FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Thomas David Martin

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Thomas David Martin with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Dates

8 and 9 April 2024

Representation

E Bill – Counsel Assisting the Coroner

L Taylor – Counsel for Department of Health (Statewide Mental Health Services)

A Mills – Counsel for the Salvation Army

Introduction

1. Thomas David Martin died between 1 and 2 April 2021, in his room at Common Ground, Campbell Street, Hobart. He was born in Launceston on 2 October 1987, the son of Catherine and Stephen. Catherine and his brother William survive him.

2. Mr Martin had a lengthy and well documented history of mental illness and alcohol and substance abuse which began when he was in high school. He suffered from schizophrenia. He had a number of psychotic episodes and many admissions as an involuntary inpatient from at least 2014 onwards. At the time of his death, he was living as a *"supported tenant"* at the Common Ground facility in Campbell Street, Hobart. The facility was run by the Salvation Army at the time. It provided accommodation for low-income earners as well as supported accommodation for those with additional needs. Employees at Common Ground facilitated connection with basic services such as housing, food, employment and alcohol and drug counselling as well as providing basic concierge services.

3. At the time of his death, Mr Martin was the subject of a treatment order made pursuant to the *Mental Health Act* 2013. The first order of its type was made in 2017 and continued until his death.

Evidence at the Inquest

4. At the inquest the following witnesses gave evidence:
   a. Catherine Martin;
   b. William Martin;
   c. Senior Constable Rance Swinton;
   d. Dr Christopher Lawrence (Forensic Pathologist);
   e. Neil McLachlan-Troup (Forensic Scientist);
   f. Dr Roger Cox, General Practitioner;
   g. Anthony Fagan (Salvation Army, Common Ground);
   h. Jason Evans (Salvation Army, Common Ground); and
   i. Dr Honor Pennington (Director, Mental Health Services).

5. In addition, a considerable amount of documentary evidence was tendered as exhibits at the inquest. The complete list of the material tendered at the inquest is annexed to this finding and marked A.

6. All of this material has informed the findings that follow.

The Role of the Coroner

7. Before considering the circumstances of Mr Martin's death in further detail, it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death that appears to have been unexpected or unnatural. Mr Martin's death meets this definition.

8. A coroner is obliged to hold an inquest (which is a public hearing) into any death that the coroner has jurisdiction to investigate where the deceased person was a person held in care at the time of their death. A person "held in care" is defined in the *Coroners Act* 1995 (the "Act") as meaning "a person detained or ***liable to be detained*** in an approved hospital within the meaning of the *Mental Health Act* 2013" [emphasis added]. [1] Mr Martin's death meets this statutory definition. Thus, an inquest was mandatory.

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[1] See section 3 of the *Coroners Act* 1995.

9. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. In an inquest, a coroner is required to answer the questions (if possible) that section 28(1) of the Act asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.

10. A coroner is required to make findings of fact about the death being investigated from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

11. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

12. As was noted above, one matter that the *Act* requires, is a finding (if possible) as to how the death occurred. 'How' has been determined to mean 'by what means and in what circumstances', a phrase which involves the application of the ordinary concepts of legal causation. Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death, so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

13. Because Mr Martin was the subject of a treatment order made under the provisions of the *Mental Health Act* 2013, there is an additional requirement for me to comment upon care, supervision and treatment.[2]

14. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[3]

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[2] Section 28(5) of the *Coroners Act* 1995.
[3] (1938) 60 CLR 336.

15. A coroner is not bound by the rules of evidence in holding an inquest and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit. To be properly received at an inquest, the evidence must be capable in some way of assisting the coroner to determine the matters under section 28(1) or, in appropriate circumstances, to assist in making a comment or recommendation. A coroner has significant latitude in receiving evidence, providing the evidence is something more than "mere supposition, guess or intuitive hypothesis". The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.

16. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness. A coroner must ensure that any person (and person includes legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

Circumstances of Mr Martin's Death

17. Between 31 January and 9 February 2021, Mr Martin was an involuntary inpatient at the Royal Hobart Hospital (RHH). He was discharged from the RHH to the so-called *"Mental Health Hospital in the Home"* program, where he received daily visits at Common Ground until 15 February 2021 when he was discharged into community care with Community Mental Health Services.

18. He was next seen by a caseworker from Community Mental Health Services on 22 February 2021.

19. Around the beginning of March 2021, some of the staff at Common Ground became aware that Mr Martin was attempting to manufacture (or actually manufacturing) drugs and had been offering them to other residents. There was evidence of observed erratic behaviour and apparent weight loss on the part of Mr Martin.

20. During this time, he was seen by his Community Mental Health Services caseworker on 1 and 9 March 2021 when no concerns were noted. The caseworker attempted to contact Mr Martin by telephone on both 12 and 23 March 2021 but was unable to make contact with him.

21. Mr Martin had a telehealth appointment with his regular long-term general practitioner Dr Cox. He sought psychoactive medication (a common request apparently) but Dr Cox refused to prescribe it for him.

22. Later still in March 2021, the evidence is that Mr Martin sent multiple disordered emails to his caseworker.[4] The caseworker spoke to Mr Fagan of Common Ground on 23 March 2021. Mr Fagan became increasingly concerned as he saw Mr Martin was plainly unwell, agitated and exhibiting delusional behaviour.

23. On 28 March 2021, Mrs Martin received a number of missed calls from her son.[5] The following day, 29 March 2021 at 10.30 am, Common Ground staff conducted a welfare check on Mr Martin as he had not been seen for 48 hours. He answered his intercom. However, he had not attended an appointment with Statewide Mental Health Services at 9.00 am. A caseworker attended Common Ground the same day at around lunchtime to administer a depo injection to him in one of the facilities common areas. This was early due to the pending Easter break.

24. On 30 March 2021, his case worker attempted to call him twice but without success. The caseworker emailed Common Ground and asked that a message be passed on to Mr Martin. The same day, Mrs Martin received a phone call from his son. He told her that his legs weren't working.[6] She told him to lie down, and she also contacted staff at Common Ground to conduct a welfare check.

25. Mrs Martin rang Common Ground again the next day, 1 April 2021 expressing concerns for her son's welfare after receiving a phone call from him. Following Mrs Martin's call, an employee at Common Ground, Mr Shane Grachen, carried out a welfare check at 11.40 pm. Mr Martin apparently sounded drowsy and slurred his words, but explained that was because he had just woken up. Mr Grachen asked if he needed medical assistance, but Mr Martin declined.[7] Mr Grachen told Mr Martin that there were two packages at reception for him to collect and Mr Martin said he would attend reception later to collect the packages.

26. A further welfare check was carried out at 7.15 pm on 2 April 2021, when Mr Jason Evans attempted to call Mr Martin's mobile as he had not been seen all day. That attempt was unsuccessful, as was Mr Evans knocking on Mr Martin's door at around 8.00 pm.[8] Mr Evans contacted Mrs Martin at 8.05 pm. She told him of her concerns and that she had not heard from her son for two days. Mr Evans returned with another support officer to Mr Martin's room and, when he did not answer the door again, entered the apartment at 8.13 pm. He found Mr Martin lying deceased on the

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[4] Exhibit C 26c.
[5] Exhibit C 14a, Affidavit – Catherine Martin, sworn 19 April 2021 page 1 of 2.
[6] *Supra*, page 2 of 2.
[7] Exhibit C 25, affidavit Jason Evans, sworn to April 2021, page 3 of 3.
[8] *Supra*.

lounge holding the headset for the intercom. Leaving the scene undisturbed, Mr Evans called for police and emergency services.

Scene Investigation

27. The fact of Mr Martin's death was reported in accordance with the provisions of the *Coroners Act* 1995. Police attended and carried out an investigation which commenced at the scene. Mr Martin's body was formally identified,[9] and his unit searched and photographed. It is evident from the photographs and body worn camera footage tendered at the inquest[10], and the evidence of attending police, that the unit was in poor condition with food scraps, rubbish, cigarette butts, cigarette ash and general household waste items covering the majority of the floor, except for a small area of a walkway.

28. Police did not identify anything at the scene which gave rise to any suspicion of the involvement of any other person in Mr Martin's death. A significant amount of medication was located (mostly outdated prescription drugs). That medication was seized by attending police for subsequent examination. In addition, paraphernalia associated with drug manufacturing was located at the scene.

29. Mrs Martin also found three insulin pens when she went to the unit a few days later, on 7 April 2021.[11]

30. After the scene had been examined, Mr Martin's body was removed from his unit and taken to the mortuary at the Royal Hobart Hospital.

Forensic Pathology Evidence

31. At the Royal Hobart Hospital, Dr Christopher Lawrence, a highly experienced forensic pathologist performed an autopsy. Following the autopsy, he prepared a report which was tendered at the inquest.[12] Dr Lawrence also gave evidence. Apart from a possible old track mark on Mr Martin's left antecubital fossa and abrasions to the right ankle and left knee, Dr Lawrence did not find any sign of violence or injury.

32. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. Mr Neil McLachlan-Troup, the forensic scientist who

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[9] Exhibits C 3 and 4.
[10] Exhibits C 20b and C16c.
[11] Exhibit C 14a, *op cit,* page 2 of 2.
[12] Exhibit C 5a – affidavit Christopher Hamilton Lawrence, sworn 17 June 2021.

carried out that analysis provided a report which was tendered at the inquest.[13] Like Dr Lawrence, Mr McLachlan-Troup also gave evidence.

33. On the basis of the evidence at the inquest, I am satisfied that the cause of Mr Martin's death was ketoacidosis. The cause of ketoacidosis was the subject of evidence at the inquest. It is clear to me that diabetic ketoacidosis can be discounted completely. While it is clear thar Mr Martin had diagnosed himself as suffering from diabetes some years earlier (and reportedly was using insulin he had purchased on the Internet), the medical evidence is quite clear that he did not suffer from diabetes, although he did suffer from a number of health type delusions. The issue of diabetes was expressly investigated by his general practitioner, Dr Cox, who found no evidence that he suffered from that condition.

34. I note, Dr Lawrence's evidence that where diabetic ketoacidosis is suspected, it is normal practice to take a vitreous humour sample for subsequent investigation. However, there was no reason to have done so in the case of Mr Martin's autopsy, as his medical records expressly indicated he did not suffer from diabetes - even though as I have said he thought he did and appears to have been administering insulin to himself.

35. The question then was what was the cause of the ketoacidosis which claimed Mr Martin's life. The possibility that it was due to malnutrition can, I consider, be discounted on the evidence. Although undoubtably Mr Martin had lost weight in the lead up to his death, Dr Lawrence said by no measure was he malnourished weighing 62.1 kilograms at autopsy.[14]

36. Viewing the evidence about the issue as a whole, I think that alcoholic ketoacidosis is the most likely explanation for Mr Martin's death. Dr Lawrence gave persuasive evidence to that effect and it fits comfortably with the known facts. However, the use by Mr Martin of medication and drugs obtained from the internet does cloud the picture somewhat. Finally, the absence of a vitreous glucose test at autopsy (which was perfectly reasonable in the circumstances as then existed) does not allow for certainty about the issue.

Common Ground

37. The evidence satisfies me that Mr Martin's accommodation at Common Ground was appropriate. He was provided basic support and assistance, noting that assistance was

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[13] Exhibit C 6 -

[14] Exhibit C 5a, *op cit.*

necessarily dependant on his cooperation, which was not always forthcoming, by reason of his poor mental health.

38. Nonetheless, it appears to me that Common Ground was a beneficial conduit between Mr Martin, his mother and mental health services. Counsel assisting submitted, and I agree, that it is evident that Common Ground were proactive in providing information to mental health services where they had concerns about Mr Martin's health (particularly after receiving disturbing emails) and not infrequently the Crisis Assessment Treatment Team attended upon Mr Martin as a result of information provided by Common Ground.

39. There was no departure from Common Ground policy and the evidence indicates that their procedures were followed appropriately in the days leading up to Mr Martin's death.

40. I do not consider that there was anything further that could or should have been done by the staff at Common Ground in providing assistance to Mr Martin in the lead up to his death.

Disclosure of Patient Information

41. Mr Martin's family raised concerns in relation to the mental health services available in Tasmania, specifically lack of continuity with regard to treating psychiatrists.

42. The issue of privacy regulations/legislation and policy is beyond the scope of this inquest. The law is what the law is. There is an almost irreconcilable tension between patient capacity (or lack thereof), patient confidentiality and the provision of best care. At the time of Mr Martin's death, his nominated senior next of kin was his estranged wife. Whether that nomination was made at a time when he had capacity to make the decision is something almost impossible to determine. The fact is, it was made and remained unaffected by the fact of their separation and even the existence of family violence orders between them. Whether the nomination of his estranged wife was a rational decision or not is a moot point.

43. It seems clear that Mr Martin's estranged wife (who took no part in the inquest – indeed refusing to even provide any assistance to investigators by making an affidavit about her late husband) being so nominated may well have inhibited the flow of information to and possibly from treating practitioners but, as Dr Pennington correctly observed, that nomination was something Mr Martin's treating team had to

respect even when the nomination was arguably illogical and/or caused practical difficulties.

Mental Illness and Drug and Alcohol Use

44. There was significant evidence at the inquest that mental illness is often associated with substance use disorders and that poses very significant treatment challenges. Mr Martin was one such challenging patient.

45. Self-evidently, an integrated approach to a multifaceted problem is for the better. So too is continuity of care where possible.

46. I received extensive evidence from Dr Pennington, the Director of Adult Community Mental Health Service in relation to these issues broadly and also in particular so far as they related to Mr Martin. Her evidence was impressive. She evidently had a high degree of familiarity with Mr Martin's case over a number of years. I accept her evidence. I note that it is recognised that there is a need for an integrated approach to caring for individuals with comorbidities associated with alcohol and substance abuse as well as serious mental illness and that work has commenced to develop a collaborative approach between Alcohol and Drug Service and the Statewide Mental Health service. This development is in my view a positive one and to be encouraged.

Findings Pursuant to Section 28(1) of the *Coroners Act* 1995

47. On the basis of the evidence at the inquest, I make the following formal findings:

    a. The identity of the deceased is Thomas David Martin;

    b. Mr Martin died in the circumstances set out earlier in this finding;

    c. The cause of Mr Martin's death was ketoacidosis; and

    d. Mr Martin died, aged 33 years, in his room at Common Ground, 87 – 91 Campbell Street, Hobart in Tasmania between 1 and 2 April 2021.

Report Pursuant to Section 28(5) of the *Coroners Act* 1995

48. The evidence of Mrs Martin, his brother William, Dr Cox, staff at Common Ground and Dr Pennington, as well as the records associated with Mr Martin's treatment, demonstrate that he was a complex and challenging patient.

49. As should be clear from the above, I am satisfied that his care, supervision [and] treatment was of an appropriate standard.

Comments and Recommendations

50. The circumstances of Mr Martin's death do not require me to make any comments or recommendations pursuant to the *Coroners Act* 1995.

51. In conclusion, I express my sincere and respectful condolences to Mr Martin's family on their loss.

Dated 3 October 2024 at Hobart in the State of Tasmania.

Simon Cooper
Coroner

Annexure A

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	REPORT OF DEATH	CONST PAGANO
C2	LIFE EXTINCT AFFIDAVIT	DR A HTAY
C3	AFFIDAVIT OF IDENTIFICATION	CONST FELLOWES
C4	AFFIDAVIT OF IDENTIFICATION	A. CORDWELL
C5	PM REPORT & IPM	DR C LAWRENCE
C6	TOXICOLOGY REPORT	N. MCLACHLAN-TROUP
C7	MEDICAL RECORDS - THS	RHH
C8	MEDICAL RECORDS - GP	DR R COX
C8a	MEDICAL RECORDS – GP – DHHS LETTER	P. SHARPE
C8b	MEDICAL RECORDS – GP – CORRESPONDENCE	M.WARDEN
C8c	MEDICAL RECORDS – GP – CORRESPONDENCE	H.PENNINGTON
C8d	MEDICAL RECORDS – GP – CORRESPONDENCE	A.SANKARANARAYANAN
C8e	MEDICAL RECORDS – GP – DISCHARGE SUMMARY	HOBART CLINIC
C8f	PROOF OF EVIDENCE	DR R COX
C8g	SUPPLEMENTARY PROOF OF EVIDENCE	DR R COX
C8h	FULL GP EVIDENCE	DR R.COX
C9	MEDICAL RECORDS	MENTAL HEALTH TRIBUNAL
C10	SMHS – POLICIES & PROCEDURES	THS

C10a	SMHS – POLICIES & PROCEDURES - ASSESSMENT PROTOCOL	THS
C10b	SMHS – POLICIES & PROCEDURES - MULTIDISCIPLINARY TEAM REVIEW PROTOCOL	THS
C10c	SMHS – POLICIES & PROCEDURES – SHARED CARE PROTOCOL	THS
C10d	SMHS – POLICIES & PROCEDURES – PHYSICAL ASSESSMENT PROTOCOL (INTERIM)	THS
C10e	SMHS – POLICIES & PROCEDURES – CLINICAL RISK MANAGEMENT	THS
C10f	SMHS – POLICIES & PROCEDURES – CARE CALL – PATIENT AND FAMILY ACTIVATED ESCALATION	THS
C10g	SMHS – POLICIES & PROCEDURES – OBSERVATION THROUGH THERAPEUTIC ENGAGEMENT	THS
C10h	SMHS – POLICIES & PROCEDURES – INTAKE AND ADMISSION PROTOCOL	THS
C10i	SMHS – POLICIES & PROCEDURES – RESPONDING TO DETERIORATION IN A PERSONS MENTAL STATE	THS
C10j	SMHS – POLICIES & PROCEDURES – MENTAL HEALTH HOSPITAL IN THE HOME OPERATION MANUAL	THS
C10k	SMHS – POLICIES & PROCEDURES – CLINICIAN SUPPORTED ENGAGEMENT WITH GP'S	THS

C10l	SMHS – POLICIES & PROCEDURES – STATEWIDE TRIAGE	THS
C10m	SMHS – POLICIES & PROCEDURES – CONTINUING CARE TEAM OPERATION MANUAL	THS
C10n	SMHS – POLICIES & PROCEDURES – TRANSFER OF CARE AND REFERRAL	THS
C10o	SMHS – POLICIES & PROCEDURES – EXIT & DISCHARGE (INTERIM)	THS
C10p	SMHS – POLICIES & PROCEDURES – CASE MANAGEMENT & CARE COORDINATION	THS
C11	RCA - THS	RHH
C12	AFFIDAVIT 10/7/23	DR H PENNINGTON
C12a	AFFIDAVIT 29/9/23	DR H PENNINGTON
C12b	AFFIDAVIT 4/4/24	DR H PENNINGTON
C13	TASCAT Records	TASCAT
C14a	AFFIDAVIT	DR C MARTIN
C14b	AFFIDAVIT	DR C MARTIN
C14c	AFFIDAVIT	DR C MARTIN
C15a	AFFIDAVIT	DR W MARTIN
C15b	LETTER TO Dr WU	DR W MARTIN
C16a	POLICE AFFIDAVIT	CONST PAGANO
C16b	IMAGES FROM AFFIDAVIT	CONST PAGANO
C16c	BWC	TASMANIA POLICE
C17	POLICE AFFIDAVIT	CONST FELLOWES

C18	CIB CORRESPONDENCE	DET SGT BONDE
C19	AFFIDAVIT - SDIS	CONST CARTER
C20a	FORENSIC AFFIDAVIT	CONST SWINTON
C20b	FORENSIC PHOTOGRAPHS	CONST SWINTON
C21	EXAMINATION OF COMPUTERS, MOBILE PHONES AND MEDIA DEVICES	TASMANIA POLICE
C22	Prior Criminal History	TASMANIA POLICE
C23	FVO	TASMANIA POLICE
C24	BORDER DETECTIONS	TASMANIA POLICE
C25	AFFIDAVIT – Salvation Army	J. EVANS
C27a	EMAIL	J.EVANS
C26	AFFIDAVIT – Salvation Army	A.FAGAN
C26a	AFFIDAVIT – 8.4.24	A.FAGAN
C26b	LEASE AGREEMENT	SALVATION ARMY
C26c	EMAIL BUNDLES – SALVATION ARMY	A.FAGAN
C26d	INCIDENT REPORT	A.FAGAN
C27	WELFARE CHECKS – Policy and Procedure	SALVATION ARMY
C27a	PRACTICE MODEL	SALVATION ARMY
C28a	COMMON GROUND	SHIP
C28b	COMMON GROUND	EMAIL CORRESPONDENCE
C28c	COMMON GROUND	EXTRACTS FROM ELECTRONIC COMMUNICATION
C28d	COMMON GROUND	DOOR ACCESS

C29	INSULIN PENS ANALYSIS	NATA QLD
C30	MISC	
C31	AFFIDAVIT – SALVATION ARMY	S.GRACHEN