187]

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[179] Exhibit 1, tab 3, p 3; tab 9, p 3.
[180] Exhibit 1, tab 9, p 6.
[181] Exhibit 1, tab 9.10.
[182] Exhibit 1, tab 9.10.
[183] Exhibit 1, tab 9.8.
[184] Exhibit 1, tab 2; tab 9.8, p 1.
[185] Exhibit 1, tab 9.9.
[186] Exhibit 1, tab 9.8.
[187] Exhibit 1, tab 9.9, p 2.

Review by EMHS

261 Martin's death was internally reviewed as a clinical incident by EMHS. The incident was 'opened' by entry into the system known as Datix CIMS on 4 January 2024,[188] which also had the consequence of notifying the Office of the Chief Psychiatrist according to mandatory reporting policies.

262 At the time, incidents were entered into Datix CIMS by EMHS with the classification of 'SAC 2' until an internal investigation identified the 'true' classification. That practice has since been rectified by EMHS.[189]

263 The Acting Program Manager at CECMHS sent an email to the Risk Manager on 4 January 2024, flagging the incident on Datix and noting the incident '*as potential SAC 1*'.[190] The Program Manager also noted an opinion that there may need to be a '*joint site investigation with SCGH, given* [Martin had been] *discharged only 5 days prior*'.[191]

264 The Risk Manager conducted an initial incident review and, by 9 January 2024, had provisionally concluded that the matter was not a clinical incident and no provision of health care (or lack thereof) contributed to Martin's death, and the matter should therefore proceed through EMHS's morbidity and mortality review process.[192] The decision was made by reference to a EMHS Business Rule, which noted that suspected suicides may or may not be related to the provision of health care or lack thereof.[193]

265 Significantly, the document also noted that if the initial clinical review concludes '*there is any suspicion of health care causation or contribution, it must be notified into Datix CIMS, confirmed as a SAC 1 clinical incident and investigated accordingly*'.[194]

266 Emails exchanged between health staff indicate that the Risk Manager contacted staff at NMHS asking if the incident should be passed to that health service, as EMHS was aware that NMHS's processes concerning identification of SAC 1 incidents concerning mental health patients who had been discharged from an in-patient setting recently was different.[195]

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[188] Exhibit 1, tab 14, p 2.
[189] Email from State Solicitor's Office to the Court dated 6 May 2026.
[190] Exhibit 8.
[191] Exhibit 8.
[192] Exhibit 9.
[193] Exhibit 5, p 2.
[194] Exhibit 5, p 2.
[195] Exhibit 9.

267 As part of that exchange, on 9 January 2024, the Executive Director of NMHS's Mental Health, Public Health and Dental Services queried the identification of the death as a SAC 2 event.[196] I infer, from the context and the email itself, that the Executive Director at NMHS queried whether that designation was deficient and should have been SAC 1.

268 A further email sent 12 January 2024 indicates that staff at NMHS requested that EMHS open the matter as a multi-site SAC 1 which EMHS would lead and in which NMHS would participate.[197]

269 On 15 January 2024, the CTT Team Leader at CECMHS completed a case review, including a summary of the case.[198] The summary of the facts in the review reflects the facts as contained in Mr Boban Joseph's file note. There is no reference to the expression of suicidality earlier on 3 January 2024 that was reported by Martin to Mr Langer, and then conveyed to Mr Boban Joseph.[199]

270 There is no evidence that the CTT Team Leader attempted to speak to either Mr Boban Joseph (or Mr Langer) when completing the case review.

271 On 17 January 2024, the Risk Manager advised staff at NMHS that it had been determined that there was no clinical incident within CECMHS, on the basis that the death was not attributable to the provision of health care (or lack thereof), and as per EMHS' business rules, the incident would be made inactive and be presented at a mortality and morbidity review.[200]

272 The incident was deactivated by the Risk Manager on behalf of EMHS on 17 January 2024.[201]

273 The case was presented for the purposes of morbidity and mortality case review on 6 March 2024.[202] The stated purposes of the mortality and morbidity case review was, at least in part, to provide a peer review of the Risk Manager's decision. The panel agreed that the event was not attributable to the provision of health care (or lack thereof), and the case could be closed with no further action.[203]

[196] Exhibit 9.
[197] Exhibit 9.
[198] Exhibit 10.
[199] Exhibit 6.
[200] Exhibit 11.
[201] Exhibit 1, tab 14.
[202] Exhibit 7.
[203] Exhibit 7.

274 It appears that the mortality and morbidity case review proceeded on the same summary of facts presented to the Risk Manager, with no reference to Martin's disclosure to Mr Langer, and repeated to Mr Boban Joseph.[204]

Cause and manner of death

275 A forensic pathologist conducted an external post mortem examination on 9 January 2024, including a CT scan which showed significant internal injuries including trauma to the chest, pelvis, and neck.[205]

276 Toxicological analysis showed therapeutic amounts of haloperidol and olanzapine, and detected metformin and sitagliptin. Other common drugs were not detected.

277 A small amount of alcohol (0.023%) was detected in preserved urine.[206]

278 The forensic pathologist formed the opinion that Martin's cause of death was multiple injuries.

279 I respectfully agree with and adopt that conclusion as my finding for the purposes of s 25(1)(c) of the Act.

280 For the purposes of s 25(1)(b) of the Act, I find, based on the above findings regarding the circumstances of his death, that Martin's death occurred by way of suicide.

Treatment, supervision, and care of Martin

Summary of opinion of Dr Brett

281 As noted, Dr Brett provided an independent expert opinion to the Court in relation to the quality of Martin's treatment based on his review of the available records. Dr Brett recognised that the clinical record can never truly reflect the totality of care provided to.[207]

282 In his report, Dr Brett expressed the view that it was poor practice for Martin to have been managed by four different teams in the mental health system across 2023, including admissions to three hospitals with varying opinions on his management.[208]

[204] Exhibit 7.
[205] Exhibit 1, tab 6.
[206] Exhibit 1, tabs 7 and 8, p 2.
[207] Exhibit 1, tab 16, par [74].
[208] Exhibit 1, tab 16, par [16].

283 Dr Brett made clear that each service managed Martin adequately and with compassion, and liaised with family and his care coordinator, but that there was inconsistency in approach.[209]

284 According to Dr Brett, Martin's case also demonstrates the lack of services available for people thought to have ASD.[210]

Did Martin receive neuropsychological assessment, as recommended?

285 In his review of the records, Dr Brett was unable to find any evidence that Martin was formally assessed for ASD, including as recommended upon his discharge from SJOG Midland.[211]

286 I accept that clinicians treating Martin while he was an in-patient were required, as the priority, to treat and manage Martin's acute symptoms including any apparent psychosis.

287 I also find that any formal assessment of Martin for ASD would have had to have occurred at a time when any acute symptoms of any psychotic illness had been treated and Martin was stable.

288 Notwithstanding, a possible neurodevelopmental disorder such as ASD was consistently raised, by both in-patient and community-based teams, throughout 2023.

289 There were many occasions where such a diagnosis appears to have been considered, but (particularly in the community setting) no plan ever developed to progress any formal assessment.

290 It is possible that clinicians who considered that Martin demonstrated symptoms of ASD, but did not recommend any formal assessment, determined that there was no therapeutic benefit in a formalised diagnosis. At the inquest, Dr Brett explained that clinicians may not pursue a changed diagnosis if it is perceived that there will be no tangible benefit to the patient by doing so.[212] I accept that this is a rationale explanation.

291 However, there is no evidence to suggest that any clinician actually took this view, or that they had considered and dismissed pursuit of a formal diagnosis on the basis it would provide no tangible benefit to Martin.

[209] Exhibit 1, tab 16, p 13, par [21].
[210] Exhibit 1, tab 16, p 14, par [23].
[211] Exhibit 1, tab 16, p 12 par [6].
[212] Ts 85.

292 The absence of any ASD assessment being pursued, particularly while Martin was in the community, was likely a consequence of the gaps in the public health system concerning treatment of existing patients who present with symptoms of undiagnosed ASD.

293 I will return to that issue further below.

Should Martin's management have changed to address the possible ASD?

294 As identified above, I am satisfied Martin's management, at least as far as it related to in-patient treatment and medication, remained appropriate notwithstanding the ASD diagnosis remained uncertain.

295 I am also satisfied that even without a formal diagnosis, those at CECMHS involved in Martin's care were very aware of the possibility, and would have been mindful of the same in their approach to his treatment.

296 In terms of his management in the community, I find that, at most, a formal diagnosis of ASD would have been included in any attempts to obtain additional funding from the NDIA.

297 This might have enabled, for example, Martin to obtain a behaviour support plan which could have further supplemented the services he was receiving from Mr Boban Joseph and Mr Langer.

Was there inconsistency in the approaches of the health services in 2023?

298 Martin's admission to different hospitals in 2023 appears to have been an unavoidable consequence of availability of beds at the relevant times.

299 As identified by Dr Gupta, readmission to the same hospital does not necessarily guarantee treatment by the exact same clinicians.[213] There is also a possibility that clinicians within different wards in the same hospital may form contrary views regarding the correct diagnosis for a mental health patient.[214]

300 I also accept that once Martin was being treated as an in-patient at a hospital, transferring him to a hospital at which he had previously been treated (even if that were possible), would not have been good practice. Doing so would have been detrimental to any therapeutic relationship that had been established to date.[215]

[213] Exhibit 2, tab 4, par [46].
[214] Exhibit 2, tab 4, par [47].
[215] Exhibit 2, tab 1, par [21].

301 To the extent the different in-patient treating teams took different approaches in diagnosis and treatment, I am satisfied that there is evidence that clinicians at each hospital took steps to identify prior treatment and that there was no marked departure from previous treatment that resulted in poor outcomes for Martin.

302 I accept Dr Gupta's evidence that the most critical aspect of ensuring continuity is the ability for clinicians to know what has happened historically with a patient.[216]

303 Any clinician with that information should be capable of providing continuity of care for that patient.

304 I am satisfied that there was clear documentation and discharge planning available to each subsequent treatment team to properly understand their approach, and to guide future treatment.[217]

305 Self-evidently, continuity is improved when there is effective liaison between those involved in a patient's care, including involved family members and other community supports.

306 There is a consensus, including between Dr Brett and Dr Gupta, that this occurred for Martin through the efforts of Mr Boban Joseph.[218]

307 I also consider that although Mr Langer was not directly involved in Martin's health care, it was clear that he was involved in ensuring continuity between service providers, including CECMHS.

308 According to Dr Gupta, there is currently movement in the State's public mental health system towards a model of integrated mental health care irrespective of catchment area or geographic location of where the patient presents.[219]

309 I expect that this kind of approach will reduce any future instances of a patient like Martin having potentially fragmented care purely on the basis of where they initially present, or where they reside.

[216] Exhibit 2, tab 4, par [49].
[217] See, e.g., ts 11.
[218] Exhibit 2, tab 4, par [50]-[51].
[219] Exhibit 2, tab 4, par [53].

310 The progress towards an entirely digital medical record (at least in the public health system) will also, self-evidently, assist in harmonising current systems for mental health records.[220]

311 At the moment, mental health records are stored in various locations, including PSOLIS.

312 Any streamlining will assist clinicians to better interrogate and understand past treatment records, at least in the public setting.[221]

Should Martin have been admitted to a staged or transitional care unit?

313 A question arose from Dr Brett's report whether Martin have benefited from admission to a transitional care unit after any in-patient admissions.

314 There was no evidence that admission to such a facility was considered by any of the in-patient treating teams (noting that they are distinct from the Rehabilitation and Recovery Unit referred to at par [92] above, which was considered but deemed unsuitable for Martin at that time).

315 The Court expressly raised with NMHS and EMHS whether there would have been scope for Martin to have been admitted to facilities such as the Bidi Wungen Kaat Centre, or the Hospital Extended Care Service at Graylands Hospital. Both Dr Gupta and Dr Hussain addressed this issue in their respective reports to the Court.

316 Dr Hussain's opinion is that it was reasonable to conclude that under the CTO, with assertive follow-up, Martin was capable of living independently, and that this was an appropriate approach given his express desire to return home.[222]

317 Dr Gupta opined that the reason such admission may not have been considered was because Martin had stable, long-term supported accommodation. Dr Gupta also noted that the risk of removing him from his home for any further extended period of time may have been destabilising,[223] and a long-term stay in a transitional care unit could also have unintended consequences, such as the loss of community supports only made available if Martin were living in the community, at home.[224]

[220] Ts 26.
[221] Exhibit 2, tab 4, pars [90]-[91].
[222] Exhibit 2, tab 1, pars [44]-[45].
[223] Exhibit 2, tab 4, par [65(a)].
[224] Exhibit 2, tab 4, par [65(b)].

318 Having considered the evidence and the opinions of Dr Hussain and Dr Gupta, I am satisfied that there was no obvious reason to aggressively pursue such a placement (including in circumstances where it is recognised that beds at such units are extremely limited, so there can be no certainty that there would have been availability at that time).

Would Martin's treatment have benefited from clinicians having access to publicly available resources concerning autism?

319 There are, currently, no dedicated services available in the WA public health system for the diagnosis of ASD.

320 Adult patients are required to access the private system for assessment that can be expensive, and lengthy.[225]

321 Although not express, I infer from the evidence[226] that the absence of such a service reinforces a view in other public health services, such as CECMHS, that they are ill-equipped to deal with issues around ASD management, including assisting a consumer to obtain a diagnosis through the private system.

322 The absence of such a service also necessarily limits the knowledge of clinicians about other private ASD services that may be accessible.

323 I consider there would have been obvious benefit had clinicians, particularly those involved in Martin's care in the community at CECMHS following his discharge from SJOG Midland, been able to obtain assistance in relation to the assessment and potential diagnosis of ASD.

324 Even if those clinicians had doubts as to the utility of progressing any formal assessment, then such a service would have been a useful resource for clinicians to discuss those considerations.

325 Dr Brett's opinion is that a State-wide autism consultation liaison service, similar to one developed for people with eating disorders, is an appropriate first step[227] (as distinct from the creation of facilities to treat autism in the public health system).

[225] Exhibit 2, tab 4, pars [68]-[69].
[226] See, e.g., exhibit 2, tab 2, par [91].
[227] Exhibit 1, tab 16, p 14, par [24].

326 I will return to that proposition in the context of recommendations I intend to make in this case.

Was the decision to discharge Martin on the CTO appropriate?

327 I am satisfied that the decision to discharge Martin on the CTO was appropriate management of his health at that time.

328 The in-patient treating team at SCGH was required by the *Mental Health Act* to adopt the least restrictive method.

329 I accept Dr Brett's opinion that Martin had risk factors that would not have been mitigated even had Martin remained in hospital for an extended period of time[228] (noting, of course, that Martin had already been in hospital for half of the 2023 calendar year).

330 I accept Dr Boyadjian's evidence that a number of Martin's long-term risk factors, including ongoing and recurring distress due to his past behaviours, were not, realistically, treatable and resolvable by a medical team on a mental health unit and that they had reached the ceiling of treatment in terms of management of psychosis and medication.[229]

331 The decision to discharge Martin on a CTO was a more robust approach than that adopted on previous occasions in 2023.

332 It was the first time such an order had been implemented upon Martin's discharge, and provided a safeguard to ensure Martin's compliance with the long-acting haloperidol depot which had successfully treated his symptoms while an in-patient.

333 As Dr Boyadjian explained, the CTO was implemented because it was expressly recognised by the treating team that although Martin appeared to recognise that his symptoms had improved with the medication, he had not verbalised the thought that he should continue this medication, voluntarily, in order to manage the auditory hallucinations in future.[230]

334 The decision to discharge Martin also had appropriate regard to the recency of his last depot injection.

[228] Exhibit 1, tab 16, p 15, par [30].
[229] Ts 21.
[230] Ts 27.

335 Having examined the records, I accept Dr Hussain's opinion that Martin's discharge plan was carefully considered, and (particularly in light of the imposition of the CTO) was more assertive.

336 I am also satisfied that the discharge planning had regard to concerns of Martin's family (including his brother's report about the threat of self-harm on discharge),[231] and although it may have required continued advocacy from Martin's brother and Mr Boban Joseph, Martin's discharge was sensibly delayed having regard to the availability of services. It is apparent that Martin was able to access support from Mr Boban Joseph and Mr Langer immediately upon discharge and in early January 2024.

337 It is apparent that CECMHS and Mr Boban Joseph had a clear treatment support and discharge plan in place at discharge.[232]

338 Dr Brett's opinion was that the decision to discharge Martin, within current resourcing, was appropriate. [233] I agree.

339 As identified above, there was no communication of the fact of Martin's discharge by the in-patient team at SCGH to Martin's family. This was not ideal, not least given the protective measures that have been implemented by Martin's family, as recommended to them.

340 I will return to the potential gap in communication with Martin's family about his discharge in the context of a recommendation concerning provision of carer support services.

Was CECMHS's management post-discharge from SCGH adequate?

341 In Dr Brett's opinion, Mr Boban Joseph's approach appeared to go beyond the usual role of a care coordinator, and his involvement was exemplary.[234]

342 I concur.

343 Mr Boban Joseph's documentation demonstrates that there was prompt and thorough engagement with Martin post-discharge.

344 Mr Boban Joseph had a well-considered plan in place to support Martin, to which he adhered.

[231] Exhibit 2, tab 1, pars [47]-[48]; ts 14-15.
[232] Exhibit 2, tab 3, par [46]; exhibit 1, tab 12.2.
[233] Exhibit 1, tab 16, p 14, par [28].
[234] Exhibit 1, tab 16, p 14, par [22].

345 I do not consider that there were any additional steps that CECMHS ought to have taken in the period between Martin's discharge from SCGH and his death.

346 Further, there is no indication, on my review of the records, that any opportunities were missed which contributed to the tragic outcome.

Was Anchorpoint's provision of support coordination services adequate?

347 The records demonstrate that Mr Langer was active and engaged in his provision of support services to Martin, including where the available funding for the same under the existing NDIS plan was limited.

348 The records demonstrate that Mr Boban Joseph and Mr Langer engaged with others involved in Martin's care and support, and with each other, in a manner that is not regularly seen in matters before this Court.

349 There is no scope to criticise the level of engagement by Mr Langer, and by extension, Anchorpoint.

350 Again, the records demonstrate that Martin had no hesitation in contacting Mr Langer in early January 2024 to discuss his future plans, from which I infer Martin considered Mr Langer to be a reliable source of support. It is also evident that Mr Langer was motivated to attempt to increase Martin's supports under his NDIS plan in the most efficient and timeous way.

Should anyone who interacted with Martin on 3 January 2024 have done more to escalate his care?

351 The fact that Martin committed suicide very shortly after having spoken with three people, including two people with whom he worked closely (in Mr Boban Joseph and Mr Langer), raises an understandable concern about what was and should have been done based on Martin's disclosures. The question becomes even more profound when it is apparent that Martin completed suicide in the manner he described to Mr Langer and Mr Boban Joseph that he had been contemplating earlier that day. In those circumstances, it is difficult to avoid an analysis which operates with the benefit of hindsight.

352 My task is to assess the evidence about what was disclosed and how the disclosures were addressed, and to assess whether the risk assessments that were undertaken and the safety planning implemented were adequate based on what was then known to each of the MHAS, Mr Langer and Mr Boban Joseph (having regard, of course, to the content of their specific and differing roles in Martin's care).

353 In doing so, I need to avoid hindsight bias, being the cognitive tendency to perceive past events as having been more predictable than they actually were before the outcome was known.

354 In his report, Dr Brett noted that schizophrenia and ASD are both high-risk conditions associated with completed suicide.[235]

355 However, Dr Brett also recognised that risk prediction in relation to people with schizophrenia and ASD is very difficult.[236]

356 Suicide is known to be a fundamentally unpredictable occurrence.

357 At the inquest, Dr Brett expressed the opinion that he held no concerns with the adequacy of clinical assessment of Martin's risk at that time.[237]

358 I am not bound to accept that opinion and must perform my own analysis.

359 Having considered the evidence, I am satisfied that the risk assessments undertaken by each of the MHAS, Mr Langer and Mr Boban Joseph were appropriate and adequate, and, viewed objectively, there was no failure on any of their parts to take any further action.

MHAS

360 Based on the contents of the file note, Martin did not express any thoughts of self-harm or suicidal ideation to the MHAS operator.

361 As such, it can be inferred that he also did not disclose to the MHAS operator – as he did to Mr Langer – that he had gone to the nearby car park contemplating suicide.

362 Given the timing of the call with MHAS, the time of Mr Langer's arrival at Martin's home, and the proximity of the car park to his unit, it is in fact possible that Martin first went to the car park between the phone call with MHAS and Mr Langer's arrival.

363 I am satisfied that the MHAS operator asked Martin directly about his safety, in order to be satisfied that he was not a risk to himself or others.

364 There were no other apparent features of the conversation that would have prompted the MHAS operator to doubt Martin's responses.

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[235] Exhibit 1, tab 16, p 12, par [10].
[236] Exhibit 1, tab 16, p 12, par [13]; ts 68.
[237] Ts 68.

365 Although he expressed that he felt overwhelmed, the operator would have been reassured by Martin's apparent calm demeanour. She also, appropriately, ensured that Martin was aware of his ability to contact her as needed.

366 The conclusion that the operator at MHAS conducted an appropriate risk assessment is reinforced by the documentation of the operator's follow up with a senior colleague.

367 The fact the operator took this step demonstrates a prudent and diligent approach, from which I infer that a proper, thoughtful risk assessment was undertaken (as distinct from a cursory exercise).

368 There is also no basis to cavil with the conclusion that there was no need to contact anyone at CECMHS at this time.

369 I am also satisfied that even if a call to CECMHS had been made by MHAS, it would not have caused any different outcome, given Mr Boban Joseph was already planning to conduct his home visit later that day. At most, Mr Boban Joseph might have attended sooner.

Anchorpoint

370 As identified above, it is imperative to assess Martin's comments and the responses of Mr Langer and Mr Boban Joseph without any hindsight bias.

371 In order to do so, it is critical to assess Martin's comments in their full context. In that regard, Martin's disclosure about having gone to the car park earlier that day was a comment in the context of a meeting between Martin and Mr Langer of about 45 minutes duration.[238]

372 That feature is significant. The length of the conversation between Mr Langer and Martin reassures me that Mr Langer was in a position to properly assess the disclosure in its full context, and to weigh it against other features of the conversation which caused Mr Langer to perceive Martin as being future focused.

373 As identified, Mr Langer clearly discussed the disclosure with Martin directly, and asked questions to satisfy himself that Martin was not at any immediate risk.

[238] Ts 42.

374 He also confirmed that Martin was aware of safety nets that existed if he required them.

375 Mr Langer would have been, properly, assured by statements by Martin that he had simple, achievable future plans for after the meeting, including his plan to get a haircut in the afternoon.[239]

376 The fact that Mr Langer relayed the disclosure to Mr Boban Joseph reinforces the view that he took it seriously, and dealt with it appropriately.

377 As identified above, Mr Langer was not directly involved in Martin's health care. Having said that, his employment history demonstrates that he had decades of experience in industries in which such disclosures would have been frequently made to him.

378 Mr Langer confirmed this at the inquest.[240]

379 As such, I am confident that Mr Langer had the tools to be able to deal with the disclosure in a direct way, and make an appropriate risk assessment.

380 I am also galvanised in my views about the adequacy of Mr Langer's approach because the evidence demonstrates that when Mr Langer had held concerns about Martin's welfare on earlier occasions, he did not hesitate to act upon them.

381 As identified above, in September 2023 when Mr Langer considered that Martin was a risk to himself and others, he contacted CECMHS, as well as WA Police without hesitation.[241]

382 Mr Langer also escalated a concern to CECMHS on another occasion when Martin verbalised some behaviour which indicated he was a risk to himself.[242]

383 These earlier exercises of sound judgment and escalation of concerns supports the conclusion that Mr Langer conducted an adequate risk assessment on 3 January, and determined that further escalation was not required at that time.

[239] Exhibit 2, tab 7, par [22.5].
[240] Ts 41.
[241] Exhibit 1, tab 18, p 6; tab 20.1, pp 7-8; ts 40.
[242] Ts 38.

384 Finally, the fact that Mr Langer debriefed with Mr Boban Joseph directly after his meeting with Martin about Martin's risk and the safety planning[243] also demonstrates a diligence and thoroughness that causes me greater certainty in concluding that the risk assessment was adequate.

CECMHS

385 Similar considerations to those I have outlined in respect of Mr Langer apply in respect of Mr Boban Joseph.

386 The evidence establishes that Mr Boban Joseph conducted his own, independent risk assessment, including asking Martin directly about his safety.

387 The records demonstrate that, historically, Mr Boban Joseph had no difficulty in engaging directly with Martin about his risk, or escalating Martin's care, including with other clinicians at CECMHS for the purposes of Martin's admission to hospital, if he considered it was warranted.

388 I am also satisfied that Mr Boban Joseph was well-positioned to conduct an informed risk assessment. He had been involved in Martin's care for over half a year by this point, having met with Martin regularly, face-to-face, both while he was acutely unwell in hospital, when he was stable while in the community, and during periods in the community when he was relapsing.

389 Given that experience, there was no likely no person involved in Martin's health care who was better placed to assess Martin's risk on the morning of his death.

390 I am satisfied that Mr Boban Joseph's documented assessment, supplemented by his evidence at the inquest and corroborated by Mr Langer's evidence, was adequate, and that his safety planning was appropriate. Although Martin had taken steps in the morning (rather than purely expressing suicidal ideation), and self-evidently had means to return to the car park if he wished, having carefully considered the evidence I do not consider that Mr Boban Joseph had sufficient cause to escalate Martin's care at that time.

[243] Ts 41.

Should EMHS have undertaken a SAC 1 investigation?

391 The question arises whether EMHS should have conducted a SAC 1 investigation into Martin's death.

392 Attribution of a severity assessment code of 1 to clinical incidents gives rise to the imposition on health services of certain investigative requirements.

393 According to Department of Health guidelines concerning multi-site incidents,[244] it was incumbent on EMHS to initiate and undertake any multi-site SAC 1 investigation that was determined to be required, not NMHS. Both Dr Hussain[245] and Dr Gupta[246] agreed with this.

394 The evidence is clear that staff within NMHS supported a multi-SAC 1 investigation, to be led (appropriately) by EMHS.

395 In his evidence at the inquest, Dr Gupta noted that the relevant policy at the time required a SAC 1 investigation to be conducted where there had been serious harm or death that had or could have been attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.[247]

396 In Dr Gupta's view, that criterion was not enlivened in Martin's case, because Dr Gupta's view was that the death was attributable to Martin's underlying condition or illness, not a lack of care.

397 His view was that the care was good.[248]

398 Dr Gupta's view was that a SAC 1 would have been warranted '*if Mr Quiterio had reported suicidality to his EMHS care team but there had been a lack of response'*.[249]

399 As it transpires, I am satisfied, upon my review of the evidence, that Mr Boban Joseph's interactions and assessment of Martin on 3 January 2024 were appropriate, and there is no basis to contend that Martin's death was properly attributable, for the purposes of the Department of Health policy, to any provision of care by Mr Boban Joseph, or lack thereof.

[244] Exhibit 2, tab 1, Annexure 3.
[245] Exhibit 2, tab 1, par [42].
[246] Ts 139-140.
[247] Exhibit 2, tab 4, par [81]; exhibit 4.
[248] Exhibit 2, tab 4, par [82].
[249] Exhibit 2, tab 4, par [84].

400 However, I have only been able to form that view after making further inquiry and obtaining additional information, particularly into the contents of the assessment performed by Mr Boban Joseph.

401 It would appear that EMHS's decision to inactivate the incident was, at least, premature, because the review had an incomplete factual picture. The review did not include the fact of Martin's disclosure to Mr Langer, and then Mr Boban Joseph, that he had experienced suicidal thoughts that morning, and gone to the nearby car park.

402 As Dr Gupta acknowledged, a recent expression of suicidality was an important feature of this case.

403 This same deficiency as to the factual basis upon which the review was undertaken appears to have carried over to the morbidity and mortality case review.

404 It is not necessary nor appropriate to speculate on why further inquiries were not made within CECMHS or the EMHS before the decision was taken to inactivate the incident, and to proceed in a manner which was, seemingly, contrary to the views being expressed by staff at NMHS.

405 I only note that it would appear that more prudence was warranted, even without the benefit of hindsight, given the severity of the incident and the recency of CECMHS's interaction with Martin before his apparent suicide. I am not satisfied that EMHS had conducted sufficient internal review to be assured that there was no possible suspicion of health care causation or contribution before the matter was deactivated.

Recommendations

Recommendation 1 – neuropsychiatric consultation/liaison service

406 As identified above, Dr Brett noted that there is no existing public health service specialising in the diagnosis and treatment of patients with neuropsychiatric conditions including ASD.

407 I am satisfied on the evidence that Martin's care would have benefited from other clinicians, particularly at the CECMHS, being able to access a public health service for clinical guidance and support.

408 An example of such an existing service, albeit in a different field of health care, is WA Eating Disorders Outreach and Consultation Service.

409 That service is a State-wide service that aims to ensure youth and adults in WA with an eating disorder can access optimal best practice care, including through up-skilling health care professionals to be able to deliver evidence-based high-quality eating disorders care.

410 The service provides:

(a) consultation liaison, mentoring and support to help clinicians of all disciplines to manage their patients;

(b) clinician training and education; and

(c) resources to guide safe inpatient, outpatient, and community management of people with eating disorders.

411 The service is available to assist practitioners and clinicians caring for people with eating disorders in WA, whether they be in emergency departments or mental health units, or are being treated by community mental health services.

412 The service sits within NMHS, and appears to be well established. The evidence at the inquest was that the service functions well and provides a valuable resource to clinicians and, by extension, their patients.

413 There is no apparent reason, structurally or theoretically, why a similar consultation liaison service could not be instituted in Western Australia with ASD and other neuropsychiatric disorders being the focus, rather than eating disorders.

414 In a response to the Court, the Director General of the Department of Health acknowledged that, notwithstanding any historical practice, Western Australian public health services are necessarily involved in the assessment and care of people with ASD, and that this will only increase as the diagnosis becomes more prevalent.[250]

415 The Director General advised that while WA Health had not previously considered developing a State-wide consultation liaison service for ASD, similar to the WA Eating Disorders Outreach and Consultation Service, there was a compelling need to reassess current system supports. As such, WA Health was advised to be exploring the feasibility and scope of a Neuropsychiatric Consultation Liaison Service.[251]

[250] Exhibit 1, tab 17.1.
[251] Exhibit 1, tab 17.1.

416 At the request of the Court, further information was supplied by Ms Fiona Kalaf, the Department's Director Mental Health, Clinical Excellence Division.

417 Ms Kalaf advised that NMHS is leading work to address the needs of adult mental health consumer with co-occurring complexities, including ASD, with the intention that the service would present on its proposed approach in May 2026. Ms Kalaf noted that work to date had recognised the need for a whole-of-health approach to education and training to upskill staff and to provide evidence-based interventions.[252]

418 Ms Kalaf advised that as a related initiative, NMHS is looking at the feasibility of a Neuropsychiatric Consultation Liaison Service which would provide consultation and support to clinicians, as well as provide training and resources.[253]

419 Dr Boyadjian agreed that increased availability of training and education in this field, available to clinicians in a centralised model, would be beneficial.[254]

420 Dr Brett's evidence was that such a consultation liaison service has been the subject of discussion for over 15 years.[255]

421 In my view, based on the evidence before me, a Neuropsychiatric Consultation Liaison Service appears to be a proportionate, achievable advancement in the State's public health service that is certainly more feasible than the introduction of a State-wide treatment service.

422 In response to a draft recommendation provided by the Court, the Department of Health advised that given the importance and statewide role of the proposed service, the Department would take on the responsibility for the proposed recommended work.

[252] Exhibit 1, tab 17.2.
[253] Exhibit 1, tab 17.2.
[254] Ts 23.
[255] Ts 76-77.

423 As such I recommend as follows:

> **1. The Department of Health take all reasonable steps to expedite the feasibility study for, and (if considered feasible) the introduction of, a State-wide Neuropsychiatric Consultation Liaison Service, to provide consultation and support to clinicians concerning conditions including autism spectrum disorder, as well as training and resources in relation to the same (including by obtaining additional funding to the extent it is required).**

Recommendation 2 – carer support services

424 As noted by Dr Brett, Martin's brother and mother were his staunch supporters over a lengthy period, including during particularly challenging times. It is inevitable that the health of family members such as Martin's brother and mother is impacted over time, and the evidence demonstrates that, at times, Martin's brother found it difficult to advocate on Martin's behalf directly with in-patient treating teams.

425 In this case, Mr Boban Joseph was a motivated and effective conduit between Martin's family and inpatient treating teams.

426 However, it will not always be the case that a patient such as Martin has a care coordinator from a community public health system involved in their case while an in-patient, let alone one who provided information to and from the patient's family in the manner Mr Boban Joseph appears to have for Martin and his mother and brother.

427 It is apparent that vital information about the timing of Martin's discharge from SCGH came to his family's attention through Mr Boban Joseph, and not from the hospital or inpatient team. That potential gap could be critical in future cases, particularly where family members have taken steps to best protect their own safety and security.

428 I consider any potential oversight is less likely to occur where there is a member of the in-patient treating team who is an identifiable point of contact for family members and carers. I expect that the employment of such carer supports would alleviate some of the pressure on treating clinicians, as well as social workers within hospitals, who will inevitably be performing this function at times.

429 As such, I recommend as follows:

2. The Department of Health engage with all Health Service Providers (HSPs) with in-patient mental health units, regarding those HSPs employing carer support workers within those units, with the role of providing support to families and carers of patients.

Conclusions

430 It is clear that Martin had dedicated support from his family, and from many of the people involved in his care. His death is a tragic outcome.

431 Martin's family's desire that he be remembered for more than his illnesses.

432 Although the recommendations above relate to Martin's health care, they are directed to ensure that all clinicians in the State, including in both in-patient and community settings, are best equipped to treat long-term and chronic patients like Martin in the optimal way, so that, as far as possible, the lives of patients like Martin can be about more than just their illnesses.

BD Nelson
Coroner
27 May 2026