JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	BRENDYN DEAN NELSON, CORONER
HEARD	:	10 - 13 FEBRUARY 2026
DELIVERED	:	4 AUGUST 2026
FILE NO/S	:	CORC 1058 of 2023
DECEASED	:	WONG, PAUL SHEN VUN

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Mental Health Act 2014 (WA)
National Disability Insurance Scheme Act 2013 (Cth)

Counsel Appearing:

Mr D McDonald assisted the Coroner

Mr E Heywood and Mr J Hang (State Solicitor's Office) appeared on behalf of the Office of the Public Advocate and the South Metropolitan Health Service

Ms C Moss, instructed by Ms S Mony (Meridian Lawyers) appeared on behalf of 360 Health + Community

Mr G Yin, instructed by Ms J Moloney (MC Lawyers) appeared on behalf of Ms Faisa Mohamud

Cases referred to in decision:

Annetts v McCann (1990) 170 CLR 596
Briginshaw v Briginshaw (1938) 60 CLR 336
Rosenberg v Percival [2001] HCA 18; (2001) 205 CLR 434 [68]
Shire of Gingin v Coombe [2009] WASCA 92 [43]
Wong v The State of Western Australia [2011] WASCA 56

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Brendyn Dean Nelson, Coroner, having investigated the death of ***Paul Shen Vun WONG*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 10-13 February 2026, find that the identity of the deceased person was* ***Paul Shen Vun WONG*** *and that death occurred on an unknown date between 13 April and 25 April 2023 at Unit 3, 12 Westralia Gardens, Rockingham, from carbon monoxide toxicity in the following circumstances:*

Table of contents

Introduction

1 Paul Shen Vun Wong was a beloved son and brother, who died at his home in Rockingham sometime on or after 13 April and by 25 April 2023.

2 He was 40 years of age.

3 Paul[1] was diagnosed with schizophrenia in 2001, after prodromal symptoms manifested in 1998. His mental illness was complex and treatment resistant.

4 Between 2001 and 2022, Paul had over 70 admissions to health facilities for the purposes of his mental health and treatment.

5 He was diagnosed with schizoaffective disorder, bipolar type, in 2022 upon his discharge from Graylands Hospital following an extended admission of over six months.

6 At the date of his death:

(a) Paul was the subject of a community treatment order (**CTO**) under the *Mental Health Act 2014* (WA), with the Rockingham Kwinana Mental Health Service (**RKMHS**) being the community health service responsible for the CTO;

(b) the Public Advocate was Paul's limited guardian, with functions including to decide where Paul was to live, and the services to which he should have access;

(c) the Public Trustee was Paul's plenary administrator;

(d) Paul was living in a rent-subsidised unit in Rockingham, pursuant to a rental agreement between Paul, by his administrator, and the corporate entity Yaran SDA Pty Ltd as the trustee for Yaran SDA Trust (**Yaran**);

(e) Paul had an approved National Disability Insurance Scheme (**NDIS**) plan which granted him funds for, amongst others, provision of core disability support services, and support coordination;

[1] Paul's family requested that he be referred to by his first name at the inquest. I have adopted that same approach in these findings.

(f) the private organisation 360 Health + Community (**360 Health**) was engaged by Paul's guardian to provide support coordination to Paul pursuant to his NDIS plan; and

(g) the private organisation Phoenix Community Care (**Phoenix**) was recommended by 360 Health (on referral by Yaran) to Paul's guardian, who engaged Phoenix to provide Paul with in-home support services, seven days a week (initially for seven hours a day, and then reduced to four hours a day).

7 Despite the extensive network identified above, the evidence at the inquest demonstrated that:

(a) Paul died at his home, alone, from carbon monoxide toxicity, from an unknown source; and

(b) his death was not identified by anyone for, potentially, up to 12 days.

8 Paul's death was a tragedy.

9 The inability to be more specific about the date and manner of his death is more than a tragedy – in light of the framework that was in place including the number of agencies dedicated to his care in the community, it is an outcome that is entirely unacceptable.

10 The inquest into Paul's death was an inquisitorial, fact-finding exercise. It was not an exercise in apportioning blame or guilt.[2]

11 The reality, however, is that Paul's care network failed, and as a result he died in unknown circumstances.

12 A significant part of the investigation, by inquest, was spent seeking to ascertain the identity and responsibilities of those involved in Paul's care (and their interrelationships), and to identify the sequence of events, particularly in March and April 2023, that permitted Paul's death to occur and not be identified for days.

13 The investigation into both of those matters was made far more complex that it should otherwise have been by:

[2] ***Annetts v McCann*** (1990) 170 CLR 596, 616. See, also, s 25(5) of the *Coroners Act* which provides that a coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

(a) the inept recordkeeping practices of Phoenix, including after Paul's death and despite the awareness of Phoenix's sole director,[3] Faisa Mohamud (also referred to as '*Fay*') (**Faisa**)[4] that the death would need to be investigated; and

(b) the consistently inadequate engagement by Faisa in the provision of material to coronial investigators and the Court prior to, and even during, the inquest.

14 As the course of the inquest demonstrated, the apparently *laissez-faire* and evasive approach taken by Faisa in engaging with authorities in relation to the investigation into Paul's death was reflective of her general approach to Paul's care and welfare in early 2023, when others involved were trying to establish whether he was receiving supports as intended.

15 Paul's death is a reminder of the high degree of trust that is invested in those that care for members of our community who are vulnerable and are unable, including for reasons of mental health, to advocate for themselves.

16 It is also a warning for all those involved in the disability care industry of the risks that can arise, and the potential consequences, when even one part of a care network, like Phoenix in Paul's case, does not operate in a manner which reflects that trust. Paul's death is a cautionary tale for those who remain involved in this vital industry to be mindful of the potential that others may seek to evade scrutiny by those who are acting in good faith and trying to perform their role.

Jurisdiction and issues raised

17 Given the CTO was an involuntary treatment order[5] which remained in place as at the date of Paul's death:

(a) Paul was an involuntary patient under the *Mental Health Act* immediately prior to his death;[6]

(b) Paul was therefore a '*person held in care*' within the definition of that term in the *Coroners Act 1996* (WA);[7] and

[3] Exhibit 1, tab 31.
[4] Ts 293. The inquest heard evidence from, and in relation to, Faisa, and to a lesser extent, her sister Hamdi Mohamud. To avoid confusion, I will refer to them both by their first names in these findings, rather than by their surname. No disrespect is intended by doing so.
[5] *Mental Health Act* s 21(2)(b).
[6] *Mental Health Act* s 21(1).
[7] *Coroners Act* s 3.

(c) an inquest was required to be held to investigate his death.[8]

18 In addition to making findings as to Paul's cause and manner of death, if possible,[9] I am required to comment on the quality of the supervision, treatment, and care that Paul received whilst held in care.[10]

19 I may also comment on any matter connected with Paul's death, including public health or safety or the administration of justice.[11]

20 The inquest focused on a number of matters relating to Paul's manner of death, his supervision, treatment and care, and matters of public health and safety including:

(a) the management of Paul's mental health, including under the CTO;

(b) the management of support services provided to Paul pursuant to his NDIS plan;

(c) the scope of the coordination services to be provided by 360 Health, and others' understanding of the same;

(d) the scope of the support services to be provided by Phoenix, and others' understanding of the same;

(e) relatedly, who was responsible for the monitoring of Paul's mental health and his compliance with the oral medications he was required to take as a condition of the CTO;

(f) Phoenix's registration as a provider of disability support services by the NDIS Quality and Safeguards Commission (**Commission**);

(g) the contractual relationships between:

(i) the Public Advocate and 360 Health;

(ii) the Public Advocate and Phoenix; and

(iii) Phoenix and Yaran, insofar as they related to application of Paul's NDIS plan funds;

[8] *Coroners Act* s 22(1)(a).
[9] *Coroners Act* s 25.
[10] *Coroners Act* s 25(3).
[11] *Coroners Act* s 25(2).

(h) relatedly, the Public Advocate's approach (both at the time, and now) to contracting external providers to ensure the provision of support coordination and support services to represented persons who have NDIS funding;

(i) the adequacy of Phoenix's provision of support services to Paul in late 2022 and 2023 – in particular:

  (i) how Phoenix was operated and managed;

  (ii) how issues between Faisa and staff impacted on provision of support services to Paul (particularly in March and April 2023); and

  (iii) what support services were actually provided to Paul, and claimed for, by Phoenix (particularly in April 2023);

(j) Phoenix and Faisa's interactions with staff of 360 Health, in response to their inquiries (including as a response to inquiries and expressions of concern by RKMHS) about whether Paul was continuing to receive support services in April 2023;

(k) how staff at 360 Health and RKMHS otherwise addressed their concerns about Paul and whether he was continuing to receive support services in April 2023 (and what changes, if any, have been made to internal processes following Paul's death);

(l) the identity of the last person to see or have contact with Paul before his death;

(m) the last known activity by Paul prior to his death;

(n) the circumstances of the location of Paul's body;

(o) the investigations by police, forensic pathologists and other specialist experts to ascertain the cause of Paul's death;

(p) the investigations to determine the manner of Paul's death, given the lack of immediately apparent source of carbon monoxide to explain his apparent death by carbon monoxide toxicity;

(q) Faisa's interactions with agencies investigating Paul's death, including coronial investigators and this Court;

(r) relatedly, Faisa's retention and management of Phoenix's records relating to Paul, and her response on behalf of Phoenix to compulsive processes issued for the purposes of this investigation;

(s) the Commission's regulation of disability support service providers generally, including registration and compliance action; and

(t) the Commission's regulation of Phoenix and Faisa.

Course of the inquest

21 The coronial inquest occurred on 10 to 13 February 2026, inclusive.

22 Members of Paul's family attended the entirety of the inquest.

23 Paul's mother supplied materials to the Court to provide some information and background about Paul and his life, and she spoke briefly at the conclusion of the evidence. I reiterate the gratitude I expressed to her at the time for her participation in the inquest.

24 I am cognisant that it would have been a particularly difficult exercise for her, including where, at the conclusion of the evidence, I made it plain to her that many questions regarding Paul and the circumstances of his death would, necessarily, remain unanswered.

25 Several interested parties appeared through counsel at the entirety of the inquest; namely the South Metropolitan Health Service (**SMHS**) (which encompasses the RKMHS), the Public Advocate, and 360 Health.

26 Faisa appeared by her counsel during the course of her oral evidence, only.

27 She was granted the opportunity, through her solicitors, to make submissions after the conclusion of the oral evidence. The provision of that opportunity is addressed further below.

28 In order to make the findings required by the Act, and address the issues identified above at par [20], the following witnesses gave oral evidence:

(a) Pauline Bagdonavicious, the Public Advocate;

(b) Dr Nilotpal Das, a consultant psychiatrist with RKMHS and Paul's supervising psychiatrist under the CTO;

(c) Rachel Rigby, a clinical nurse specialist with RKMHS and Paul's case manager under the CTO;

(d) Mark Cooper, a senior social worker with RKMHS who provided some assistance to Paul's treating team, and who attended Paul's residence on 25 April 2023 and found his body;

(e) Man Cheng Leong, a former employee of 360 Health who provided support coordination to Paul from late November 2022 to mid-February 2023;

(f) Naomi James, a former employee of 360 Health who assumed the role of Paul's support coordinator from Ms Leong, and was in that role in April 2023;

(g) Judith Templeman, Senior Manager, NDIS Support, 360 Health, who had oversight of Paul's care coordination at all relevant times, and also assisted the Court by giving evidence in relation to 360 Health's internal root cause analysis review of the circumstances of Paul's death, and improvements made by that organisation since his death;

(h) Faisa;

(i) Hamdi Mohamud, Faisa's sister and a former employee of Phoenix (although the term of her employment and the exact nature of her role were unclear, including after her evidence);

(j) Ayub Abdi, a former employee of Phoenix who commenced as a support worker and was promoted to a managerial role before resigning in November 2022;

(k) Mahmud Badawy, a former employee of Phoenix who was promoted to a managerial role following Mr Abdi's resignation;

(l) Jaafar Ain, a former employee of Phoenix who worked as a support worker on a casual basis, and was Paul's primary and, seemingly, sole support worker from Phoenix during late 2022 and early 2023 prior to his resignation;

(m) Detective 1/C Jennifer Pen, a member of the WA Police's Coronial Investigation Squad;

(n) Catherine Myers, Deputy Commissioner, Regulatory Operations at the Commission, who gave evidence in relation to reports and information provided by the Commission to the Court regarding:

    (i) the registration and regulation of Phoenix; and

(ii) the Commission's approach to regulation of the disability support industry, generally (both at the time of Paul's death and as at today); and

(o) Dr David Joyce, a qualified medical practitioner and Emeritus Professor at the University of Western Australia, with specialties in pharmacology and forensic toxicology, who provided the Court an expert opinion on the results of postmortem toxicological analysis and the possible means of Paul's carbon monoxide intoxication.

29 At the inquest, the two volumes of the coronial brief were tendered. An additional ten exhibits were tendered during the course of the inquest.

30 As identified above, Paul's mother provided some of the documents from Paul's funeral, which provided me valuable context regarding Paul's life and his personality. Those documents were not received as formal exhibits, but I have had regard to them in making findings about Paul's personal background.[12]

Materials received after the inquest

Further exhibits

Material from Mr Ain

31 During the course of the inquest, Mr Ain gave evidence about:

(a) text messages and WhatsApp messages that he had sent to, and received from, Faisa in March and April 2023 about, amongst others, his work for Phoenix and provision of support services to Paul during that time, and which he had retained on his mobile telephone; and

(b) calls and text messages that he had made to Paul, including after he had stopped working for Phoenix, which were documented in the call history and the messages he had retained on his mobile.

32 In some cases, Mr Ain read the entirety of relevant text messages from his phone during the course of his giving evidence.

33 At the Court's request, screenshots of these messages were supplied by Mr Ain after the oral evidence, and were tendered as exhibits.

[12] Section 41 of the *Coroners Act* provides that a coroner holding an inquest is not bound by the rules of evidence and may be informed in any manner the coroner reasonably thinks fit.

34 Specifically:

(a) screenshots of a series of text messages between Faisa and Mr Ain from 7 March 2023 and 27 April 2023 became exhibit 13A;

(b) a screenshot of a WhatsApp message thread entitled '*PCC*' and showing messages on 22 December 2022, including from Faisa and relating to the employment of Hamdi by Phoenix, became exhibit 13B; and

(c) screenshots of a series of text messages from Mr Ain to Paul from 2 April 2023 to 18 April 2023, and Mr Ain's's call history with Paul from 31 March 2023 to 6 April 2023 became exhibit 13C.

35 Copies of exhibits 13A, 13B and 13C were supplied by the Court to the interested parties' solicitors, including the solicitors for Faisa, by emails dated 23 and 26 March 2026. This occurred prior to the request for any submissions by Faisa, as outlined below.

Material from Yaran and 360 Health

36 During the course of the oral evidence, it became apparent to the Court for the first time that a contractual relationship existed between Phoenix and Yaran that was relevant to the application of Paul's NDIS funds.

37 As a result, and at my direction, Counsel Assisting wrote to Yaran seeking clarification of its contractual relationship with Phoenix, including insofar as it related to the accommodation in which Paul resided prior to his death.

38 The director of Yaran Property Group responded by letter dated 20 March 2026, which was tendered as exhibit 14.

39 The letter was accompanied by:

(a) a copy of a '*Supports Property Subsidy (SPS) Agreement*' (**SPSA**) executed on behalf of both Yaran and Phoenix (which was tendered as exhibit 14A);

(b) a copy of Yaran Realty Pty Ltd's Tenancy Ledger in respect of Paul with entries from 15 July 2022 to 14 August 2023 (which was tendered as exhibit 14B); and

(c) a copy of the residential tenancy agreement between Yaran and the Public Trustee, for and on behalf of Paul as his plenary administrator (which was tendered as exhibit 14C).

40 Copies of exhibits 14, 14A, 14B and 14C were supplied by the Court to the interested parties' solicitors, including the solicitors for Faisa, by email dated 25 March 2026.

41 As a consequence of the contents of exhibit 14, namely disclosures alleged to have been made by Yaran to staff of 360 Health, the Court sought clarification from Yaran on specified factual matters. Yaran provided a further response by letter dated 2 April 2026. That letter was tendered as exhibit 16.

42 Exhibit 16 was provided to the solicitors for 360 Health on 7 April 2026, and the Court invited any response on behalf of 360 Health.

43 The solicitors for 360 Health responded by letter dated 4 May 2026, which was tendered as exhibit 17.

Material from the Office of the Public Advocate

44 Several matters arose during the course of Ms Bagdonavicious's evidence, upon which the solicitors acting for the Office of the Public Advocate indicated further information could be provided.

45 The Court received an email from the solicitors for the Office of the Public Advocate on 25 March 2026, which became exhibit 15.

46 The email referred to and attached:

(a) a copy of the Office of the Public Advocate's template Support Coordination Service Agreement (which was tendered as exhibit 15A);

(b) a copy of the Office of the Public Advocate's template Miscellaneous Services Agreement (which was tendered as exhibit 15B); and

(c) an extract of the Final Report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, including recommendations concerning the establishment of Community Visitor Schemes (which was tendered as exhibit 15C).

Material from the Commission

47 During the course of Ms Myers's evidence, several matters arose giving rise to a request by the Court for further information from the Commission regarding the regulation and compliance of disability support services.

48 On 9 April 2026, the Commission produced a report listing compliance matters involving Yaran Property Group, a deregistered provider linked to Yaran SDA Trust, and the Trustee for the Yaran SDA Trust.

49 The report was tendered as exhibit 18A.

50 On 29 May 2026, the Commission produced a further report, providing some additional information and annexing a report of the Commonwealth Auditor-General on the effectiveness of the Commission's regulatory functions dated 20 August 2025.

51 The further report, including annexures, was tendered as exhibit 18B.

52 Both reports were authorised disclosures to this Court pursuant to the exercise of the Commission's power under s 67E(1)(a) of the *National Disability Insurance Scheme Act 2013* (Cth).

Submissions

53 During the inquest, counsel representing the Public Advocate, SMHS and 360 Health were provided the opportunity to make oral submissions, including in response to provisional views that I expressed at the conclusion of the oral evidence, on the basis of the existing evidence. I have considered those submissions and dealt with them in the findings and comments made below.

54 At the conclusion of Faisa's evidence, I advised her counsel:

(a) that I would not be seeking oral submissions on her behalf at the end of the oral evidence[13] (which was a course consistent with her counsel's position at the time[14]); and

(b) that a set of potential adverse comments would be put to Faisa in writing for her response.[15]

[13] Ts 253.
[14] Ts 157.
[15] Ts 253.

55 Faisa's counsel agreed with that course.[16]

56 On 27 March 2026, I directed Counsel Assisting to send a letter to the solicitors acting for Faisa (who had appeared for her, and assisted her during her examination, at the inquest).

57 The letter attached an annexure containing 119 paragraphs representing findings and comments that I indicated may be made in relation to Paul's death and which concerned Phoenix or Faisa (or both).

58 The letter made plain that the purpose of the letter and annexure was to enable Phoenix and Faisa to file any submissions in response of the proposed findings and comments, including insofar as such an opportunity was required by s 44(2) of the *Coroners Act*.

59 That section provides that:

> Before a coroner makes any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

60 The letter was sent by Counsel Assisting to Faisa's solicitors on 27 March 2026, by email.

61 The letter directed that any response be provided by 4pm (WST) on 24 April 2026.

62 The Court did not receive any response from Phoenix, or Faisa or her solicitors by that time.

63 On 28 April 2026, and in the absence of any response, I caused a Judicial Support Officer of this Court to write to the solicitors for Faisa, noting the absence of any response, and advising that the Court would proceed on the basis that Faisa did not seek to respond.

64 I am advised by the Judicial Support Officer that, as of today's date, no response had been received from Faisa or her solicitors in relation to either of the emails of 27 March and 28 April 2026.

65 I therefore proceed on the basis that Faisa and Phoenix do not seek to make any submissions in respect of any of the proposed findings in relation to Paul's death.

[16] Ts 253.

Factual findings

66 In this part, I make factual findings about the circumstances leading up to and including Paul's death, including any findings which may underpin comments on the matters identified at par [20] above.

67 In making any findings of fact, I apply the principles arising from ***Briginshaw v Briginshaw***[17] concerning the evaluation of evidence and standard of proof in relation to allegations of a serious nature.

68 In assessing the evidence and reaching any conclusions (particularly in relation to the actions of officers from 360 Health, RKMHS and the Office of the Public Advocate), I have remained mindful of, and sought to avoid making findings or comments which are infected by, the potential cognitive influence referred to as '*hindsight bias*'.[18]

Assessment of witnesses

69 Given the dearth, and in many respects complete absence, of documentary records of Phoenix concerning the provision of support services to Paul, and some of the conflicting evidence between witnesses as to the same, it is necessary to assess the credibility and reliability of witnesses involved in Phoenix's operations.

70 I make some general findings regarding the same, as follows.

71 I had the benefit of observing the witnesses give evidence in Court, save for Faisa, who I observed give evidence via audiovisual link.

72 I was able to observe and hear Faisa at all times during the course of her oral evidence.

73 I have made assessments as to the credibility and reliability of witnesses based not just on their demeanour and the manner in which they gave evidence, but having regard to other matters consistency of their oral evidence with contemporaneous documentary evidence.

[17] (1938) 60 CLR 336.

[18] Although arising in different legal contexts which are not analogous, the principle is described in general terms in ***Rosenberg v Percival*** [2001] HCA 18; (2001) 205 CLR 434 [68]; ***Shire of Gingin v Coombe*** [2009] WASCA 92 [43].

Faisa

74 Faisa was summonsed to give evidence pursuant to s 46(1)(a) of the *Coroners Act 1996*.

75 Early in the course of her examination by Counsel Assisting, Faisa declined to answer questions on the grounds that her answer would criminate or tend to criminate her, pursuant to s 47(1) of the Act.[19]

76 I determined that it would be expedient, for the ends of justice, that Faisa be compelled to answer the question, and on that basis told her that if she answered the question and other questions that were put to her, I would grant her a certificate under s 47 of the Act.[20]

77 At the conclusion of her evidence, I determined that Faisa had given evidence to my satisfaction, and as such I was required to give her a certificate to the effect that she was called as a witness and that her evidence was required for the ends of justice and given to my satisfaction.[21] The effect of that certificate is as stated in s 47(3) of the Act.

78 As I indicated to Faisa (and her representatives) at the time, my determination that she had answered questions to my satisfaction within the meaning of s 47(2) of the Act did not mean that I accepted her evidence, in whole or in part, as being truthful or reliable.[22]

79 By my assessment, Faisa was an entirely unreliable witness who lacked credit.

80 Unless I have indicated otherwise, in any event where her evidence was in conflict with the documentary record or the evidence of another witness, I have preferred the latter and rejected her evidence.

81 I formed my view as to Faisa's credibility and reliability as a witness of fact for a number of reasons.

82 First, it was apparent that during her evidence, Faisa consistently sought to minimise the involvement of her family, including Hamdi and her brother Ayub Mohamud, in Phoenix's operations, historically, in a manner which did not reflect the limited contemporaneous documentary evidence.

[19] Ts 164.
[20] Ts 164.
[21] Ts 252.
[22] Ts 252.

83 By contrast, Faisa appeared, at every opportunity, to seek to inflate the involvement and responsibility of other employees of Phoenix who were not members of her family, including Mr Badawy and Mr Abdi.

84 For example, on one occasion during her evidence, Faisa initially indicated that Ayub Mohamud had been tasked with a certain responsibility, but then shortly thereafter, and for no clear reason, altered her evidence and stated that it was Mr Badawy who was responsible.[23]

85 It was one example of many occasions where Faisa appeared to mould her evidence to shield a family member, or herself, from any potential criticism, and to seek to ascribe responsibility for any potential failing to another employee of Phoenix.

86 Faisa's tendency to give answers which attributed any responsibility for oversight or failure in Phoenix's provision of services to Paul to employees such as Mr Badawy was, in a way, consistent with her ultimate acceptance that despite the fact that she was the sole director of Phoenix and bore ultimate responsibility for its operations, she (purportedly) delegated all of her responsibilities to others.[24]

87 However, her tendency to seemingly mould her evidence causes me, amongst other reasons, to doubt the accuracy of any of her evidence about the involvement of others in the operations of Phoenix, and the provision of support services to Paul by Phoenix.

88 Secondly, I doubt the veracity of Faisa's evidence where:

(a) in almost all circumstances, she was unable to recall any dates, or even give estimates of dates when asked; but

(b) she had an immediate recollection of a specific date in late March in response to a question from Counsel Assisting.[25]

89 The doubt as the veracity of her evidence was compounded by her subsequent refusal to accept the, seemingly uncontroversial, proposition that she was able to recall that specific date as a result of having either examined the coronial brief or a contemporaneous document shortly before giving her evidence.[26]

[23] Ts 210.
[24] Ts 233.
[25] Ts 199-200.
[26] Ts 200.

90 I conclude that given her consistent inability to recall specific dates or details, both in relation to Phoenix's operations generally, and in relation to the provision of services to Paul, Faisa would only have been capable of recalling that specific date with any immediacy as a result of reviewing materials more recently.

91 Faisa's refusal to accept that proposition from Counsel Assisting caused me to form the view that her evidence lacked candour, and undermined her credibility as a witness.

92 Thirdly, Faisa's evidence lacks credibility entirely where her initial, seemingly unequivocal, evidence was that:

(a) she understood Mr Ain to be attending on Paul daily, after she visited Paul in late March; and

(b) she was unaware that Mr Ain was not attending his address in Rockingham to provide support services until after Paul's death.[27]

93 That evidence was directly contradicted by Mr Ain's text messages with Faisa at the relevant time.[28]

94 Faisa only departed from this position once it was apparent that the Court was aware of the existence of those text messages,[29] and her presumably becoming aware that her account would be exposed, by those text messages, as being untruthful.

95 I do not consider, given the clarity of the questions put to her and the clear significance of the issues raised, that there was any basis for a conclusion that Faisa simply forgot, or was confused, about these matters when she was asked about them initially at the inquest.

96 It is apparent from the text message exchanges between Faisa and Mr Ain in April 2023 that she was acutely aware, particularly after becoming aware of Paul's death, of the importance of the issue as to whether Mr Ain had been attending to provide Paul with support services.[30]

97 Faisa's initial evidence that Mr Ain did not '*tell us anything*'[31] was demonstrative not just of her general untruthfulness, but also her tendency

[27] Ts 204.
[28] See, e.g., exhibit 13A, p 2.
[29] Ts 206.
[30] Exhibit 13A, pp 24-26.
[31] Ts 204.

to attempt to shift blame onto employees of Phoenix rather than accept responsibility herself.

98 Fourthly, Faisa was a persistently evasive witness.

99 She consistently returned to seemingly rehearsed refrains (such as '*been so long*'[32], and '*going through a lot at the time*'[33]) when confronted with questions or evidence which was seemingly contrary to her interests.

100 Her evasiveness was also evident in her attitude and responses to the requirement for Phoenix to produce all records relating to Paul, and her engagement with coronial investigators in relation to the same prior to the inquest and as recently as late 2025.

101 I find, as became apparent during her oral evidence, that Faisa, as director of Phoenix, did not take steps to secure and maintain that organisation's records relating to clients who were receiving NDIS-funded supports, including Paul.

102 During the course of her evidence, Faisa stated that Phoenix's records were in a storage unit, which had been organised by her mother, who had moved the records there.[34]

103 She agreed that she did not tell coronial investigators any of those facts as late as November 2025,[35] having been served with a Form 8 on behalf of Phoenix requiring production in September 2025, speaking with police investigators in the interim, and having received correspondence from then-Counsel Assisting seeking production of material.

104 I have serious doubt, given the vague nature of her evidence on the topic, and the somewhat self-serving nature of the evidence, that Faisa's evidence as to existence of the storage unit is truthful.

105 However, if her evidence were to be accepted as truthful, the inevitable conclusion is that Faisa abdicated responsibility for the storage and maintenance of confidential records about provision of services to NDIS participants to a family member who was not an employee of Phoenix.[36]

[32] See, e.g., ts 166-167, 170-171, 203, 206, 212, 229-230, 235-236, 238, 240, 243-244.
[33] See, e.g., ts 166, 168, 185-187, 209-210.
[34] Ts 183.
[35] Ts 188, 190.
[36] Ts 195.

106 Further, if the evidence as to how the documents were dealt with after Paul's death were to be accepted as truthful, then it follows that she did not take reasonable steps open to her – for example, making enquiries of her mother[37] – to identify and produce all records within the scope of the Form 8 issued to Phoenix, or in order to assist investigating police or this Court in the performance of its function.

107 The Form 8 issued on 23 September 2025 to Phoenix required production of *'all documentation/records relating to Paul Shen Vun Wong*'.[38]

108 Faisa's evidence that she did not identify the potential location of hard copy records despite knowing that that they were directly relevant to an ongoing coronial investigation, because she was not asked directly by the coronial investigator,[39] is at best, reflective of her general evasiveness toward this Court's inquiry.

109 I accept Detective 1/C Pen's evidence that she expressly asked Faisa Mohamud for '*everything*' relating to Paul when they spoke in November 2025.[40]

110 There is no conceivable basis for Faisa to have failed to disclose the potential location of hard copy documents in September 2025 (when the Form 8 was issued to her on behalf of Phoenix)[41] or in November 2025 (when spoken to by Detective 1/C Pen).

111 Faisa engaged with Detective 1/C Pen on multiple occasions by email, at least to the extent of explaining her need to collate all of the documentation and records and requesting additional time to be able to do so.[42] Faisa, at no point, gave any indication that she held hard copy records[43] including in any storage unit.

112 The damning nature of her failure to provide this information is even starker having regard to her text message to Mr Ain on 27 April 2023, correctly identifying that a police investigation may follow and urging him

[37] Ts 193.
[38] Exhibit 1, tab 34.1.
[39] Ts 188.
[40] Ts 385.
[41] Exhibit 8, p 9.
[42] See, e.g., exhibit 8, p 9.
[43] Ts 387.

to assist her with her '*inquiries*' in order to '*cover not only* [her]*self but* [Mr Ain] *too since* [he] *was the last person to be with* [Paul]'.[44]

113 That message shows a clear understanding by Faisa, from as early as April 2023, that she would be called upon to account for what happened to Paul and that any records held by Phoenix in that regard would likely be required.

114 The fact that she clearly expressed this understanding as of 27 April 2023 renders the various accounts provided during her evidence about the management of documents after Paul's death even more incoherent and incredible.

115 Faisa's evasiveness and lack of credibility are also demonstrated by the fact that, during the course of her examination by Counsel Assisting, it became apparent that she had at least two additional undisclosed sources of relevant documents notwithstanding her purported compliance with the Form 8 – the accounting software Xero (which she had accessed as late as the day prior to giving evidence),[45] as well as a Gmail email account.[46]

116 Faisa did not pro-actively disclose the existence of either of those sources of records of Phoenix to the Court, even after the issue of retention of documents and failure to produce had been expressly raised, and canvassed with her at length, during her evidence.

117 The failure is compounded by the fact that the existence of those two different sources of further documents arose at different times during her examination. At no point after the first additional source was identified, did Faisa raise the possibility of another. It only became apparent due to her answers to further questions put to her.

118 I find that Faisa's repeated reliance on matters being in the past and difficult to remember were justifications that she relied upon when convenient to her, including as part of her evasiveness in relation to the location of Phoenix's records.

119 For the reasons expressed above, Faisa was aware that any records of Phoenix that may have been stored by her mother on her behalf were critical to the Court's investigation. It was self-evident in April 2023, and continued to be so after the Form 8 had been served in September 2025.

[44] Exhibit 13A, p 26.
[45] Ts 227.
[46] Ts 233.

120 For that reason, she should have been able to readily recall whether, at any time since September 2025, she had asked her mother about the existence or location of such records. She was not able to answer that question, stating:

> I don't remember, honestly. It's been so long ago.[47]

121 The matters identified by Faisa during her re-examination by her counsel, reflecting personal difficulties she says she was experiencing prior to and at the time of Paul's death, are not an explanation for that specific failure, or her general failure to transparently engage with police or this Court's investigation of Paul's death.

122 Even if those matters had impacted her performance of her responsibilities in early 2023, they did not prevent her from making the barest, patently relevant inquiries about the documents in order to assist this investigation.

123 Her persistent failure to do so damages her credibility, and undermines her attempt to rely on personal matters as the reason for her apparent failures during the course of Paul's care.

124 Faisa's lack of candour and evasiveness is also demonstrated by her non-responsiveness to inquiries directly by the Court, prior to the inquest. For example:

(a) on 15 August 2024, in response to correspondence from the Court's Principal Registrar requesting a report by 26 August 2024, Faisa replied asking for more time, citing personal circumstances;

(b) Faisa failed to submit any report by 27 September 2024 (being the date to which an extension was granted) and failed to respond to an inquiry by then-Counsel Assisting on 11 October 2024;

(c) on 16 October 2024, Faisa replied seeking an additional two weeks, again citing personal circumstances and suggesting that a report was nearly complete;

(d) on 21 November 2024, then-Counsel Assisting sent a reply email, requesting an update, without response;

(e) on 13 February 2025, then-Counsel Assisting sent a further email, requesting an update, without response; and

[47] Ts 193.

(f) on 15 May 2025, Counsel Assisting sent an email reiterating the request for the promised report, and clearly requesting all records in relation to Paul, without response.

125 All of the above is in addition to the lack of transparency in dealings with Detective 1/C Pen including, in particular, her failure, at any time between service of the Form 8 and prior to her purported compliance, to raise the fact that despite previous suggestions she '*nearly had all documents together*',[48] she had only identified a single, unsigned document.[49]

126 Finally, Faisa's evasiveness in relation to any investigation of Paul's death was evidenced by her failure to respond to the Commission when it contacted her on 11 May 2023, raising Paul's death, or any of the follow up emails by the Commission on 16 May, 18 May or 24 May 2023.[50]

Mr Ain

127 To the extent of any inconsistency between the evidence of Faisa and Mr Ain, I prefer Mr Ain's evidence. I do so both for the reasons articulated above in relation to Faisa's evidence, but also because – unlike Faisa – Mr Ain's evidence was relatively consistent, in important respects, with seemingly open accounts he had provided to investigating officers, including in June 2023.[51]

128 Further, one of the primary disputes between Faisa's and Mr Ain's evidence was in relation to whether Mr Ain was paid, particularly in early 2023, for attending and acting as Paul's support worker, or whether his pay was delayed (being part of his rationale for resigning in April).

129 I expressly accept Mr Ain's evidence about performing work for Phoenix and not being paid, and pay being significantly delayed on occasions, in 2023 and reject Faisa's evidence to the contrary. I do so where (in addition to finding Faisa to be an unreliable witness generally):

(a) Mr Ain's evidence about complaining about delays in his pay, including in the context of the obvious need for a secondary support worker for Paul,[52] is inherently plausible;

[48] Ts 183.
[49] Ts 387.
[50] Exhibit 9.
[51] Exhibit 1, tab 15.1, p 3.
[52] Ts 109.

(b) Mr Ain's evidence is supported by records including Phoenix's bank records[53] and his text message exchanges with Faisa; and

(c) Mr Ain's evidence is consistent with the evidence of other former employees of Phoenix. [54]

Mr Badawy

130 To the extent there is a dispute between the evidence of Faisa and Mr Badawy about the course of his employment with Phoenix, I prefer the evidence of Mr Badawy.

131 I reach that conclusion for the three following reasons.

132 First, Mr Badawy consistently responded directly to questions from Counsel Assisting, without any apparent equivocation or seeming attempt to evade the question and any implication that might arise from it.

133 To the contrary, he readily made what might be considered concessions contrary to his own interests during the course of his evidence, without first needing to be taken to contradictory evidence.[55]

134 Secondly, his evidence about the manner of his formal resignation and his doing some additional work for Phoenix after that date was consistent with Hamdi's evidence.[56]

135 Thirdly, I am also inclined to accept Mr Badawy's evidence as being truthful given the candour in his acceptance that there was clear scope for improvement in the provision of services to Paul by Phoenix, and his appropriate expression of remorse toward Paul's family,[57] which were offered without any attempt to minimise his role.

Hamdi

136 As identified above, there was a lack of clarity about the role for which Hamdi was hired and the duties she performed at Phoenix.

137 The lack of clarity was due both to the absence of contemporaneous documentation, and the quality of Hamdi's oral evidence.

---

[53] Exhibit 1, tab 33.
[54] Ts 136, 138.
[55] Ts 137.
[56] Ts 266.
[57] Ts 139.

138 The WhatsApp message from Faisa to staff on 22 December 2022 makes plain that, at least at that time, Faisa intended that Hamdi would be the new service coordinator at Phoenix.[58]

139 The precise course of her employment and her responsibilities cannot be known, including where her oral evidence demonstrated that she was an abjectly poor historian,[59] and she frequently tended to answer that she did not know or could not remember, rather than seek to carefully recollect.

140 I place very little weight on most of her oral evidence, including where:

(a) she had to be prompted repeatedly to explain her own evidence;[60] and

(b) where she denied using a Phoenix email account at any stage, or engaging with any agencies about Paul[61] but ultimately accepted that she did so when confronted with contradictory evidence.[62]

Paul's personal background

141 Paul was born in East Fremantle on 19 November 1982.[63]

142 He was described as a caring, loving and sensitive, but lonely child.

143 Paul grew up in Rockingham in a relatively chaotic family environment. His father suffered from suspected bipolar disorder and alcohol use disorder.[64]

144 His parents separated in 1996, and his father was later imprisoned until his release on parole in October 2001.[65]

145 Paul left school at 16 and attended TAFE for a short time.[66] He worked at a fast-food restaurant and a lawn mowing company for a short period, but

[58] Exhibit 13B.
[59] Ts 255.
[60] Ts 259-260.
[61] Ts 260-261.
[62] Ts 266.
[63] Exhibit 1, tab 8, p 1.
[64] Exhibit 1, tab 20, p 3.
[65] ***Wong v The State of Western Australia*** [2011] WASCA 56 [5]. Paul's father had been convicted in 1997 for offences against a family member. In 2010, after trial, Paul's sister was convicted of the murder of Paul's father in June 2008: ***Wong v The State of Western Australia*** [2011] WASCA 56 [3], [7].
[66] Exhibit 1, tab 20, p 1.

was otherwise unemployed.[67]

146 At that time of his death, he was receiving a disability support pension.[68]

147 He had a limited network of friends and social connections.[69]

148 He enjoyed listening to music, especially the band Metallica, and had two guitars at home. He hoped to be able to join a guitar group.

149 He enjoyed going to the cricket and AFL and liked going to the library when he could go with support.[70]

150 Prior to moving to Rockingham, he lived alone in a unit in Osborne Park for about two years. He would visit his mother who continued to live in Rockingham, on which occasion he would see his younger brother.[71]

Paul's health

151 Paul had a complex mental health illness that was treatment resistant.

152 His mental illness started to manifest in 1998. He was initially diagnosed with depression and adjustment disorder while being treated by the Child and Adolescent Mental Health Service in 1999.[72]

153 He appears to have suffered his first documented acute psychotic episode in 2001, at which time he was diagnosed with schizophrenia.[73]

154 Between 2001 to 2022, he had at least 70 admissions to various health facilities due to medication non-adherence, relapse of psychosis and self-neglect.[74] He had 15 admissions to Graylands Hospital, alone, prior to November 2022.[75]

155 His treatment, frequently as an involuntary patient, meant that he was not trusting of mental health services.[76]

---

[67] Exhibit 1, tab 20, pp 1-2.
[68] Exhibit 1, tab 20, p 1.
[69] Exhibit 1, tab 20, p 1.
[70] Exhibit 1, tab 28, p 4.
[71] Exhibit 1, tab 28, p 4.
[72] Exhibit 1, tab 27, p 3.
[73] Exhibit 1, tab 20, p 2; tab 27, p 3.
[74] Exhibit 1, tab 20, p 2.
[75] Exhibit 1, tab 22.1, p 1.
[76] Ts 44.

156 He had been managed historically on community treatment orders from 2001 with durations between 3 weeks and 6 months. Those orders had, to an extent, allowed him to live relatively stabilised in the community, but with close supervision and fairly assertive treatment including in relation to medication compliance.[77]

157 Paul's psychotic symptoms would fluctuate in intensity and frequency,[78] and affected his functioning, but the intensity of symptoms including auditory hallucinations were significantly diminished by medication.[79]

158 According to Dr Das, Paul was incapable of understanding information about his diagnosis and treatment, in circumstances where even at his baseline his mental processing speed was extremely low, and worsened by episodes of psychosis.[80]

159 Even when his treatment was going well, Paul still had a base level of paranoia, which manifested in his feeling like he was being followed or that people were looking into his home from the park across the road.[81]

160 From the perspective of provision of support services, Paul was considered vulnerable, and a high risk and complex case.[82]

161 Paul was reclusive, and often unwilling to answer phones or doorknocks, or maintain appointments.[83]

162 He did appear, however, to build rapport with some staff providing him support at various times, including Mr Cooper and Mr Ain.

163 Mr Cooper interacted with Paul periodically over 12 to 13 years, having worked at the Alma Street Clinic between 2006 and 2016.[84] He first encountered Paul as his case manager when Paul was being managed by the Assertive Outreach Team in 2011.[85]

[77] Exhibit 1, tab 20.1, p 3.
[78] Exhibit 1, tab 20.1, p 2.
[79] Ts 12.
[80] Exhibit 1, tab 20.1, p 4.
[81] Exhibit 1, tab 21.1, pars [16]-[17].
[82] Ts 316.
[83] Exhibit 1, tab 12, p 2.
[84] Exhibit 1, tab 8, p 5.
[85] Exhibit 1, tab 10, pars [2], [4].

164 Mr Cooper would see Paul a few times a week, and sometimes a few times a day.[86] He saw Paul again in early 2022, to assist colleagues in RKMHS who were having some difficulty in case managing Paul.[87]

165 Mr Ain saw Paul regularly, and communicated with him including by phone. In terms of management of his own health, Mr Ain said that Paul regularly missed taking his medication, and Mr Ain would have to regularly remind him to take his medication.[88]

166 Paul was a chronic smoker.[89] He also had a history of alcohol abuse.[90]

167 He suffered from chronic obstructive pulmonary disease,[91] and had a lot of physical co-morbidities[92] including:

(a) chronic lymphoid leukaemia, which was stable;

(b) congestive heart disease;

(c) hyperprolactinaemia; and

(d) vitamin D deficiency.[93]

Paul's CTO

168 Paul had several admissions to Graylands Hospital, predominantly as an involuntary patient, in 2022.[94] He was first admitted in January-February 2022 for 18 days.[95]

169 As identified above, he had an extended 6-month admission at Graylands Hospital, ending in discharge in October 2022.[96]

170 He had been referred to hospital on that occasion from the Stirling Intensive Clinical Outreach Team due to the deterioration in his mental and physical health.

[86] Exhibit 1, tab 10, par [7].
[87] Exhibit 1, tab 8, p 6.
[88] Exhibit 1, tab 15, p 3.
[89] Exhibit 1, tab 10, par [6]; ts 52.
[90] Exhibit 1, tab 27, p 3.
[91] Exhibit 1, tab 10, par [13].
[92] Exhibit 1, tab 21.1, par [8].
[93] Exhibit 1, tab 8, p 7.
[94] Exhibit 1, tab 20, p 2.
[95] Exhibit 1, tab 22.3.
[96] Exhibit 1, tab 22.3.

171 As expanded on below, Paul's guardian determined that he should not be living independently any longer and organised a return to hospital.[97]

172 His diagnosis on discharge in October 2022 was schizoaffective disorder, bipolar type (having previously been diagnosed with schizophrenia and chronic residual symptoms and chronic paranoid schizophrenia).[98]

173 Paul had previously been engaged with RKMHS. On his discharge on 21 October 2022, he was subject to the CTO and required ongoing community mental health input and regular mental state assessments.[99]

174 Paul was referred back to Graylands Hospital by RKMHS on 10 November 2023 after the initial discharge failed, primarily due to non-compliance with medication and management.[100]

175 He was re-admitted for 15 days, and discharged on the CTO. During his comparatively short stay, he kept a *'very low profile*', and responded to encouragement to manage his personal care and hygiene.[101]

176 In relation to his compliance with medication, Paul had vehemently protested depot medication in the past and treating staff did not consider that he would comply with that medication.

177 For that reason, he was discharged on a CTO requiring compliance with oral medication.[102] A decision was taken to provide Paul with oral medication in Webster-packs, and treating staff had some comfort that Paul would comply in order to avoid re-admission to hospital.[103]

178 On 23 February 2023, Dr Das made an order for the CTO to continue for a further period of 2 months and 29 days (and to expire on 22 May 2023).[104] As a consequence, the CTO remained in operation during the window of time in April 2023 in which I have determined that Paul died.

179 Under the CTO, Paul was required to:

(a) attend the Rockingham Community Mental Health Clinic for regular psychiatric reviews with Dr Das, and to accept regular appointments

[97] Exhibit 1, tab 22.3.
[98] Exhibit 1, tab 21, par [10].
[99] Exhibit 1, tab 21, par [9].
[100] Exhibit 1, tab 22.1, p 1.
[101] Exhibit 1, tab 22.1, p 1.
[102] Exhibit 1, tab 20, p 2; ts 13-14.
[103] Ts 14.
[104] Exhibit 1, tab 20, p 4; exhibit 2, tab 1.

with Ms Rigby or other staff from the treating team either at the clinic or at home for ongoing support and monitoring of Paul's health;

(b) accept and take the prescribed medication (which at that time was olanzapine tablets 20 mg at night, aripiprazole tablets 15 mg in the morning and escitalopram 10 mg in the morning) or any other treatments as prescribed by treating psychiatrist; and

(c) allow support workers access to his home for provision of required care and support including cleaning, support with personal care, supervision of medication, community access and other support as per his treatment plan.[105]

RKMHS's case management

180 As identified above, RKMHS was the responsible service under the CTO when Paul was discharged from hospital in 2022.

181 The CTO, by its terms, required Paul to receive treatment from, and engage with, Dr Das and Ms Rigby.

182 Ms Rigby formed part of RKMHS's South Community Treatment Team, which provides long-term treatment for patients with severe mental health issues that cannot be managed through the ordinary course of consultations with community psychologists and psychiatrists.[106]

183 Ms Rigby holds a Masters degree in mental health nursing, and worked in RKMHS as a clinical nurse from December 2015 before becoming a clinical nurse specialist in 2023.[107]

184 As a senior clinician, Ms Rigby regularly managed clients with higher acuity or complexity, and she allocated Paul to her caseload for that reason.[108]

185 Ms Rigby first met Paul at a multi-disciplinary team meeting at Graylands Hospital in October 2022, which was also attended by representatives of 360 Health and Phoenix, including Mr Abdi and Mr Ain.[109]

[105] Exhibit 2, tab 1.
[106] Exhibit 1, tab 21.1, par [4].
[107] Exhibit 1, tab 21, pars [3]-[5].
[108] Exhibit 1, tab 21, par [11].
[109] Exhibit 1, tab 21, par [7].

186 I interpose that the documents indicate that this meeting was part of comprehensive interagency discharge planning.[110]

187 According to Ms Rigby, Paul did not tolerate long visits from her or any RKMHS clinicians. Paul was difficult to engage, and it took time to build any rapport with him. Despite being anxious and irritable in their meetings, he was rarely abusive towards her and never aggressive.[111]

188 Ms Rigby's attempts at building rapport with Paul were complicated by the fact that she had been required to refer Paul back to hospital after the discharge in October 2022, and again in mid-January 2023.[112]

189 Most visits that Ms Rigby conducted at Paul's home were held in the small courtyard outside the front of his unit,[113] on the basis that he did not want her to enter his home.

190 Paul received additional assistance through Rockingham Hospital's 'Hospital in the Home' (**HiTH**) program from 17 January to 30 January 2023, following a presentation to the Emergency Department due to poor sleep and mood.

191 It was documented in a discharge summary from that time, that Mr Ain was working collaboratively with the HiTH staff as Paul's carer 7 days a week, and there was no reference to any other carer from Phoenix attending to Paul at that time.[114]

Paul's guardianship, administration and NDIS plan

192 The Public Advocate was Paul's appointed guardian in 2022 and 2023, with functions to decide where he was to live, permanently or temporarily and to determine the services to which he should have access.[115]

193 The role of the Public Advocate in that circumstance is that of a legally appointed substitute decision-maker.

[110] Exhibit 1, tab 22.3, pp 3-4.
[111] Exhibit 1, tab 21, par [18].
[112] Exhibit 1, tab 21, par [14].
[113] Exhibit 1, tab 21, par [17].
[114] Exhibit 1, tab 22, p 3.
[115] Exhibit 1, tab 22, p 3; tab 25.

194 The Public Advocate does not play a direct role in the actual provision of disability services and supports, but consents to the services and supports to which a represented person, like Paul, has access.[116]

195 The delegated guardian's role was to provide advocacy as required to inform Paul's NDIS planning and then consent to the implementation of appropriate services and supports as provided for in his NDIS plan.[117]

196 Paul's delegated guardian made the decision in early 2022, based on his deterioration, that Paul was no longer capable of living independently,[118] and advocated for him to remain in hospital until new supported accommodation could be sourced.[119] While Paul was admitted to Graylands Hospital from 2 April 2022 to 21 October 2022, work was undertaken to source suitable accommodation, and to implement supports.

197 On 16 June 2022, Phoenix quoted the Office of the Public Advocate $177,405.12 for the provision of in-home support to Paul.

198 The quote does not contain any substantive details about the nature of the support to be provided, other than the quoted figure being based on provision of support for 7 hours a day, 7 days a week.[120]

199 On 17 June 2022, the delegated guardian provided advocacy on behalf of Paul by submitting a change of situation form to the National Disability Insurance Agency (**NDIA**) to seek a review of his existing NDIS plan.

200 It was hoped that this plan review would facilitate the inclusion of more targeted support to address Paul's needs and enable a successful hospital discharge and transfer back to community living.[121]

201 On 21 July 2022, the NDIA advised the Office of the Public Advocate that Paul did not meet the criteria for '*Independent Living Options*', '*Specialist Disability Accommodation*' or access to 24/7 supports.[122]

202 On 1 August 2022, Paul's new NDIS plan commenced with a total plan value of $200,557 which included an increase in core support funding from that provided in the previous plan.

---

[116] Exhibit 1, tab 27, p 1.
[117] Exhibit 1, tab 27, p 3.
[118] Exhibit 1, tab 22.3, p 1.
[119] Exhibit 1, tab 27, p 3.
[120] Exhibit 1, tab 27.1, p 3.
[121] Exhibit 1, tab 27, p 4.
[122] Exhibit 1, tab 27, p 4.

203 Around that time, the delegated guardian also provided consent for Paul to become a voluntary patient residing at the rental accommodation that had been located for him in Rockingham.[123]

204 360 Health notes that the results of the review of Paul's plan were:

(a) 90 days of '*medium-term accommodation (transition)*';

(b) 7 hours per day, 7 days per week of personal care support for the first 12 weeks of the new plan (from 1 August 2022);

(c) 4 hours per day, 7 days per week of personal care support for the remaining 40 weeks of the new plan (to 1 August 2023);

(d) occupational therapy;

(e) behaviour support; and

(f) 60 hours of support coordination (level 2).[124]

205 An individual living plan, including provision of supports by Phoenix, was executed, including on Paul's behalf, in August 2022.[125]

206 As identified, the Public Trustee was Paul's plenary administrator.

207 By email 28 May 2025, the trust manager at the Public Trustee confirmed that Paul's pension was managed in order to provide funds to him for groceries and an allowance, to pay rent, to pay utilities and to pay chemist accounts.[126]

208 An officer of the Public Trustee executed the lease on Paul's behalf for his subsidised accommodation in Rockingham on 25 August 2022.[127]

Support coordination by 360 Health

209 Paul was first registered as a client of 360 Health on 1 September 2021.[128]

[123] Exhibit 1, tab 27, p 4.
[124] Exhibit 1, tab 30, p 4.
[125] Exhibit 5.
[126] Exhibit 1, tab 26.
[127] Exhibit 14C.
[128] Exhibit 1, tab 30, p 2.

210 On 3 August 2022, the delegated guardian renewed the service agreement between the Office of the Public Advocate with 360 Health to continue to provide support coordination for Paul.

211 Ms Leong was the support coordinator at 360 Health allocated to Paul from 30 November 2022 to 7 February 2023. Ms Emma McNamara performed the role prior to Ms Leong.

212 Ms James was appointed to Paul's case from 20 February 2023 onward, replacing Ms Leong.[129] Ms Leong produced a detailed and comprehensive handover memo to Ms James which was in evidence.[130]

213 The role of the support coordinator was to connect Paul to his NDIS supports, monitor plan budgets and broker supports and services that aligned with Paul's wishes and the plan budget.[131]

214 The support coordinator had oversight of day-to-day service delivery matters and was required to keep the guardian informed of progress, changes and concerns.[132]

215 The support coordinator was required to liaise with support providers and the NDIA to ensure that Paul was getting the supports that he required, and that existing supports were appropriate and advocate for them as required.[133]

216 Despite only being funded under his plan for level 2 support coordination, 360 Health allocated a specialist (being a coordinator with qualifications beyond those required to provide level 2 coordination) and billed at the lower rate, in recognition of the complexity of Paul's case.[134]

217 As identified above, rental accommodation was sourced for Paul upon his discharge from hospital in 2022 in Rockingham. It is apparent that the accommodation was identified as a result of 360 Health contacting Yaran.

218 Ms McNamara emailed others involved in Paul's care on 5 May 2022, noting that she had contacted Yaran, who had two-bedroom apartments

[129] Exhibit 1, tab 30, p 2.
[130] Exhibit 1, tab 30, p 23.
[131] Exhibit 1, tab 27, p 3.
[132] Exhibit 1, tab 27, p 3.
[133] Ts 291.
[134] Ts 315-316.

available in Rockingham, including Unit 3, 12 Westralia Gardens, Rockingham.

219 Ms McNamara observed that Yaran charged a percentage of a person's income in rent, and that they '*are partnered with several SIL providers who provide the in home support*'.

220 She provided links for some of those providers, including Phoenix.

221 Ms McNamara advised that she had worked with Phoenix previously with other participants and had received positive feedback.[135]

Registration of Phoenix as a provider of disability support services

222 The Commission is the independent quality and safeguarding regulator for the NDIS established under s 181A(1) of the *National Disability Insurance Scheme Act*.[136]

223 The Commission regulates the NDIS to promote safe practices and improve the quality and diversity of providers' services.

224 The Commission's core functions include securing compliance with the Act through effective compliance and enforcement arrangements[137] as well as registration of providers and reportable incidents.[138]

225 The Commission is responsible for making determinations about the registration of providers to deliver services and supports to people with disability under the NDIS, and to monitor providers' compliance with their conditions of registration.[139]

226 Phoenix applied under s 73C of the *National Disability Insurance Scheme Act* to be a registered NDIS provider on 15 June 2021.[140]

227 On 16 September 2021, a provisional audit was submitted to the Commission, undertaken by approved quality auditor, QMS Certification Services (**QMS**).[141]

[135] Exhibit 4.
[136] Exhibit 12, par [8].
[137] Exhibit 12, par [9].
[138] Exhibit 12, par [10].
[139] Exhibit 12, par [11(a)].
[140] Exhibit 44, p 11.
[141] Exhibit 1, tab 44, p 12.

228 Phoenix's application for registration was approved by the Commission on 4 January 2022.[142]

229 Phoenix was approved to provide classes of support including:

(a) assistance in coordinating or managing life stages, transitions and supports;

(b) assistance with daily personal activities;

(c) assistance with travel/transport arrangements;

(d) community nursing care;

(e) assistance with daily life tasks in a group or shared living arrangement;

(f) development of daily living and life skills;

(g) household tasks;

(h) participation in community, social and civil activities; and

(i) group and centre based activities.[143]

230 A condition was imposed on Phoenix's registration under s 73G of the *National Disability Insurance Scheme Act* for the assessment of the remaining elements of the certification audit to be conducted three months after service delivery had commenced in any of the classes of support that required certification assessment.[144]

231 Phoenix was subsequently the subject of an out of cycle audit by QMS which identified two major non-conformities in incident management, as well as 17 minor non-conformities in Human Resource Management and Support Planning.[145]

232 The minor non-conformities were upgraded to an overall major non-conformity for each standard practice.[146]

[142] Exhibit 1, tab 44, p 12.
[143] Exhibit 1, tab 44.4, p 3.
[144] Exhibit 1, tab 44, p 13.
[145] Exhibit 2, tab 2, p 2.
[146] Exhibit 1, tab 44.4, p 3.

233 On 3 January 2023, QMS assessed Phoenix as not meeting the applicable standards and other prescribed requirements.[147]

234 On 28 June 2023, Faisa contacted the Commission in relation to Phoenix's mid-term audit due on 4 July 2023, advising that a mid-term audit had been booked for 18 August 2023 with an approved quality auditor, Global Compliance Certification (**GCC**).[148]

235 On 12 September 2023, QMS advised the NDIS Commission that it had withdrawn its ongoing certification of Phoenix.[149]

236 On 18 April 2024, Phoenix was issued a notice of requirement to give information and documents under s 73F(2)(i) of the *National Disability Insurance Scheme Act* by the Commission's Registration Monitoring Team. The notice required Phoenix to advise the Commission of scheduled mid-term audit dates.

237 It became apparent that Phoenix had sought transfer of certification from GCC to AQC Group Pty Ltd at some point before 20 June 2024.[150]

238 On 9 September 2024, the Commission issued an invitation to Pheonix to make a submission in respect of the intention to revoke registration. Phoenix did not make any submissions.[151]

239 On 4 November 2024, a delegate of the Commissioner advised Phoenix that its registration was revoked, on bases including that it had contravened and was contravening the *National Disability Insurance Scheme Act*.[152]

240 Based on the above, I find that at no time during its operations, including while providing support services to Paul, was Phoenix ever fully certified as capable of complying with the requirements to be a registered provider the *National Disability Insurance Scheme Act* and the associated rules.

241 Further, although conditionally registered with the Commission, Phoenix never completed all requirements of an approved audit.

242 I also find, based on the evidence that:

[147] Exhibit 1, tab 44, p 13.
[148] Exhibit 1, tab 44.4, p 3.
[149] Exhibit 1, tab 44.4, p 4.
[150] Exhibit 1, tab 44.4, p 4.
[151] Exhibit 2, tab 2, p 2.
[152] Exhibit 1, tab 44.4, p 5.

(a) contrary to her position,[153] Faisa's attempts to move from QMS to other auditors was not solely based on a potential cost saving;

(b) consistent with the view expressed by Ms Myers on her examination of the materials, given Phoenix's performance in the initial audit with QMS, Faisa was aware that QMS was unlikely to pass Phoenix in any further audit; and

(c) Faisa sought (unsuccessfully) to '*shop*' for other auditors that may pass Phoenix, and as per Ms Myer's independent assessment, Phoenix was, seemingly, '*obfuscating from their responsibility to complete the audit*'.[154]

243 In addition to the above, I find that when Phoenix was conditionally registered with the Commission:

(a) Faisa had no formal qualifications in the provision of disability services;[155]

(b) Faisa had never run any other business, including any business providing disability services;[156]

(c) Faisa's only previous experience in the provision of disability services was community access work she performed from 2019, for approximately a year, as a casual employee of a company called 'Perth Disability Services';[157] and

(d) no other employee of Phoenix had any formal qualifications in provision of disability services.[158]

244 That position remained unchanged throughout the period of time Pheonix provided services to Paul.

245 I reject Faisa's, seemingly equivocal, evidence that '*some of them*' (meaning employees of Pheonix) had a Certificate III[159] on the bases:

(a) there is no documentary evidence to this effect;

[153] Ts 243.
[154] Ts 409.
[155] Ts 161.
[156] Ts 163.
[157] Ts 162.
[158] See, e.g., ts 133.
[159] Ts 172.

(b) it is contrary to the oral evidence of other employees of Phoenix; and

(c) Faisa had no apparent basis make such an assumption, where she did not conduct any checks of employees' qualifications herself.[160]

Phoenix's operations and staffing, generally

246 Faisa was the sole director and, as a consequence, the controlling mind of Phoenix at all relevant times.

247 As identified above, she had no qualifications in provision of disability support services or running a business.

248 All of Phoenix's policies and procedures were produced by an external entity in New South Wales.[161]

249 There is no evidence that Faisa had any involvement in the production of Phoenix's policies or procedures, other than reading them before they were submitted to the Commission.[162]

250 In 2023, despite being the sole director of Phoenix, Faisa considers that she delegated all her duties and responsibilities to other staff at Phoenix.[163]

251 Faisa considers that she did so, despite being aware that no other employee of Phoenix had any experience in the provision of disability services, or running a business providing such services.[164]

252 I find that, in fact, Faisa did choose to have direct involvement in some aspects of the day-to-day operations of Phoenix, but primarily in relation to matters of Phoenix's banking, and payment to staff.

253 I find, including on the basis of Mr Ain's evidence and other documentary material, that on multiple occasions, including in early 2023, Faisa did not pay employees of Phoenix, including Mr Ain, for work they had performed for Phoenix, promptly or at all.

254 In about September 2022, Mr Abdi's access to Phoenix's bank accounts was removed by Faisa, and he was unable to pay staff.

[160] Ts 173-174.
[161] Ts 175-176.
[162] Ts 176-177.
[163] Ts 233.
[164] Ts 233.

255 Faisa told him that she was going to pay staff from then.[165]

256 Mr Abdi's recollection is that some staff went seven weeks without being paid and that staff members did unpaid support work for Paul.[166]

257 Mr Badawy states that he did the payslips for employees however he was not allowed to pay the employees and the pay was sent through by Faisa.[167]

258 The bank records in the brief[168] support the inference that there was no consistent payment of wages to Phoenix staff, including Mr Ain, in 2023.

259 I find that:

(a) Mr Ain was, in effect, the sole support worker for Paul from 10 August 2022 to 31 March 2023;[169]

(b) Mr Ain continued to work for the three weeks prior to 31 March 2022 despite not being paid by Phoenix, and formally resigned on 18 April 2023; and

(c) that, generally, on any days that Mr Ain was not at work, no one would cover his shifts.[170]

Phoenix's engagement with Yaran

260 360 Health approached Yaran in May 2022 as part of the attempt to identify suitable accommodation for Paul. Yaran referred Phoenix to 360 Health, who in turn recommended Phoenix to Paul's guardian.

261 During the course of Faisa's evidence,[171] it became apparent that there was, at that time, an existing commercial agreement between Yaran and Phoenix, which extended to the accommodation in which Paul was eventually housed in Rockingham.

262 Yaran and Phoenix executed the SPSA on 2 March 2022.[172]

---

[165] Exhibit 1, tab 37, par [28].
[166] Exhibit 1, tab 37, par [29].
[167] Exhibit 1, tab 38, par [20]; ts 138.
[168] Exhibit 1, tab 33 and 33.1.
[169] Exhibit 1, tab 39, par [11]. This is corroborated by the observations and recollections of other staff involved in his care, including Ms Rigby: exhibit 1, tab 21.1, pars [41], [46].
[170] Exhibit 1, tab 39, par [18]; ts 113-114.
[171] Ts 179.
[172] Exhibit 14A, 'Reference Schedule'.

263 In summary, Phoenix was required by the SPSA to pay Yaran an agreed contribution towards the costs of accommodation leased by Yaran to relevant participants such as Paul, calculated and invoiced in accordance with the terms of the SPSA.[173] The SPSA referred to the contribution as the '*Supports Property Subsidy*'.

264 That term was defined in the SPSA[174] to mean:

> …a 50% / 50% share of the Profits between the Supports Provider and the Accommodation Provider. GST at 10% will be added to the Supports Property Subsidy and a tax invoice raised by the Accommodation Provider.

265 The term '*Profit*' was defined to mean:

> …Supports Revenue plus Rent plus Rent Assistance minus Support Staff Wages minus Support Overheads.

266 The term '*Supports Revenue*' was defined to mean:

> …the revenue received by the Supports Provider from the NDIS for the provision of the Supports to the Client which will generally be at the maximum rates published from the NDIS from time-to-time.

267 In my view, Phoenix's entry into the SPSA, as a NDIS service provider, created a clear conflict of interest in relation to Paul.

268 The capacity for conflict was self-evident to experienced witnesses such as Ms Bagdonavicious and Ms Templeman when they both came to learn of the arrangement for the first time at the inquest.[175]

269 Entry into the SPSA created, at least, a potential disincentive for Phoenix to provide support services to clients, such as Paul, fully commensurate to the funding allocated under their respective NDIS plans, where part of the funds were liable to be redirected by Phoenix to Yaran.

270 Put another way, the requirement for Phoenix to pay a commission to Yaran in respect of a client meant that there was a potential incentive for Phoenix to allocate less resources (including by provision of less support, or services of an inferior quality) to clients than would otherwise reflect the funding it was receiving through the NDIS.

[173] Exhibit 14, p 3.,
[174] Exhibit 14A, cl 1.1.
[175] Ts 322, 358.

271 I find that the Public Advocate was not aware of the SPSA, and accept Ms Bagdonavicious's evidence that the agreement was not something to which consent would have been given by Paul's guardian.[176]

272 There is no documentation that indicates the conflict was raised with Paul's guardian, including by Phoenix, and no consent to entry into the SPSA, notwithstanding this conflict, was obtained from Paul's guardian.

273 Yaran stated that to the best its recollection, the SPSA and the payment by Phoenix of a '*subsidy towards the rent*' was explained to Paul's support coordinator.[177]

274 I find, based on the following, that staff of 360 Health were not aware of the effect of the SPSA, as it related to Paul's NDIS funds.

275 First, the SPSA contained a confidentiality clause constraining (absent consent of the party) use, disclosure or publication of '*Confidential Information*' to any person,[178] defined to include the existence and contents of the SPSA.[179]

276 The existence of this clause militates against the substantive terms of the SPSA being disclosed to 360 Health or its staff by Yaran or Phoenix.

277 Secondly, Ms James's evidence was that she had never encountered such an arrangement in her experience as a support coordinator.[180]

278 Thirdly, to the extent there was communication between staff of 360 Health and Yaran about the nature of any arrangement between Yaran and Phoenix, I accept Ms McNamara's explanation that she understood that a reference to '*income*' was a reference to Paul's Centrelink payments, not entitlements under NDIS funding.[181]

279 Fourth**ly,** when pressed, Yaran clarified that the recollection at par [273] above was the recollection of Mr Caio De Araujo, Yaran's NDIS Business Development Manager, and that he provided the verbal explanation to Ms McNamara. However, Yaran has no contemporaneous records recording the exact terms of any explanation.[182]

---

[176] Ts 357.
[177] Exhibit 14, p 3.
[178] Exhibit 14A, cl 6.
[179] Exhibit 14A, cl 1.1.
[180] Ts 302.
[181] Exhibit 17, par [16].
[182] Exhibit 16.

280 Based on the above, I find that neither Paul's guardian or 360 Health were aware of the operation of the SPSA insofar as it applied to Paul's NDIS funds payable to Phoenix.

281 I accept that Yaran had no direct involvement in provision, supervision or control of Paul's support services, and that the interactions between Yaran and Phoenix were limited to the SPSA and leasing logistics.[183]

282 I also note that Yaran has advised the Court that it has phased out the use of arrangements like the SPSA.[184]

Service agreement between Paul and Phoenix

283 I find that there was no service agreement between Phoenix and the Office of the Public Advocate, on Paul's behalf.[185] I also find that there was no service agreement between Phoenix and Paul, directly.

284 I make this finding, notwithstanding Faisa's evidence that entry into a service agreement with a client, and provision of a copy of that agreement to a client's guardian, was Phoenix's ordinary practice,[186] and that Paul had such an agreement.[187]

285 The evidence at the inquest was that neither Paul's guardian nor his support coordinator ever received a copy of such a document, and Ms Leong never saw one.[188]

286 I find that it is more likely (particularly given the findings above about how Phoenix was operated and the level of experience of relevant staff) that there was never a service agreement between Paul and Phoenix, than:

(a) there having been a service agreement that was not supplied to Paul's guardian or to his support coordinator; or

(b) there having been a service agreement with Paul that was provided to Paul's guardian and service coordinator at the time, but both have failed to retain it as part of their records.

[183] Exhibit 14, p 2.
[184] Exhibit 14, p 4.
[185] Exhibit 1, tab 27.3.
[186] Ts 194.
[187] Ts 195.
[188] Ts 278.

287 I draw the inference contrary to Faisa's evidence, in circumstances where Faisa did not check if there was a service agreement between Paul and Phoenix.[189]

288 I find that Faisa, at best, simply assumed that a service agreement existed between Paul and Phoenix, but never took any steps to confirm that this was the case.

289 The existence of a service agreement was not a prerequisite for the provision of NDIS supports by Phoenix to Paul.

290 However, it is recommended by the NDIA,[190] and the absence of such an agreement is, in my view, reflective of the standards of Phoenix's operations and delivery of support services at the time.

Events in late February to mid-April 2023

291 Ms Rigby had limited interactions with Phoenix,[191] but she knew Mr Ain to be Paul's main support worker. When Paul did not want support, Mr Ain was known to sit in the street and wait for Paul to contact him if needed.[192] Ms Rigby noted that Mr Ain had a good rapport with Paul, and would provide information to Ms Rigby on the basis that the source of the information would not be disclosed, so he could maintain his supportive relationship with Paul.[193]

292 On 23 February 2023, a phone call was made by RKMHS to Paul, during which Paul advised that he had not '*got his Support Worker as he was not getting paid*'.[194] Paul reported, later that day, that he had a support worker coming on 26 February.[195]

293 On 7 March 2023, Paul contacted RKMHS advising that he had been unable to collect his medications because the support worker did not show up on 26 February because he was not being paid.

[189] Ts 197.
[190] Exhibit 1, tab 27.1, p 1.
[191] Exhibit 1, tab 21, par [35].
[192] Exhibit 1, tab 21, par [24].
[193] Exhibit 1, tab 21, par [26].
[194] Exhibit 1, tab 20, p 11.
[195] Exhibit 1, tab 20, p 12.

294 Ms Rigby attempted to call Mr Ain, who did not answer. Ms Rigby contacted Ms James, who advised that she was '*unaware of the situation*' with the support worker and that she would follow up and make contact.[196]

295 Ms Rigby conducted a home visit to Paul that day.[197] During home visits, Ms Rigby's aim was to complete a mental state assessment, check medication compliance, look for signs of relapse that required escalation and ensure that Paul was not at risk of harm to himself or others.[198]

296 On 7 March 2022, Ms James called Faisa, who confirmed that Paul was receiving supports.[199]

297 There is no evidence that Faisa took any steps to confirm that this was the case, or was accurate.

298 Ms James emailed Ms Rigby, advising that Phoenix had confirmed that Paul's services were ongoing.[200]

299 Faisa and Mr Ain exchanged text messages on 16 March and 17 March 2023. The content of those text messages is as follows:

16 March 2023

Text messages from Faisa to Mr Ain:

Message 1: *"Hi I have been trying to get in contact with u since March 7th can you please call me asap"*

Message 2: *"I have being informed that Paul hadn't received any supports from u"*

Message 3: *"If you have stopped working you need to let us know I have being trying to call you no luck please call me back*"

17 March 2023

Text message from Mr Ain to Faisa:

"Hi Fay, I won't be taking any calls until we at least get paid on time. Since I've started, I've been working day in and day out nearly every day without making a fuss. Adding to that, none of my requests have even been acknowledged, and no one has gotten back to me about anything.

[196] Exhibit 1, tab 20, p 13.
[197] Exhibit 1, tab 21.1, par [25].
[198] Exhibit 1, tab 21, par [15].
[199] Exhibit 1, tab 30, p 6.
[200] Exhibit 1, tab 30, p 6.

I've worked every single day and have dealt with Paul alone with no help or concern from anyone. The responsibility has been only on me, and no one has even bothered to check in on him from phoenix this whole time.

The drive to work is 1 hour, and I have never complained. The only days I took off were the 3 days last week because I didn't get paid on time, and I had no fuel. Which I let Paul know about. I don't know who's been telling you otherwise.

I am there pretty much every day, and I'm always in the area if Paul goes to sleep or wants his space. I am there when he needs me and might not always be around when the mental health people are around because he tells me when he wants me to come in (I'd be around the corner).

Moving forward, I don't appreciate the calls coming in only when you hear something. Because when we need help or have requests, we never hear back about it. As well as for the last few months we aren't even getting paid on time. And it isn't a small delay either. It's weeks.

I'm doing right on my part, and as long as I know that. I'm not at fault. Especially when I've been the only one there helping Paul every day. No one else. I could have chosen not to go to work. Every day that we didn't get paid. But I still went in."

Text messages from Faisa to Mr Ain:

Message 1: *"I have being informed that you haven't been attending any of your shifts by the client"*

Message 2: *"I need to confirm"*

Message 3: *"As today is pay day"*

Message 4: *"Can you please call as I need to inform this"*

Message 5: *"This is very important as I need to speak with u in regards to Paul as I have being informed by the support coordinator that he hasn't being getting any support by you and I can't pay u if u don't get in touch with me by today 5pm"*

300 I find, based on the text message exchanges between Faisa and Mr Ain on 16 March 2023 and 17 March 2023[201] that:

(a) Mr Ain had not attended Paul's home on at least three occasions the previous week;

(b) Mr Ain had not attended due to his not having been paid by Phoenix for work he had performed in supporting Paul; and

[201] Exhibit 13A, pp 2-5.

(c) that from at least 17 March 2023, Faisa was aware of both of those circumstances.

301 I also note that there is no evidence which corroborates the assertion by Faisa in her text messages that '*the client*' had advised her that he was not attending shifts. There is no evidence that Faisa spoke to Paul, or was advised this by him.

302 Further, the reference to what Faisa had been '*informed by the support coorindator*' was not an accurate representation of what Ms James had asked on 7 March, nor what Faisa had told Ms James to have been the position on that date.

303 I interpose that the fact that Faisa engaged with Mr Ain directly through text messages contradicts any suggestion that issues concerning his attendance on Paul, and payment of his salary, were delegated to others, such that Faisa was unaware how they were being addressed.

304 Ms Rigby conducted another home visit on 20 March.

305 During the home visit on 20 March, Paul indicated that Mr Ain continued to '*provide support*'.[202]

306 During the home visit on 29 March 2023, Paul reported that he was receiving ongoing support from Mr Ain, although it was noted that Mr Ain was not present at the time.[203]

307 I place limited weight on the reports by Paul to Ms Rigby on 20 and 29 March that he was continuing to receive support. I accept Ms Rigby's evidence that Paul was inconsistent with his reports of the support Mr Ain was providing.[204] Further, the statements by Paul do not go so far as to affirm that Paul had in fact received support from Mr Ain, or another support worker from Phoenix, seven days a week.

308 During the home visit on 29 March, Paul was not displaying any acute psychotic symptoms, and was presenting at his baseline.[205] He was dishevelled, but otherwise pleasant and polite, and advised that he had been complying with his medication.

[202] Exhibit 1, tab 20, p 13.
[203] Exhibit 1, tab 20, p 14.
[204] Exhibit 1, tab 21, par [33].
[205] Ts 80.

309 Ms Rigby did not identify any acute risk.[206]

310 This is the last occasion that Ms Rigby saw Paul.[207]

311 I find, based on the evidence, that Faisa last spoke with Paul on 28 March 2023 during a home visit that she conducted.

312 I find that she attended to speak with Paul about provision of a new carer as she knew Mr Ain was likely leaving Phoenix,[208] and, based on the text message exchanges on 16 and 17 March, that Mr Ain had not been attending at Paul's home seven days a week.

313 This is consistent with her disclosure to a police officer on 28 June 2023 that she visited Paul on 28 March 2023:

> …in relation to finding a new carer due to [Mr Ain] no longer being able to care for the deceased.[209]

314 On 30 March 2023, Faisa contacted Ms James and told her that she had seen Paul the day before and he seemed fine.[210]

315 Faisa did not raise or discuss any concerns with Ms James about any interruptions in provision of services to Paul which, as I have found above, she knew to have been occurring.

316 Mr Ain last saw and worked with Paul on 31 March 2023.[211] He appears, on the evidence, to be the last known person to have seen Paul alive.

317 Mr Ain exchanged text messages with Faisa that day.[212] The following are extracts of two messages sent by Mr Ain to Faisa of particular relevance:

> Message 1: "Hi Fay, this is the last time I'll be addressing this. If I don't get paid by today or latest Tuesday I'll be reporting to NDIS that you are not paying your support workers and taking the money. I have already emailed my (4 week) hours to you earlier this week and have yet to be paid. We are up to the 5th week now. Thanks."
>
> Message 2: "…Good luck dealing with NDIS when they ring you and ask why I haven't been coming in from next week onwards. You can explain to them why you haven't been paying me and why Paul will have no care. Thanks"

[206] Exhibit 1, tab 8, p 8.
[207] Exhibit 1, tab 21.1, par [28].
[208] Exhibit 1, tab 12, p 2.
[209] Exhibit 1, tab 15.1, p 2.
[210] Exhibit 1, tab 30, p 7.
[211] Exhibit 1, tab 12, p 2; tab 15.1, p 3.
[212] Exhibit 13A, pp 11-16.

318 Those text message made it entirely plain that Mr Ain would not be attending to Paul from the following week, because he had not been paid.

319 I find that there is no conceivable basis upon which Faisa could have assumed that Paul was receiving continued supports from Mr Ain after his text message to her on 31 March 2023.

320 As a consequence, I find that as 31 March 2023, Faisa was aware that:

(a) Mr Ain had not been paid; and

(b) Mr Ain would not return to work (and attend on Paul) until he was fully paid; and

(c) no alternative carer had been sourced to attend to Paul.

321 I find, as a result, that there was no basis for Faisa to believe that after 31 March 2023, Paul was receiving any support services from Phoenix, or to advise others involved in his care that he was.

322 Ms Rigby expressed her concerns about whether Paul was being provided supports on 31 March 2023 to Ms James.

323 On 4 April 2023, Ms James emailed Ms Rigby advising that they had reached out to the care provider and assured Ms Rigby that Paul was still receiving regular support.[213]

324 Mr Ain sent text messages to Paul in early April, but he did not respond.[214]

325 On 14 April 2023, Ms James attended Paul's home.

326 She entered the gate, knocked and shouted out for Paul but there was no answer. She tried but was unable to contact Phoenix or Mr Ain.[215]

327 Faisa returned her phone call, and stated that she would try to see Paul that afternoon.[216]

328 Again, there is no indication that Faisa disclosed anything to Ms James about Mr Ain no longer providing supports and that no other replacement carer had been organised.

[213] Exhibit 1, tab 21, par [34].
[214] Exhibit 13C.
[215] Exhibit 1, tab 30, p 7.
[216] Exhibit 1, tab 30, p 7.

329 Around 16 April 2023, Mr Badawy resigned from Phoenix.[217]

330 Prior to his resignation, Faisa told Mr Badawy that Paul was still being cared for by Mr Ain.[218]

Last known activity by Paul

331 Records obtained from Uber indicate that the last activity on the account associated with Paul's name, phone number and email was a request for a delivery to 3/12 Westralia Gardens at 12.47 pm on 13 April 2023.[219]

332 The transaction is confirmed by his bank statement. There are no transactions suggesting any further activity by Paul after that date.[220]

333 Investigations by police did not identify any CCTV footage or mobile phone activity to assist in ascertaining the last people to see, or have contact with, Paul before his death.[221]

334 On that basis, and in the absence of any further evidence, I find that Paul died on or after 13 April 2023.

Events on 18 April 2023

335 Ms James attended Paul's home again on 18 April 2023.

336 Having received no response, Ms James contacted Faisa.[222] Ms James's file note, which I accept as being accurate records that:

> …Fay from Phoenix (core provider)…stated that Paul should be with support worker, however the support worker was not answering their phone. [Ms James] explained that this was unacceptable and wnated (*sic*) to confirm if Paul was actually receiving supports. Fay confirmed that he was. [Ms James] asked if Fay could follow up and keep her informed.[223]

337 Ms James waited outside for 30 minutes and attempted to knock again and call out to Paul but go no answer, so she left.

[217] Exhibit 1, tab 38, par [4].
[218] Exhibit 1, tab 38, par [17].
[219] Exhibit 1, tab 41.
[220] Exhibit 1, tab 43, p 7.
[221] Exhibit 1, tab 12, p 2.
[222] Exhibit 1, tab 30, p 37.
[223] Exhibit 1, tab 30, p 37.

338 Ms James then called Yaran, who advised that they were having difficulties getting in touch with Phoenix.

339 Ms James then called Faisa again to discuss the indication that Yaran wanted to look at Paul being moved to a new provider.

340 Ms James's file note records that:

> …Fay reassured that she will contact Yaran. She also stated that Paul will get distressed if support worker is changed due to the rapport he has built with the current support worker. [224]

341 I find, expressly, that Mr Ain was not paid in April 2023.

342 As a consequence, Faisa, based on her communications with Mr Ain by text message in March 2023, had no basis to believe that Mr Ain would be attending to Paul. Her reference to a '*current*' support worker was inaccurate and misleading.

343 Faisa had no basis upon which to make the statements that she did, with the knowledge that she had at the time.

344 It is not apparent from the file note at what time Ms James spoke to Faisa on 18 April.

345 However, it is apparent that at 12.31 pm on that date, Mr Ain sent Faisa the following text message, which included the following extract:

> *"Hi Fay, please count this as my resignation.*
>
> *I already told you in my last msgs that I wasn't going to go into work until you paid me in full, and that was 2 weeks ago. I left Paul in your hands. His responsibility was on you until you paid me what was owed."*

346 Given the absence of any evidence about the timing of Ms James's phone calls to Faisa on 18 April, I am unable to make a finding as to whether this text message was sent by Mr Ain, and received by Faisa, before she spoke with Ms James.

347 The evidence does indicate that Faisa received the message at about the time it was sent, because she sent messages in reply to Mr Ain.

348 As such, assuming favourably to Faisa that the text message was received after both occasions she spoke with Ms James, it is apparent that having received that text message, Faisa did not attempt to contact Ms James

[224] Exhibit 1, tab 30, p 37.

again – either that day, or later – to provide her with additional, highly relevant information about Paul's welfare, including that he had not received any attendance by a support worker for the past two weeks.

349 Further, this evidence makes it abundantly clear that Faisa's evidence that had she been told that Mr Ain was not attending to Paul, she would have organised another worker to go and do that shift, was false.[225]

350 She had been told on 31 March that Mr Ain would not be attending, and was told on 18 April that he had not attended in the preceding two weeks.

351 Even had she directed another Phoenix staff member to attempt to find a replacement at some time after 31 March (which is not established by any evidence other than her own self-serving account, and is contrary to Mr Badawy's evidence), she had no information by 18 April to suggest that this had occurred.

352 The fact that she did not disclose to Ms James:

(a) that, as she knew, Mr Ain had not been attending since end of March;

(b) that, as she suggests was the case, she had instructed other staff to find a replacement carer for Paul; or

(c) that she was simply assuming that Paul had a replacement carer,

leads me to conclude that her evidence about directing another staff member to find a replacement is a concoction developed after the fact.

353 Faisa, at best, took no steps to satisfy herself that Paul was receiving supports from a replacement carer, nor did she have any excuse to fail to advise Ms James of the true position as of that date.

354 Given the evidence, it cannot be said with certainty that Paul was alive at this time.

355 However, I find that Faisa's conduct on this day, including her complete lack of transparency and diligence, resulted in Ms James being denied any opportunity to take emergency action which might have ensured that Paul, if he were still alive, obtained necessary supports.

[225] Ts 210.

356 I find that Faisa was not transparent with Ms James, including on this date, to avoid disclosing what she knew to be the true state of affairs, which was that:

(a) Mr Ain had not been attending on Paul, certainly from the end of March 2023;

(b) no replacement carer had been identified by Phoenix from that time, and that no one had been attending on Paul from Phoenix; and

(c) yet, despite no one being identified to replace Mr Ain and attend on Paul, Phoenix was continuing to receive payment for provision of support services to Paul.

357 Additionally, Faisa advised an investigating police officer in June 2023 that she made further attempts at contacting Paul over the next few weeks after 28 March 2023 via phone calls, but they were unanswered by Paul.[226]

358 The available documentary evidence does not corroborate that account,[227] and I reject it.

359 Faisa advised the officer that '*no carer* [was] *provided due to not being able to meet and speak with* [Paul]'.[228] I consider that this was a concoction, and did not represent the true state of affairs in April 2023, as known to Faisa.

Ms Rigby's call for welfare check on 24 April 2023

360 Ms Rigby had attended Paul's home on 20 April 2023, but he did not answer the door.[229]

361 She re-attended Paul's home on 24 April 2023, and he did not answer. She noted that it was very unlike him not to be at home.[230]

362 Paul's apartment was within a unit complex consisting of multiple two-storey buildings with single storey units within. Unit 3 was a ground floor

[226] Exhibit 1, tab 15, p 2.
[227] Exhibit 1, tab 42.
[228] Exhibit 1, tab 15, p 2.
[229] Exhibit 1, tab 21.1, par [29].
[230] Ts 84.

unit, with access via a front gate facing the road.[231] The unit had a clear glass sliding door and large window leading into a private courtyard.[232]

363 Ms Rigby saw no evidence that Paul was at home, and everything appeared to be in the same place as it was from the previous visit on 20 April.[233] She tried calling Paul's phone, but was it was disconnected.[234]

364 She then tried to contact Mr Ain, and 360 Health.[235]

365 She called his mother, who advised that she had not received contact from him for about two months.[236]

366 Ms Rigby sent photos she took of Paul's entrance[237] to a number of recipients including Mr Abdi. She was unaware that Mr Abdi was no longer an employee of Phoenix.[238]

367 Ms Rigby consulted Dr Das about her concerns.[239]

368 Ms Rigby received a call from Ms James at 3.15pm, who advised of her unsuccessful attempts to conduct a home visit, and her difficulties in communicating with Phoenix.[240]

369 At about 4.30pm, Ms Rigby contacted the Police Assistance Centre and advised that Paul was missing from his home.[241]

370 The relevant entry in the WAPF Incident Report notes:

(a) that Paul had last been seen on 29 March 2023 at 9 am, at his home;

(b) that medication was visible inside Paul's home, which did not appear to have been touched since 20 April 2023, at least;

[231] Exhibit 1, tab 12, p 1.
[232] Exhibit 1, tab 12, p 1.
[233] Exhibit 1, tab 21.1, par [30].
[234] Exhibit 1, tab 21.1, par [31].
[235] Ts 83.
[236] Exhibit 1, tab 10, par [16].
[237] See exhibit 1, tab 45, pp 6-7.
[238] Ts 85.
[239] Exhibit 1, tab 21.1, par [33].
[240] Exhibit 1, tab 20, p 14.
[241] Exhibit 1, tab 8, p 1.

(c) that the house appeared to be undisturbed and unchanged to the staff from RKMHS who had visited on multiple occasions but had been unable to contact Paul.

371 The PAC took a number of actions, and Rockingham Police were tasked to undertake a welfare check on 25 April.[242]

372 I interpose that Ms Rigby emailed Mr Abdi on 24 April regarding her significant concerns for Paul's welfare. The only response she received from Phoenix was an email on 1 May 2023 (after Paul had been found deceased), from Hamdi advising that Mr Abdi had left and that she had taken over his role.[243]

Discovery of Paul's body

373 At about 10.50am on 25 April 2023, Mr Cooper attended Paul's apartment with Elizabeth Muronda, a registered nurse.[244]

374 Mr Cooper was aware that Paul had not been contacted or sighted recently, and because his shift was relatively quiet and he knew Paul, he made the decision to attempt a home visit that day.[245]

375 The front sliding door to the unit was unlocked,[246] and the door leading to the rear passageway of the building was locked.[247]

376 All external doors[248] and windows were closed.[249]

377 The air-conditioner in the main living room was on,[250] and set at a temperature of 21 degrees.[251]

378 No other appliances or water were running.[252]'

[242] Exhibit 1, tab 8, p 1; tab 14, p 3.
[243] Exhibit 1, tab 21, par [36].
[244] Exhibit 1, tab 10, par [18].
[245] Ts 54-55.
[246] Exhibit 1, tab 10, par [20]; tab 15, p 2.
[247] Exhibit 1, tab 2, p 2.
[248] Exhibit 1, tab 11, p 2; ts 56.
[249] Exhibit 1, tab 8, p 5; tab 15, p 2.
[250] Exhibit 1, tab 15, p 2; ts 56.
[251] Exhibit 1, tab 2, p 2.
[252] Exhibit 1, tab 15, p 2.

379 Mr Cooper recalls seeing multiple ashtrays piled full of used cigarettes.[253] He also recalls seeing used cigarettes on the floor.[254]

380 Ms Muronda described the state of the apartment as '*filthy*', with rubbish scattered around the unit.[255]

381 Photographs depict fast food and other food containers strewn on the floor of the living space adjacent to the kitchen.[256]

382 Photographs also depict mounds of cigarette butts and cigarette ash on a coffee table and small round table inside the entrance to the unit.[257]

383 The door to the bedroom was open,[258] and all internal doors were open.[259]

384 Mr Cooper did not observe any particular odour,[260] or any fire damage.[261]

385 Mr Cooper called out to Paul, but there was no response. He checked the front room and bathroom, before entering Paul's bedroom.[262] He has no recollection if the exhaust fan in the bathroom was on or off.[263]

386 Upon entering his bedroom, Mr Cooper observed Paul lying on his side, unmoving, wedged between the bed and the bedroom wall.[264]

387 Ms Muronda examined Paul, and was unable to find a pulse or observe any rise and fall in his chest. He was cold to the touch,[265] and unresponsive.[266]

[253] Ts 56.
[254] Ts 57.
[255] Exhibit 1, tab 11, p 1.
[256] Exhibit 1, tab 13, p 1.
[257] Exhibit 1, tab 13.
[258] Exhibit 1, tab 15, p 2.
[259] Ts 57.
[260] Ts 57.
[261] Ts 58.
[262] Exhibit 1, tab 10, pars [21]-[22].
[263] Ts 60.
[264] Exhibit 1, tab 10, pars [23]-[24].
[265] Exhibit 1, tab 10, par [25].
[266] Exhibit 1, tab 8, p 6.

Police investigations

388 At about 11 am, officers from Rockingham Police Station attended the address while Mr Cooper was on the telephone, having called emergency services.[267]

389 On arrival, they encountered Mr Cooper and Ms Muronda, who advised that they had come to check on Paul and found him dead on the floor of his bedroom.[268]

390 One of the officers was struck by an unpleasant odour upon entering the unit. He observed that Paul's body was on the floor between his bed and the bedroom wall, and that he was wearing a shirt and jeans.[269]

391 He noted that there no obvious injuries to Paul's body, and there were no signs of any struggle or any suspicious wounds.[270] There was significant pooling in the hands and feet.[271] Rigor mortis was present in all limbs.[272]

392 The officers took photographs of Paul's body *in situ*.[273]

393 One of the officers walked through the unit, and observed that the unit was extremely unclean, specifically noting:

(a) that there was rubbish all over the bedroom floor, including fast food packaging and leftover food; and

(b) that there were '*hundreds of cigarette butts*' all over the unit.[274]

394 Photographs taken from within the unit include a depiction of a small round wooden table next to the couch in the living space.

395 The photograph depicts a mound of cigarette butts and ash. There also appear to be more cigarette butts on the top of a glass top living room table.[275]

[267] Exhibit 1, tab 9, p 1; tab 10, par [26].
[268] Exhibit 1, tab 9, p 1.
[269] Exhibit 1, tab 9, p 1.
[270] Exhibit 1, tab 9, p 2.
[271] Exhibit 1, tab 9, p 1.
[272] Exhibit 1, tab 9, p 2.
[273] Exhibit 1, tab 9, p 2.
[274] Exhibit 1, tab 9, p 1.
[275] Exhibit 1, tab 13, p 2.

396 Photographs taken of Paul's bed depict, amongst others, what appear to be a number of small, pink balloons which have been tied off, but deflated.[276] At least two more can be seen on a photograph of the floor of the bedroom.[277]

397 Mr Cooper recalled seeing these, and advised investigating police that his initial thought was that Paul may have been inhaling nitrous oxide, but Mr Cooper searched and could not see any nitrous oxide cannisters.[278] None are visible in the body worn camera footage from attending police officers.[279]

398 Paul's mobile phone was searched, and no findings were made relevant to the circumstances of his death.[280]

399 The investigating officers formed the view that Paul's death was not suspicious, and there was no evidence of criminality or involvement of any third person.[281]

400 Webster packs were located, which had been dispensed on 2 March 2023 and 30 March 2023 and which appeared to be untouched.[282] None of the medication had been taken with every tablet dispensed still within the sealed packaging.[283]

401 I infer, from this, that Paul had not been taking his medication regularly in over a month, at least.[284]

402 At 11.08 am, Police Communities contacted St John Ambulance and requested their attendance at the address.[285]

403 Ambulance officers responded, arriving at 11.14 am.[286]

[276] Exhibit 1, tab 13, p 5.
[277] Exhibit 1, tab 13, p 6.
[278] Exhibit 1, tab 15, p 2.
[279] Exhibit 1, tab 46.
[280] Exhibit 1, tab 9, p 3.
[281] Exhibit 1, tab 9, p 3.
[282] Exhibit 1, tab 8, p 4; tab 13.
[283] Exhibit 1, tab 8, p 4.
[284] Exhibit 1, tab 2, p 2.
[285] Exhibit 1, tab 16.
[286] Exhibit 1, tab 8, p 2; tab 16.1.

404 Ambulance officers noted that Paul was obviously deceased, with gravitational dependant post-mortem hypostasis and rigor mortis.[287]

405 Officers also observed that there were no suspicious circumstances, or signs of any obvious trauma.[288]

406 Paul was declared life extinct by an ambulance officer at 11.24 am on 25 April 2023.[289]

407 His body was identified by Mr Cooper on 25 April 2023.[290]

SAC 1 investigation

408 SMHS conducted a Severity Assessment Code (**SAC**) 1 investigation into the circumstances of Paul's death. The report of the panel investigation was finalised in May 2023.

409 SAC 1 clinical incidents are clinical incidents that have or could have caused serious harm or death that is attributable to health care provision (or lack thereof) rather than the patient's underlying condition or illness. SAC 1 investigations form part of public health services clinical incident management.

410 In summary, the panel conducting the SAC 1 investigation:

(a) undertook a thorough examination of the RKMHS's engagement with Paul and other agencies, and outlined a detailed chronology based on the available medical records;

(b) identified that there was evidence of frequent communications from members of RKMHS to those providing services to Paul as part of his NDIS funding;[291] and

(c) concluded that RKMHS, including Ms Rigby, provided thorough management and extended the scope of their practice to facilitate Paul's support services remaining engaged in actively managing his other needs.[292]

[287] Exhibit 16.1, p 2.
[288] Exhibit 16.1, p 2.
[289] Exhibit 1, tab 4.
[290] Exhibit 1, tab 1.
[291] Exhibit 1, tab 24, p 13.
[292] Exhibit 1, tab 24, p 14.

411 I concur with these views. I express further comments on RKMHS's supervision, treatment and care of Paul, below.

Review and investigation by the Commission

412 On 11 October 2024, Counsel Assisting wrote to the Commission requesting that specified information be disclosed under s 67E(1)(b)(iv) of the *National Disability Insurance Scheme Act*, namely:

(a) whether the Commission investigated Paul's death; and

(b) whether a copy of the investigation report could be made available to this Court.[293]

413 By email dated 14 March 2025, a staff member of the Risk, Intelligence & Delivery, Regulatory Operations team of the Commission responded, advising that the Commission did not hold any records relevant to the request.[294]

Cause of death

414 Dr Daniel Moss, Forensic Pathologist and Head of Department at the State Mortuary Service, conducted an internal post mortem examination on 2 May 2023.

415 Following that examination, Dr Moss observed in his interim report that no definitive cause of death was identifiable, and further investigations and records were requested.[295]

416 In his initial report, Dr Moss identified that:

(a) there were early post mortem changes;

(b) the spleen and heart were enlarged;

(c) there were marked emphysematous changes to the lungs;

(d) there were pigmented spots in the stomach; and

(e) there was no evidence of any significant injury.[296]

[293] Exhibit 1, tab 32.
[294] Exhibit 1, tab 32.
[295] Exhibit 1, tab 5.2.
[296] Exhibit 1, tab 5.1, pp 1-2.

417 Following the completion of extensive further investigations, Dr Moss issued a supplementary report on 8 March 2024 in which he expressed his opinion that the cause of death was carbon monoxide toxicity.[297]

418 Dr Moss noted that:

(a) microscopic examination of tissues showed early post-mortem changes;

(b) early bronchopneumonia was seen within the lungs;

(c) microbiology and virology testing did not show the presence of specific pathogenic organisms;

(d) blood tests showed reasonable recent sugar levels;

(e) neuropathological examination of the brain showed cherry pink discolouration without further significant abnormality;[298]

(f) toxicology analysis showed a blood carbon monoxide level of approximately 55% haemoglobin saturation, a level well within reported fatal ranges; and

(g) toxicology analysis showed low levels of alcohol,[299] and other common drugs were not detected.[300]

419 The alcohol concentrations are low and of no toxicological importance.[301]

420 Toxicological analysis did not detect any of the medications prescribed to Paul.[302]. As observed by Dr Joyce, this outcome could be expected[303] given the evidence of the unopened medication located in Paul's home.[304]

---

[297] Exhibit 1, tab 5, p 1.
[298] In her report, the neuropathologist observed that the cherry pink discolouration of the brain parenchyma, which faded on exposure to air, raised the possibility of carbon monoxide toxicity: exhibit 1, tab 7, p 2.
[299] Toxicology testing demonstrated an alcohol level of 0.01% and 0.018% respectively in two preserved post-mortem blood samples. In the chemist's report, it was noted that the alcohol levels should be interpreted with caution as the exhibits displayed evidence of putrefaction: exhibit 1, tab 6.
[300] Exhibit 1, tab 5, p 1.
[301] Exhibit 1, tab 17, p 6.
[302] Exhibit 17, p 4.
[303] Exhibit 17, p 4.
[304] Ts 383.

421 I infer that Paul was not taking his medications prior to death, which is unsurprising given he was not receiving visits from any carer, responsible for monitoring the same,[305] for some time.

422 As identified by Dr Joyce, there was no evidence that Paul had access to or used high potency smokable drugs like synthetic cannabinoids, or high potency oral or injectable drugs like fentanyl derivatives or nitazenes.[306]

423 Dr Moss observed that although it was not clear from the history what the source of carbon monoxide might have been in this case, given Paul's levels, carbon monoxide toxicity was considered to be the cause of his death.[307]

424 According to Dr Joyce:

(a) the important finding for a toxicological perspective is evidence for carbon monoxide exposure sufficient to displace oxygen from binding in approximately 55% of circulating haemoglobin, to form carboxyhaemoglobin;[308] and

(b) there are two important areas for consideration prior to any acceptance of carbon monoxide poisoning as the cause of Paul's death.

425 The first is whether Paul's health and circumstances rendered him susceptible or resistant to carbon monoxide toxicity, and the second is whether the material measured as carboxyhaemoglobin was, truly, carboxyhaemoglobin.[309]

426 In relation to the first point, Dr Joyce observed that Paul's advanced, smoking-related chronic lung disease would have increased his risk of a lethal outcome from carbon monoxide exposure.[310] The failure to oxygenate tissue is compounded by lung conditions that themselves compromise oxygen transfer onto haemoglobin. Dr Joyce concluded that, overall, Paul presented the clinical picture of a person facing a relatively high risk of lethality from carbon monoxide exposure.[311]

[305] Ts 372.
[306] Exhibit 1, tab 17, p 5.
[307] Exhibit 1, tab 5, p 2.
[308] Exhibit 1, tab 17, p 6.
[309] Exhibit 1, tab 17, p 6.
[310] Exhibit 1, tab 17, p 6.
[311] Exhibit 1, tab 17, p 6.

427 Paul's advanced smoking related chronic lung disease would have increased his risk of lethal outcome from carbon monoxide exposure.[312] I find that Paul's chronic obstructive pulmonary disease increased his vulnerability,[313] but that his chronic lymphatic leukaemia did not increase his vulnerability (where he was not anaemic, according to Dr Joyce's review).[314]

428 In relation to the second point, Dr Joyce opined that ensuring the analyte measured was, indeed, carboxyhaemoglobin is essential in this case because the source and presence of carbon monoxide can only be inferred, with absolute confidence, from the circumstances of the death.[315]

429 In his report, Dr Joyce outlined further inquiries he had made, including with the chemist who performed the toxicological analysis, in order to exclude the possibility of other forms of haemoglobin being mistakenly recognised as carboxyhaemoglobin.

430 It is unnecessary to set out those matters in full, but it is relevant that Dr Joyce was able to conclude that the carboxyhaemoglobin concentration was measured with sufficient specificity and accuracy to be able to confidently draw the conclusion that it was truly present, and a consequence of Paul being exposed to carbon monoxide during life.[316] I accept his evidence in respect of these matters, in its entirety.

431 Given the above, I respectfully adopt the opinion of Dr Moss of carbon monoxide toxicity as my finding of Paul's case of death for the purposes of s 25(1)(c) of the Act.

Manner of death

432 There is no evidence that Paul sought to intoxicate himself with carbon monoxide to cause his own death. He had made no recent threats to himself, and had not demonstrated any signs of intention to self-harm. He generally felt safe in his own home, but unsafe outside.[317]

433 Similarly, there is no evidence of any other person seeking to expose him to carbon monoxide to cause him harm. There was no indication of Paul

[312] Exhibit 1, tab 17, p 6.
[313] Ts 372.
[314] Ts 373.
[315] Exhibit 1, tab 17, p 7.
[316] Exhibit 1, tab 17, p 7.
[317] Exhibit 1, tab 8, p 8.

expressing any concern prior to his death that he was going to be the subject of harm by others.[318]

434 There were no signs or evidence of anyone else being at the property shortly before Mr Cooper attended.[319]

435 The evidence is that Paul did not have regular visitors, other than Mr Ain and staff from community mental health.[320]

436 Paul had not sustained any observable injuries, and there was no evidence of any criminality identified by investigating police.

437 Based on the above, I exclude the involvement of any intentional act by a third party in Paul's death.

438 The circumstances in which Paul was exposed to, and was intoxicated by a fatal level of carbon monoxide, cannot be known with certainty.

439 Carbon monoxide kills because it displaces oxygen from haemoglobin, so the blood cannot carry oxygen to tissue in amounts needed to sustain life.[321] Carbon monoxide effectively starves tissues, and can create problems even if there are significant amounts of oxygen otherwise available.[322]

440 It is an is odourless gas.[323] On that basis, Mr Cooper would not have been able to smell it when he arrived on 25 April. Further, Paul would not have been alert to it increasing within his house prior to his death (including where his mental health was likely deteriorating, in the absence of medication monitoring and compliance).

441 A common cause of carbon monoxide toxicity in homes arises from the incomplete combustion of fuels, such as gas, oil, wood or coal, in malfunctioning or improperly vented appliances. Carbon monoxide could also be released from incomplete combustion of material in a house fire, for example carpet or a sofa.[324]

442 There was evidence of some burn marks within Paul's home.

---

[318] Ts 48.
[319] Ts 66.
[320] Ts 130.
[321] Exhibit 1, tab 17, p 6.
[322] Ts 368.
[323] Ts 367.
[324] Ts 367.

443 The carpet burns observed by Dr Joyce in available photographs appeared to be '*a long way short*' of what he considered might be required for carbon monoxide poisoning.[325] I agree with that view.

444 There was no garage or car parking with a vehicle within the vicinity of Paul's unit,[326] from which petrol engine exhaust may have been percolating through the home through the air conditioner unit.

445 Even though reticulated gas in Western Australia does not contain carbon monoxide, circumstances of incomplete combustion in a gas appliance could still generate carbon monoxide.[327]

446 The person who resided in the unit from 14 June 2023 for three months provided a statement to police.

447 In her statement, she noted that she was the only occupant of the property, and that when she moved in, all appliances appeared to be in working order.[328]

448 She noted that when she turned the air conditioning unit on in the living area, there was a strong smell of cigarette smoke.[329] She also noted that when she used the bathroom exhaust fan, the smell of cigarette smoke became worse.[330]

449 She did not refer in her statement to experiencing any health issues during or immediately after the three-month period of her living in unit 3.

450 The fact that the subsequent occupant of the unit did not experience any apparent intoxication permits an explanation of carbon monoxide being distributed into the home by some fault in the air conditioning to be safely set aside.[331]

451 Further, the properties at 12 Westralia Gardens, including unit 3, were built without a gas connection.[332] There were no gas appliances in the

[325] Ts 375.
[326] Exhibit 1, tab 17, p 7.
[327] Exhibit 1, tab 17, p 8.
[328] Exhibit 1, tab 19, pars [3]-[6].
[329] Exhibit 1, tab 19, par [9].
[330] Exhibit 1, tab 19, par [20].
[331] Ts 380.
[332] Exhibit 1, tab 18, par [5].

building at all,[333] and all applications in the unit, including rangehood, cooktop and oven, were electronic when Paul was living in the unit.[334]

452 Investigating police identified no other sources of carbon monoxide other than cigarette smoke.[335]

453 Dr Joyce's opinion was:

(a) that smoking, and smouldering cigarette butts, appeared to be the only remaining putative source of the carbon monoxide; and

(b) that intense cigarette burning, perhaps with some contribution from smouldering carpet burns and perhaps in a room with a closed door is a '*just credible*' source of the carbon monoxide.[336]

454 Dr Joyce noted that in smokers the percentage of total haemoglobin which was carboxyhaemoglobin was typically up to about 10%.[337]

455 There are examples in literature of smokers reaching concentrations sufficient to cause symptoms of carbon monoxide poisoning, including rare examples of up to 35% carboxyhaemoglobin.[338]

456 Dr Joyce was not able to locate examples with concentrations approaching the approximately 55% found in Paul's blood.[339] He was also not able to identify any reported case of cigarette smoke causing fatal carbon monoxide toxicity.[340] This was the only case Dr Joyce had encountered, in his professional experience and upon his review of the literature where it appeared that the most plausible explanation for fatal carbon monoxide was cigarette smoking.[341]

457 There was ample evidence, from multiple witnesses, that Paul was a very heavy smoker.

[333] Ts 382.
[334] Exhibit 1, tab 18, pars [6]-[7].
[335] Ts 382.
[336] Exhibit 1, tab 17, par [28].
[337] Ts 376; exhibit 1, tab 17, p 8.
[338] Exhibit 1, tab 17, p 8.
[339] Exhibit 1, tab 17, p 8.
[340] Ts 379.
[341] Ts 369.

458 Mr Cooper observed that Paul would smoke excessively '*continually puffing cigarettes, drag after drag*'.[342]

459 When Paul smoked inside at home, Mr Ain would have to remind him to leave the door open to let smoke out.[343]

460 Mr Ain stated that Paul often left his cigarette butts around the house, which Mr Ain would clean up.[344]

461 Ms Rigby referred to Paul as a chronic heavy smoker, whose unit smelled of stale tobacco smoke, and explained that when he was avoidant of support services, his unit was often dirty with cigarette ash.[345]

462 Carboxyhaemoglobin concentrations rise over time, when carbon monoxide is present in inhaled air, with evidence that a concentration exceeding 55% can be achieved by inhaling air containing 1000 parts per million for five hours.

463 Where cigarette smoke contains 50,000 to 70,000 parts per million, it is credible that a person who was inhaling 2% of his total air intake as cigarette smoke could get to a carboxyhaemoglobin of 55%.[346]

464 In order to have reached the level identified, Paul would have had to have continued to inhale carbon monoxide from the smoke being released by smouldering cigarette butts, even after he, inevitably, reached the point of stupor and, potentially, coma.[347]

465 In other words, even if Paul had been smoking excessively, in order to reach the level of toxicity identified, he would have had to have continued to inhale carbon monoxide while incapacitated, prior to death.

466 Having watched the body worn camera footage of attending officers, it appears most likely that Paul has rolled off his bed, on to the floor of the bedroom, at some point.[348] I am prepared to infer that Paul became incapacitated at some point while lying on his bed, and rolled on to the floor, where his body was found.

[342] Exhibit 1, tab 15, p 2.
[343] Exhibit 1, tab 39, par [34].
[344] Exhibit 1, tab 39, par [35].
[345] Exhibit 1, tab 21, par [21].
[346] Exhibit 1, tab 17, p 9.
[347] Ts 377-379.
[348] Exhibit 1, tab 46.

467 At the inquest, Dr Joyce confirmed that carbon monoxide would continue to be released from smouldering cigarette butts.

468 As identified above, attending police on 25 April stated that there were hundreds of cigarette butts all over the unit.[349] The photographic evidence demonstrates that there were substantial mounds of cigarette butts and ash on the tables in the living area, at the front of the house.

469 However, there is no evidence of substantial amounts of cigarette butts or ash being located in his bedroom, where his body was found.

470 The photographs and footage that are available depict far fewer cigarette butts strewn on the floor of the bedroom, and no mounds comparable to the piles on the table toward the entrance to the unit[350]

471 I note the evidence that the internal doors in the home were open and all exterior doors and windows were closed, such that any carbon monoxide released from cigarette butts smouldering in the living space may have been capable of being inhaled by Paul in the bedroom.

472 However, this feature of the evidence causes me doubt, even where – as Dr Joyce correctly observes – cigarette smoke is the only remaining putative source.

473 I accept Dr Joyce's evidence in its entirety, and find no fault in any of his analysis or logic. Notwithstanding, I do not consider the evidence of what investigating officers were able to observe at the time, in addition to Dr Joyce's expert opinion, is sufficient to make a finding, to the requisite standard, that cigarette smoke was the cause of the fatal carbon monoxide toxicity.

474 However, I consider that where other all verdicts (including suicide and natural causes) can be excluded, and there is no evidence of any third-party involvement, I am in a position to find that death occurred by way of accident (although the precise means remain unknowable).

475 For the purposes of s 25(1)(b) of the Act, I find that Paul's death occurred by way of accident.

[349] Exhibit 1, tab 9, p 1.
[350] Exhibit 1, tab 13, p 7.

Comments on treatment, supervision, and care

476 Based on the evidence at the inquest, I accept the submission made by counsel for 360 Health that the number of supports provided to Paul created some complexities, particularly where the structure of those systems was not strictly hierarchical.[351]

477 It would also be abundantly clear from the above, and I accept that, most of the agencies involved in Paul's care were dependent on other agencies '*doing the right thing*' and acting in good faith.[352]

478 The only observation I make, at a general level, is that there was clearly scope for someone involved in Paul's care to seek to convene a case conference at some stage – if not in March 2023, then sometime in April, in order to discuss concerns about provision of supports to Paul and communication by his support provider, generally.

479 It is common for case conferences to occur between health agencies and support services and carers,[353] and they can permit a more thorough exchange of information.[354]

480 At the inquest, Ms James accepted that such a conference was necessary.[355]

481 In this instance, I conclude that such a conference was likely the only mechanism that might have allowed staff at RKMHS, the Office of the Public Advocate and 360 Health to identify that they were all, ultimately, operating with reliance on information supplied by Phoenix, which was creating an, as at the time unidentified, issue of circuity.[356]

482 The above comments do not detract from the findings and comments I have already expressed, identifying the part that Phoenix, and in particular Faisa, played in depriving others involved in Paul's care the opportunity to perform their roles to their best ability.

[351] Ts 433.
[352] Ts 434.
[353] Ts 326, 364.
[354] Ts 362.
[355] Ts 301.
[356] Ts 323.

Public Advocate

483 I find that the Public Advocate, through her delegate, performed the role of guardian adequately, and that there is no basis for any adverse comment in relation to Paul's death.

484 The Public Advocate was, as of 31 December 2025, the guardian of last resort for over 4,000 Western Australian adults, more than 2,500 of which were NDIS participants.[357]

485 As of 31 March 2023, the Public Advocate was appointed guardian for around 3,300 people.[358] I infer that the proportion of NDIS participants amongst represented persons in late 2022 and early 2023 would not have been markedly different to the ratio in 2025.

486 Although Paul's psychiatric condition was serious and complex, I accept that his case was one of the delegated guardian's relatively routine cases because, absent any reports of concern, few guardianship decisions were required to be made.[359]

487 I find that the Public Advocate took appropriate steps in 2022 in order to ensure that Paul was provided with sufficient medical care, and that accommodation and support services were procured in order to ensure his health and wellbeing.

488 I also find that the Public Advocate made appropriate attempts in July 2022 to increase Paul's NDIS funding, but that those efforts were unsuccessful through no fault of the guardian. [360]

489 I accept that the Public Advocate is necessarily reliant on specialists to identify suitable support providers,[361] and must act on recommendations from others[362] where the Public Advocate and delegates do not necessarily have qualifications in support coordination and provision of support services, and are not working in those industries on a daily basis.[363]

490 I also accept the position taken by the Public Advocate at the inquest that, given the way in which the NDIS operates and the Public Advocate's

[357] Exhibit 1, tab 27.3, p 4.
[358] Exhibit 1, tab 27.3, p 4.
[359] Exhibit 1, tab 27.3, p 4.
[360] Ts 27-28.
[361] Ts 350.
[362] Ts 354.
[363] Ts 447.

function as the guardian of last resort, guardians are almost effectively obliged to have a support coordinator in place for any represented person with NDIS funds, from the guardian's perspective.[364]

491 I do not consider that there is scope for criticism regarding the acceptance of the accommodation that was obtained from Paul, which was clearly suitable and consistent with Paul's views and wishes.

492 I also accept that there was no outward indication available to the Public Advocate, as of mid-2022, that Phoenix was not suitable to contract with in relation to provision of support services to Paul.[365]

493 To the extent that the Public Advocate engaged Phoenix without a service agreement in place, I accept that the Public Advocate implemented its own service agreements into everyday practice in March 2025 (after a necessary period of consultation), and that the agreements have been improved and strengthened further since.[366]

494 I accept that by virtue of these standard agreements, the Public Advocate, as guardian, now has an increased ability to have a line of sight over service providers.[367]

495 There are now far greater express obligations placed on service providers like Phoenix, contractually, than was the case, historically,[368] ensuring greater protection for the protected person and the State[369]

496 Specifically, the standard service agreements:

(a) require mandatory reporting by service providers of serious concerns about a participant's health, safety and wellbeing to the guardian within 24 hours;

(b) make plain the duty for service providers to declare conflicts of interests, and the requirement for the guardian to approve of real or perceived conflicts;

(c) require service providers to notify the guardian of any compliance action taken by the Commission against the provider; and

[364] Ts 355, 362.
[365] Ts 450.
[366] Exhibit 15; see also exhibit 1, tab 27.3, p 7.
[367] Ts 353.
[368] Ts 359.
[369] Ts 360.

(d) require support coordinators to undertake specified due diligence in relation to service providers.[370]

SMHS

497 I consider that RKMHS's treatment and care for Paul was satisfactory.

498 RKMHS took appropriate and adequate steps to monitor Paul under the CTO. Home visits were conducted regularly, at least once if not twice a month from October 2022 onward,[371] including when Paul refused to attend the clinic as required.[372]

499 Ms Rigby understood Phoenix would be monitoring his medication compliance, and that she would be contacted if he was non-compliant.[373]

500 This is consistent with Mr Ain's,[374] and Ms Templeman's evidence.[375]

501 It is also consistent with the terms of the CTO,[376] and the content of the discharge summary after Paul's admission to Graylands Hospital in November 2022.[377]

502 Although the network of care providers was complex and there may have been lack of precision about other responsibilities,[378] there was clear consensus on this point.

503 Therefore, I find that it was commonly understood that part of Phoenix's function would be to monitor Paul's compliance with medication, and to report concerns to the care team at RKMHS as required.

504 On that basis, I find that Ms Rigby, in 2022 and 2023, operated on the basis of the shared understanding that Phoenix was monitoring medication compliance and would have reported any concerns to RKMHS.[379]

[370] Exhibit 15. See also exhibits 15A and 15B.
[371] Ts 20; exhibit 1, tab 21.1, par [25].
[372] Ts 22.
[373] Ts 72.
[374] Ts 115.
[375] Ts 327.
[376] Exhibit 2, tab 1.
[377] Exhibit 1, tab 22.1, p 2.
[378] Ts 432.
[379] Ts 275.

505 The evidence demonstrates that, notwithstanding this arrangement and in any event, the home visits afforded Ms Rigby the ability to independently check Paul's Webster-packs, which she did.[380]

506 The evidence also makes plain that Ms Rigby engaged with the care coordinator and carers to attempt to get Paul to see a GP to address his physical health issues including COPD.[381]

507 I consider that Ms Rigby's ability to act in relation to her concerns in early 2023 was hampered by, amongst others, equivocal reports from Paul about support workers not being paid or attending,[382] and the fact that he was evasive and guarded with her.[383]

508 The latter is not a criticism, and is reflective of the fact that Ms Rigby had a function including the escalation of Paul's care to re-hospitalisation if that were considered necessary.[384]

509 I find that, for that reason, Ms Rigby was unlikely to receive fulsome information from Paul. It is clear that he had a much more trusting and open relationship with Mr Ain, for example.

510 Ms Rigby would, appropriately, use her observations to determine Paul's general health and mental state, including whether he had escalated from his 'baseline' psychotic illness, which included ongoing paranoia.[385]

511 Like his guardian, Ms Rigby also advocated for an increase in Paul's NDIS supports.[386]

512 In my view, there is no basis to criticise RKMHS or Ms Rigby in relation to the fact that Mr Ain's ceasing to attend, and Paul's death, were not identified earlier.

513 I reach that conclusion where:

[380] Ts 22-23, 71. Of course, staff were limited to clarifying if the medication had been dispensed from the packaging, and were not in a position to monitor whether Paul was, in fact, taking the medication.
[381] Ts 24.
[382] Ts 36.
[383] Ts 44.
[384] Exhibit 1, tab 21.1, par [19].
[385] Ts 70; exhibit 1, tab 21.1, par [16].
[386] Ts 70.

(a) I accept Ms Rigby's evidence that she held concerns about the capacity for Mr Ain to provide the level of support individually, and raised concerns with 360 Health;[387]

(b) Ms Rigby made inquiries and was expressly told by 360 Health that Paul was continuing to receive supports;[388]

(c) Ms Rigby was never advised by anyone from Phoenix that Mr Ain had resigned from Phoenix, or had stopped attending;[389]

(d) I accept Ms Rigby's evidence that had greater information about the frequency of attendance come to her attention, she would have communicated concerns to Paul's guardian;[390] and

(e) Ms Rigby was the person who, ultimately, broke through the circuity by contacting police for a welfare check when she had exhausted all other means to attempt to establish Paul's welfare.

360 Health

514 I find that to the extent 360 Health was involved in Paul's supervision, treatment and care, the performance of its staff was, generally, adequate.

515 It is apparent that 360 Health placed some reliance on Yaran's support of Phoenix when recommending that agency to the Office of the Public Advocate.[391] This was not inappropriate where it is apparent that Ms McNamara's opinion was based, in part, on her own direct experience and where there was no basis to know of, or suspect, the existence of the SPSA and the conflict of interest it created in relation to Phoenix.

516 360 Health otherwise undertook coordination services in Paul's best interests and as identified above, did so at a discounted rate in recognition of his complexity.

517 It is apparent that support coordination was heavily embedded within the multidisciplinary planning prior to his discharge from hospital in 2022.

[387] Ts 453.
[388] Ts 77, 102.
[389] Ts 87.
[390] Ts 87.
[391] Ts 321.

518 The evidence is also clear that Ms Leong took steps to conduct home visits and build rapport with Paul when she assumed responsibility.[392]

519 I find that in March and April 2023, 360 Health was heavily reliant on the candour of staff from Phoenix.[393]

520 As identified above, Ms James was never advised that Mr Ain had advised that he would not be attending after 31 March, or that he had resigned on 18 April.[394]

521 She was also in the difficult position of inheriting the support coordinator role without having any existing rapport with Paul.[395]

522 She was, absent contacting authorities to conduct a welfare check, unable to verify what she had been told by others; and almost wholly reliant on the accuracy of information from Faisa.

523 I find that there was no cardinal event in late March, or the beginning of April that would have prompted 360 Health staff to escalate the issue of whether Paul was receiving support services.[396]

524 I do find, consistently with Ms Templeman's agreement at the inquest, that earlier intervention was warranted[397] particularly by mid-April when it was apparent that 360 Health had been unable to independently verify, including with Paul, what they were being told by Faisa.

525 Further, at the inquest, Ms James accepted that by 24 April 2023 it would have been appropriate to have escalated the situation and her concerns internally, and to have called for a welfare check (even though she was aware that Ms Rigby was doing so that day).[398]

526 That concession is reflective of the conclusion in 360 Health's Root Cause Analysis, performed shortly after Paul's death.[399]

527 That analysis raised:

[392] Ts 277.
[393] Ts 277.
[394] Ts 302.
[395] Ts 293-294.
[396] Ts 441-442.
[397] Ts 324.
[398] Ts 307.
[399] Exhibit 6.

> The question as to whether it would be reasonable to rely on those parties that provide daily services to initiate a Welfare Check and whether advice from other parties about their success or otherwise in making contact with the consumer is sufficient to allay concerns.[400]

528 The Root Cause Analysis properly recognised that while statements by others involved in the care of a care recipient may be taken at face value, they are ultimately insufficient for a support coordinator to form their own independent view about the health and welfare of a consumer.[401]

529 The Root Cause Analysis caused 360 Health to, appropriately, consider its guidelines and procedures for the initiation of welfare checks,[402] and to determine that guidance be given to staff on the issue of relying on statements by other parties about the health and status of a consumer.[403]

530 The guidance note issued by 360 Health to its staff on 31 July 2023 was in evidence.[404]

531 In my view, the guidance in the note is succinct, clear, and appropriate, and demonstrates that 360 Health has sought to overcome a similar gap arising in future cases.

532 As part of her handover to Ms James, Ms Leong recorded that there was a need for a secondary support worker for Paul, because he was highly reliant and dependant on Mr Ain.[405]

533 Her recommendations included contacting Phoenix to reinforce the need for a secondary support worker.[406]

534 I agree with the concession made by 360 Health through its counsel that:

(a) the issue of Paul appearing to only have one support worker from Phoenix, who was expected to work seven days a week, had been identified within 360 Health as early as January 2023; and

[400] Exhibit 6, par [5].
[401] Exhibit 6, par [5].
[402] Exhibit 6, p 4.
[403] Exhibit 6, p 5.
[404] Exhibit 7.
[405] Exhibit 1, tab 30, p 24.
[406] Exhibit 1, tab 30, p 26.

(b) where it was known how reliant Paul was on Mr Ain, that 360 Health should have interrogated Phoenix more on this point, and taken more decisive action, between 20 January and 18 April.[407]

535 This was particularly so where staff at 360 Health considered that Mr Ain working seven days a week as a carer was uncommon, and something that they had not seen elsewhere.[408]

536 I find, as 360 Health's counsel conceded, that the issue of the single carer could have been escalated to the guardian.[409]

537 The evidence is that Public Advocate would have been concerned by this, had it been known to them, because it was patently unsustainable.[410]

538 The evidence suggests that Ms Rigby had this view as well.[411]

539 Again, an early case conference in relation to this issue, if nothing else, would have been prudent to ensure that the issue was properly ventilated, and that the views of others involved in Paul's care were obtained.

Phoenix

540 The evidence of Paul's supervising psychiatrist at the inquest was clear - without the provision of daily supports, Paul could not be managed on a CTO in the community.

541 The provision of supports was one of the primary pillars of the thinking behind the CTO,[412] which is self-evident having regard to the requirements contained in the CTO itself.

542 Without continuing support in the community, the CTO was not viable.[413]

543 For all of the reasons identified above, Phoenix and Faisa abjectly failed in their care of Paul.

544 Specifically, I find that Faisa, as the director and controlling mind of Phoenix, failed to take sufficient steps to replace Mr Ain from the end of

[407] Ts 442.
[408] Ts 296.
[409] Ts 444.
[410] Ts 363.
[411] Exhibit 1, tab 21.1, par [46].
[412] Ts 17.
[413] Ts 36.

March 2023 when it was plain that he was not continuing to provide support services as other support agencies expected.

545 That failure is made more egregious by the fact that it was agreed that Phoenix would be responsible for the monitoring of Paul's medication compliance. Without provision of daily supports, Paul's mental and physical health was always going to deteriorate precipitously.

546 Further, I find that Faisa failed to provide patently relevant information about the difficulties with providing a carer to Paul in March and April 2023 to any of his guardian, his treating team at RKMHS[414] or his care coordination team at 360 Health.

547 The failure is made more egregious because she received direct inquiries from staff at 360 Health. This was not simply a case of there being no communication – direct inquiries were made of Faisa, and she was not open and honest in her responses, leaving Paul in a position of extreme vulnerability.

548 Faisa's complete lack of any transparency with others impeded:

(a) Ms Rigby's ability to investigate her express concerns about Paul's welfare, and to remedy the situation to ensure the maintenance of Paul's mental health;

(b) staff from 360 Health to alleviate their own concerns, and to properly respond to Ms Rigby's enquiries; and

(c) the ability of Ms Rigby or 360 Health to escalate any concerns to Paul's guardian.

549 To the extent Faisa was experiencing personal difficulties at the time,[415] they are not sufficient to excuse her failure. If she were experiencing difficulties, it was then plainly incumbent on her to be frank and employ candour when dealing with others who were actively attempting to support Paul and who had the capacity to assist him.

550 Rather than try to support others in assisting Paul, Faisa hindered them.

[414] Ts 77.
[415] Ts 303.

551 Her text message to Mr Ain indicates that she was aware that information about Paul potentially not having a case worker attend was highly relevant information to agencies such NDIS or the police after his death.[416]

552 However, her conduct in failing to disclose any such information, including even the possibility of some doubt concerning Paul being attended to by a case worker, to any of 360 Health, SMHS or Paul's guardian throughout the entirety of April 2023 was entirely to the contrary.

553 This dissonance reinforces the conclusion that she, in fact, sought to conceal the true position from Ms James, and other agencies involved in Paul's case.

554 That is also consistent with her conduct when completing the mandatory report of Paul's death to the Commission on 25 April 2023, which was not done in the proper form and made no mention of these difficulties.

555 I find that this failure was another instance of Faisa seeking to deflect any investigation into the true nature of Paul's care.

556 The actions of Phoenix and Faisa caused the care network to malfunction and fail.

557 Paul was left without necessary supports, in circumstances where others were available and willing to assist, but had been hampered.

558 Phoenix and Faisa's unacceptable reflects an organisation:

(a) that was never fully compliant with the requirements of any performance audit;

(b) that had procedures and policies that were entirely co-opted, and had not been produced with any regard to Phoenix's likely operations, and which had not been the subject of any material consideration by the sole director of the company;

(c) that appears to have been liable to be deregistered by the Commission from as early as January 2023, at least;

(d) was run by a director without adequate qualifications or experience who was comfortable purportedly delegating all responsibilities to staff, even though the evidence demonstrates she was directly

[416] Exhibit 13A, p 6.

involved at times, and when she was involved she actively and directly impacted on the care and welfare of individual clients;

(e) which introduced new staff into senior positions, but who also had no experience or qualifications, and appear to have had no clarity as to their actual function or duties; and

(f) which appears to have been brought into Paul's care network, in part, due to an arrangement which created a clear conflict of interest on Phoenix's part that was never disclosed to Paul's guardian.

Comments concerning public safety or the administration of justice

Phoenix's registration and Faisa's eligibility to provide support services

559 As identified above:

(a) the Commission regulates the NDIS to promote safe practices and improve the quality and diversity of providers' services;

(b) Phoenix was the subject of an out of cycle audit which identified multiple major non-conformities;[417] and

(c) by 3 January 2023 (prior to Paul's death) QMS had assessed Phoenix as not meeting applicable standards and prescribed requirements.

560 Notwithstanding, there was an almost two-year period before Phoenix's registration was finally revoked.

561 Phoenix' registration was revoked under s 73P(1)(a) of the *National Disability Insurance Scheme Act 2013* (Cth) on 4 November 2024,[418] on basis that the delegate reasonably believed that Phoenix had contravened, was contravening or proposed to contravene the Act.[419]

562 Ms Myers, who was not directly involved but undertook reviews and searches in order to give evidence at the inquest, was unable to proffer an explanation at the inquest as to the reason for such substantial delay.[420]

563 I accept her evidence that from 2023, the Commission began to place greater emphasis on stronger compliance and enforcement action, rather

[417] Exhibit 1, tab 44.4, p 3.
[418] Exhibit 1, tab 32.1, 44, p 11.
[419] Exhibit 1, tab 44, p 13.
[420] Ts 308.

than education,[421] and as at today, a case of a provider such as Phoenix failing to demonstrate the remediation of a major non-compliance would be escalated.[422]

564 Relatedly, in July 2025, the Commissioner introduced the Regulatory Risk Prioritisation Model to risk manage the highest priority intelligence, complaints, reportable incidents and compliance matters.[423]

565 Notwithstanding, the Court was advised that the Commission had, as of 29 May 2026, not yet considered whether Faisa, or any other individuals engaged by or associated with Phoenix, are unsuitable to deliver or support he delivery of NDIS services and supports.[424]

566 As the date of inquest, Faisa had not been barred from providing services within the NDIS.[425]

567 Searches of the Commission's public register do not identify any barring notices issued in relation to Phoenix or Faisa.

568 As such, it appears that both Phoenix (subject to registration) and Faisa continue to be eligible to provide disability support services.

569 Pursuant to s 50(1) of the *Coroners Act*, a coroner may refer any evidence, information or matter which comes to the coroner's notice in carrying out their duties to a body having jurisdiction over a person carrying on a trade or profession if the evidence, information or matter touches on the conduct of that person in relation to that trade or profession.

570 The term '*body having jurisdiction over a person carrying on a trade or profession*' is defined by s 50(2) to mean a body empowered under a written law to –

(a) register, licence or otherwise approve a person as a prerequisite to the person lawfully carrying on that trade or profession; and

(b) impose or recommend any publishment or liability in respect of wrongful, incompetent or otherwise unsatisfactory conduct of that person in relation to that trade or profession.

[421] Exhibit 12, par [13].
[422] Ts 408-410.
[423] Exhibit 12, par [91].
[424] Exhibit 18B, par [12].
[425] Ts 417.

571 In addition to holding the responsibility concerning registration of service providers, the Commission has the power to issue banning orders, precluding individuals from delivering services within the NDIS.[426]

572 In my view, as a consequence, the Commission falls within the definition in s 50(2) of a body having jurisdiction over a person carrying on a trade or profession.

573 Phoenix is currently in external administration.[427] It appears unlikely that the organisation will provide disability support services in future, including where it would need to obtain registration.

574 However, the evidence identified at the inquest clearly demonstrates that the organisation is unsuitable to carry on disability support services.

575 Further, I consider that the evidence identified in this inquest, particularly in relation to Faisa's engagement with other support providers in 2023, is highly relevant to the question of her suitability to carry on disability support services.

576 For that reason, I intend to refer both Phoenix and Faisa to the Commission upon publication of these findings.

Other matters

577 The evidence demonstrates that Phoenix claimed and received amounts from Paul's NDIS Plan Manager for services that were never provided to Paul, including, for example, support services said to have been provided for the period 1 to 9 April 2023.[428]

578 Applying the findings above, those payments were received at a time when Faisa was aware that Mr Ain had not attended, and that no one had been identified to replace him to provide services to Paul.

579 Phoenix also overcharged for the number of hours of support provided to Paul on other occasions. For example, on 25 January 2023, Paul was charged for seven hours of care when his hours of care had been, consistently with his NDIS Plan, reduced to four hours daily. This occurred on a number of other subsequent occasions.[429]

---

[426] Ts 416-417.
[427] Exhibit 1, tab 31.1. Searches confirm that Phoenix's registration with ASIC remains unchanged since the excerpt in the coronial brief was obtained.
[428] Exhibit 1, tab 29.2, exhibit 2, tab 3.
[429] Exhibit 2, tab 3.

580 There were also instances where Phoenix was paid for provision of hours of support when Paul was in hospital.[430]

581 I find that these payments were based on various records of Pheonix created in relation to provision of services to Paul, particularly in early April 2023, which are inaccurate and, at best, were created without any regard to the true state of matters.

582 On the first day of the inquest, it became apparent to the Court for the first time as a consequence of the evidence of Mr Ain, that Phoenix used an online software designed for businesses providing NDIS support services called '*Supportmate*', including for staff to log their hours.[431]

583 In response to a Form 8 issued to the entity responsible for the software, the Court was provided with all progress notes logged in Supportmate in relation to Paul for the dates 2 September 2022 to 30 April 2023.

584 Those notes were tendered as exhibit 3 during the inquest.

585 Every entry is ascribed to Mr Ain as the 'Carer'. There is a care note entry for every day from 1 January 2023 to 30 April 2023, including the five days after Paul had been found deceased at home.

586 Based on those records, I infer that someone within Phoenix, with access to the Supportmate system, created records which did not accurately reflect the provision of services to Paul.

587 I infer that those records formed the basis for claims for amounts that were paid which did not accurately reflect the provision of services to Paul.

588 During the inquest, Faisa gave evidence that to the extent there was an overpayment to Phoenix in relation to Paul's care, she was willing to pay that money back.[432]

589 There is no evidence that Faisa has made any efforts to attempt to identify the extent of seemingly inaccurate claims and overpayments to Phoenix in relation to Paul's case, or to make repayment of the same.

[430] Exhibit 2, tab 3.
[431] Ts 112.
[432] Ts 229.

Recommendation

590 I am satisfied from the evidence that the Office of the Public Advocate and 360 Health have taken sufficient steps to address any areas for improvement arising from Paul's death.

591 I am also satisfied that the Department of Communities, as the lead agency, is already taking steps to implement recommendations by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (and which have been accepted by the Western Australian State Government) concerning a Community Visitor Service in this State.

592 For those reasons, there is no need to make any recommendations directed to those agencies.

593 I note that in 2025 the Australian National Audit Office published a performance audit regarding the effectiveness of the Commission's regulatory functions, which included a series of recommendations which have already been accepted by the Commission.[433]

594 Having reviewed the report, I do not consider there is any need to reiterate any of those recommendations in the context of this matter.

595 I am satisfied that the issue of conflict of interest created in the disability services industry by agreements like the SPSA was an issue which was already known to the Commission prior to this inquest, and is one which the Commission is already taking steps to address.[434]

596 I am also mindful that it is a matter of public knowledge that the NDIS system, at large, is the subject of legislative review, and as a consequence any recommendations relating to the functions of the Commission may be rendered otiose.

597 In my view, the primary outstanding issue is the availability of information to the public and others involved in the provision of disability services about registered providers like Phoenix, which was, for a considerable period of time, only conditionally registered, had never wholly satisfied the requirements of a performance audit, and lacking qualified staff.

[433] Ts 419.
[434] Ts 420.

598 The evidence adduced in the inquest demonstrated considerable delay in relation to the deregistration of Phoenix, and a limitation on what information would have been available to any others involved in Paul's care about Phoenix's registration in the interim.

599 Section 73ZDA of the *National Disability Insurance Scheme Act 2013* provides that the Commissioner must establish and maintain the NDIS Provider Register (**Register**).

600 There are numerous requirements relating to what the Register must include, and there is also provision for information the Commissioner may include. Section 73ZDA(8) provides that the Commissioner may include '*other*' information on the Register if the Commissioner is satisfied that it is relevant to the provision of supports or services to people with disability.

601 The Register does not currently include information relating to:

(a) total duration of a provider's registration;

(b) audit of a provider, including outcomes; or

(c) other characteristics of provider entities including, for example, workforce size.[435]

602 Anyone seeking to review Phoenix's status through the Register would also have been unaware that they were determined to have major non-conformities, which were never addressed.[436]

603 I agree with Ms Myers that there is significant value in the public being informed when they make choices about which providers or workers they are going to engage. In my view, within reasons, the more information that is available to assist consumers to identify and select quality providers and workers the better.

[435] Exhibit 18B, pars [4]-[8].
[436] Exhibit 2, tab 2; ts 407-408.

604 As such, I recommend as follows:

The National Disability and Safeguards Commissioner expand the information available on the register established under s 73ZDA of the *National Disability Insurance Scheme Act 2013* (Cth) to enable members of the public to identify, at least:

(a) the total duration of a service provider's registration;

(b) whether a provider's registration is conditional; and

(c) if a provider's registration is conditional, a summary of the substance of the conditions upon which the registration is approved (including whether the provider has been determined by audit to have any major non-conformities which are unaddressed).

Conclusions

605 Paul's death may have been avoidable, if his care network had operated effectively.

606 One part of the network thwarted the efforts of others.

607 People with disability are entitled to enjoy the same rights as others, and disability support services should always strive to improve the quality of life and enhance the lives of those they serve.

608 Paul's death should act as a constant reminder that non-adherence to that precept can lead to disastrous consequences, and negate the efforts of others who are genuinely seeking to achieve that aim.

609 I express my condolences to Paul's family.

BD Nelson
Coroner
4 August 2026