STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ross Martin
Hearing dates:	23-27 September 2019
Date of findings:	21 November 2019
Place of findings:	Coroners Court, Lidcombe, NSW
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – self-inflicted death, discharge from mental health care, pentobarbitone toxicity
File numbers:	2016/276872
Representation:	Counsel Assisting Jason Downing instructed by Lena Nash of NSW Crown Solicitor's Office Richard Sergi instructed by Ashley Clancy of McCabe Curwood for Western Sydney Local Health District and its medical practitioners Dr Julian Nasti, Dr Prashadhinee Soma Devan, Dr Peter Kelly and Dr Tangina Sultana Ryan Coffey instructed by Emma O'Brien of NSW Office of General Counsel for the Commissioner of Police Paul Madden instructed by Ken Madden of Walter Madden Jenkins
Non publication orders:	Pursuant to section 75 of the Coroners Act 2009 (NSW), I permit publication of the information contained in these findings in accordance with these redactions.

I strongly urge that any further published report of this death includes reference to suicide prevention contact points.

Findings:

The findings I make under section 81(1) of the *Coroners Act* 2009 (NSW) are:

Identity
The person who died was Ross Martin.

Date of death
He died 13 September 2016.

Place of death
He died in his car, outside 18 Eldridge Road, Greystanes NSW.

Cause of death
He died of acute pentobarbitone toxicity. There were a number of other drugs in his system, including zopiclone which was detected in the upper end of the toxic blood level range.

Manner of death

His death was intentionally self-inflicted. He died less than a fortnight after premature discharge from a mental health facility.

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Introduction

1. Mr Ross Martin was found deceased in his car on 13 September 2016. He had struggled with depression for some years and had recently been discharged from involuntary mental health care after a drug overdose. Mr Martin had researched suicide on the internet and had purchased prescription drugs online.

2. Mr Martin was described as a loving and charismatic man, proudly of Maori descent. He was a dad, a partner, a grandpa, a son, a brother, a father-in-law and a friend to many. Although he looked tough, he was actually gentle and kind. He was always there whenever his family needed him and would put aside what was going on for him for to help others. He was never shy of standing up for what was right. [1]

3. Mr Martin was a contributing member of society, who was passionate about his work and had a strong work ethic. His work choices revolved around helping others. Throughout his career he worked as a fire-fighter, a nurse, a prison officer, a social worker, a youth justice worker and as a manager caring for dozens of people living with intellectual disabilities as well as mental illness.

4. He was a much loved member of his family, who, sadly at the time of his death was living with a serious yet treatable mental illness. Mr Martin's death is a terrible tragedy. He died at a time when his family were trying desperately to get him the care he needed.

The role of the coroner

5. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[2] In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[3]

6. In this case there is no dispute in relation to the identity of Mr Martin, or to the date, place or medical cause of his death. For this reason the inquest focused on the manner and circumstances surrounding his death. It was also necessary to consider whether or not his

[1] Family Statement provided by Mr Martin's daughters and statement of Ms McAlpine
[2] Section 81 *Coroners Act* 2009 (NSW)
[3] Section 82 *Coroners Act* 2009 (NSW)

death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent similar tragedies occurring.

7. A finding that a death is self-inflicted should not be made lightly. The evidence should be extremely clear and cogent in relation to intention.[4] However, in this case there is little doubt as the steps taken by Mr Martin indicate a clear intention to take his own life.

8. Consideration was given as to whether Mr Martin died "as a result of a police operation,"[5] and therefore whether an inquest was mandatory. Police returned medication to Mr Martin on the morning of his death. It is possible that the seizure, storage and return of that medication constitutes "police services" and would be caught by the definition of "police operation." However, while it is possible the medication returned contributed to Mr Martin's death, there is no certainty in that regard. It is likely that the medication returned was zopiclone. Medical advice confirms that while that drug was present in Mr Martin's system at toxic levels at the time of death, the most likely cause of death was acute pentobarbitone toxicity. The other basis on which it could be found that an inquest was mandatory was that Ms McAlpine's emergency call triggered a "police operation". However, I am of the view that it is likely that what occurred would be characterised as a "search and rescue operation" and therefore excluded from the amended s 23. On reflection I am of the view that the inquest was not mandatory. However, in the circumstances of this case, little turns on that question. There were strong discretionary reasons for the holding of an inquest.

9. Section 81 (1) of the *Coroners Act* 2009 NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Ross Martin.

Scope of the inquest

10. A number of issues relevant to Mr Martin's death were identified prior to the inquest commencing. In summary, these issues included examination of the adequacy of Mr Martin's mental health treatment, the manner in which Mr Martin obtained the drugs which killed him, and the decision by police to return a package of drugs to Mr Martin on 13 September 2016.

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[4] The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard (*Briginshaw* v *Briginshaw* 60 CLR 336).

[5] Section 23 (1)(c) of the *Coroners Act* was amended after Mr Martin's death, but prior to a determination being made as to whether to hold an inquest. In my view the amended form of section 23 applies in these circumstances and the test is narrower than previously mandated.

The evidence

11. The inquest took place over five days. A seven volume brief was tendered including statements, photographs, and medical records. A number of witnesses gave oral evidence including Mr Martin's treating doctors and two expert psychiatrists, Dr Eagle and Professor Large.

Background

Mr Martin's family background

12. Ross Martin was born on 31 March 1960 in Christchurch New Zealand. He was one of six children born to Vivienne Miller and James Martin.

13. When Mr Martin was about 28, he married Bernadette O'Connor, with whom he had five daughters: Hannah Winter, Lucy Martin, Claire Sherwood, Bridie Martin and Rachel Martin (deceased). Mr Martin also had a daughter named Calina Parrant with Susan McGiffert. Ms Parrant was born prior to Mr Martin's marriage to Ms O'Connor. Mr Martin is said to have been first diagnosed as "*clinically depressed*" following the death of his daughter Rachel Martin in 1989, when she was three weeks old.

14. Mr Martin's daughters Bridie, Claire and Hannah recall him exhibiting symptoms of depression intermittently throughout his life such as "*going to bed and not getting up for a week*". Claire gives an account that Mr Martin's general practitioner in New Zealand was aware he was depressed and prescribed him Aropax (a SSRI anti-depressant).

15. Mr Martin's relationship with Ms O'Connor appears to have been difficult. She is said to have attempted suicide at one point and appears to have struggled with addiction to alcohol.

16. There is evidence that in about 2010, Mr Martin had an extra-marital affair with April Erikson, an American woman and sometime throughout 2011, Mr Martin and Ms Erikson moved to the US. During this time Mr Martin apparently had a transient ischaemic attack or "mini stroke."

17. Mr Martin moved between New Zealand, the US and Australia for a period of time, before moving to the Gold Coast in 2011. Mr Martin and Ms Erikson married and they apparently moved to the Gold Coast together in 2012. Mr Martin and Ms O'Connor had in fact never divorced, and Ms O'Connor later made a complaint to the New Zealand police and the

Queensland police about what she believed to be an illegal second marriage. At one point, Mr Martin and Ms Erikson apparently sought a divorce online from Mexico.

18. The relationship between Mr Martin and Ms Erikson was apparently unhappy, and Mr Martin and Ms Erikson "broke up" a number of times. Mr Martin's daughter, Bridie, lived with him on the Gold Coast for a period of time in 2012 and states during the end of the relationship he became "quite suicidal" and "deep down he was broken." In December 2012 Mr Martin and Ms Erikson separated permanently and Mr Martin moved to Sydney.

19. A statement from Dr Philip Nitschke, on behalf of Exit International, indicates that Mr Martin first contacted Exit International by email on 12 March 2013 and on 14 March 2013. He again contacted Exit International in August 2016 and was referred by email [redacted] [redacted] The [redacted], is an online publication, published and updated by Exit International ePublishing BV (a privately held Dutch company), which provides information about assisted suicide and voluntary euthanasia.

20. In about 2014, Mr Martin started a relationship with Ms Elizabeth McAlpine, with whom he was living at the time of his death. Ms McAlpine states that when she first met Mr Martin he "*was not depressed.*" However, in mid-2014 when Ms McAlpine began living with Mr Martin she noticed that he "wouldn't eat much", would stay in a different room to her "*and sleep in that room for most of the day*", and would have a low mood with "*minimal motivation to do anything.*" Ms McAlpine states she suspected that he was suffering from a mood disorder.

21. In August 2014, Mr Martin told Ms McAlpine that "on the way to work [he] was considering driving straight into a tree", but that he was not suicidal and just wanted to avoid going to work. According to Ms McAlpine, Mr Martin was diagnosed with depression and prescribed anti-depressants. Records from Mr Martin's then GP, Dr Mohammed Akhtar, in Rouse Hill, show that in about mid-August 2014, he began prescribing Mr Martin the SSRI anti-depressant, Sertraline, and also, referred him to a psychologist.

22. During this period, Mr Martin complained that he was being bullied by a new manager at work. He was eventually "*put on Workcover*" whilst an investigation into the bullying in his workplace was conducted. Ms McAlpine states that she also believes that a number of workplace incidents put pressure on Mr Martin and that he could not cope with it.

23. In January 2015, Mr Martin travelled with Ms McAlpine to New Zealand as his daughter Claire, was getting married. Claire had previously told Mr Martin that he was not invited to the wedding. Ms McAlpine says this "had an effect on Ross" and it was one reason she was

concerned that he may be suicidal. During this trip, according to Ms McAlpine, Mr Martin became very intoxicated and said to her "*What's the point of going on*?"

24. On 27 February 2015, Mr Martin returned to work, under approval of Dr Akhtar. In October 2015, Mr Martin and Ms McAlpine bought a property in Greystanes and moved there.

25. On 25 January 2016, Mr Martin suffered chest pains and was taken to hospital. On 4 February 2016, he underwent a triple bypass operation. He was also diagnosed with type II diabetes at this time. Ms McAlpine states that whilst recovering from surgery Mr Martin had stated that "*he hoped he would just die*." Mr Martin left hospital in severe pain and according to Ms McAlpine, had to take "28 tablets" daily to manage his pain levels.

First overdose

26. According to Ms McAlpine, between May and July 2016, Mr Martin told her on several occasions that he would "*end his life*" and that he "*wanted to die*." Ms McAlpine also found Mr Martin searching on Google for methods to kill himself. A review of Mr Martin's laptop computer shows that in mid-June 2016 and early July 2016, he visited a number of websites related to voluntary euthanasia and may have purchased euthanasia drugs online.

27. On 17 Jul 2016, Mr Martin texted Ms McAlpine "*I'm going to sleep now*." On 18 July 2016, Mr Martin appears to have taken a deliberate drug overdose at home and was taken to Westmead Hospital by ambulance.

28. Mr Martin was thought to have taken an overdose of temazepam (a benzodiazepine), as well as amitriptyline (a tricyclic anti-depressant) and zopiclone (a non-benzodiazepine hypnotic agent used for short-term treatment of insomnia), empty boxes of which Ms McAlpine found in Mr Martin's bedroom. Temazepam had been prescribed to Mr Martin since 28 April 2016 by various general practitioners at Doctors on Macquarie Medical Centre, as a treatment for chronic insomnia. Dr Akhtar had also prescribed Mr Martin temazepam and amitriptyline at about this time. However, there are no records to indicate that any treating doctor prescribed Mr Martin zopiclone at this time, or indeed, at any time. It is a schedule 4 drug in NSW and thus can only be supplied with a script.

29. During his stay at Westmead Hospital, Mr Martin was treated for an infection and aspiration pneumonia. He also contracted an extended spectrum beta lactamase ("ESBL") infection. He was reviewed by psychiatric registrars (Dr Nagarajah and Dr Nasti) on 22 July 2016. He told doctors he had taken amitriptyline and temazepam (which he said he had been

prescribed), zopiclone (which he had bought from the internet) and also ecstasy. Ms McAlpine found packets of these drugs (excluding ecstasy) within the home. He told doctors he had suffered fleeting suicidal ideation for three to four months in the context of a relationship breakdown. He denied current suicidal ideation and expressed remorse for the suicide attempt. Ms McAlpine and family members, including his brother Kahu Martin, were contacted and visited him in hospital.

30. Mr Martin was not considered to be involuntarily detainable under the *Mental Health Act* 2007 at that stage. He was re-commenced on sertraline, which he had taken previously in the community.

31. Records indicate that on 29 July 2016, Mr Martin was discharged into the care of his brother, Kahu Martin, with a plan to contact mental health services at Sylvania Waters and follow up with his general practitioner. However, it appears this discharge plan relied on inaccurate information.

Admission for pneumonia

32. Mr Martin was admitted to Westmead Hospital from 2 – 9 August 2016, on referral from Dr Akhtar, for pneumonia caused by the first overdose. While he was in hospital, the respiratory team sought a psychiatric review and Dr Nasti, as well as another psychiatric registrar, Dr Soma Devan, saw Mr Martin on 9 August 2016.

33. During this admission, Ms McAlpine provided information to hospital staff in which she expressed her concern about Mr Martin's risk of self-harm and suicide.

34. Dr Nasti and Dr Soma Devan reviewed Mr Martin on 9 August 2016 and concluded that there were no clinical grounds upon which he could be involuntarily detained. This psychiatric consultation was arranged by medical staff who had been treating Mr Martin for his pneumonia. It appears that in reaching their conclusion, Dr Nasti and Dr Soma Devan were reassured by information provided by Mr Martin to the effect that he was being contacted daily by the Merrylands Community Mental Health Team, was taking sertraline daily and intended to seek treatment from The Black Dog Institute and Relationships Australia. It appears that Mr Martin also provided information to the effect that he was receiving support from his brothers and had made arrangements for a return to work.

35. By the time of the discharge on 9 August 2016, the recorded plan was for Mr Martin to be referred to a psychologist, for him to contact The Black Dog Institute and Relationships Australia and for him to continue taking sertraline 50mgs daily.

36. On 10 August 2016, Mr Martin attended Dr Akhtar, for a review of his physical and mental health. Dr Akhtar referred him to The Black Dog Institute, but it does not appear Mr Martin made contact with it, nor with any other mental health services.

37. A review of Mr Martin's laptop computer reveals that in August 2016, he visited many online drug retailers and seems to have made a number of purchases. However, it is not possible to determine precisely which drugs he bought. It appears that he also visited [redacted] [redacted] and accessed the [redacted] on a number of occasions.

Second overdose

38. On 12 and 13 August 2016, Mr Martin seems to have been active on [redacted] [redacted] Evidence indicates that Dr Nitschke, [redacted] [redacted] are responsible for the day to day operation and management of the [redacted] [redacted]. Mr Martin also viewed a pdf of what is known as an [redacted].

39. Mr Martin subsequently contacted a person going by the name Jorge Hernandez by email. Jorge Hernandez appears to operate a website which offers Nembutal for sale globally. Nembutal (pentobarbitone) is a short acting barbiturate, which in high doses can cause death by respiratory arrest. It is often referred to as [redacted] and is promoted by supporters of voluntary euthanasia as the best and most peaceful way to die. In Australia, Nembutal is a Schedule 4, prescription only medication, though the Therapeutic Goods Administration is apparently considering making it a Schedule 8 controlled drug.

40. Mr Martin exchanged emails with Mr Hernandez, ultimately ordering Nembutal for $630. In these emails, Mr Martin requested that the pills be hidden as dietary supplements or the like so they would not be withheld by customs.

41. Evidence from Dr Nitschke indicates that Jorge Hernandez is a well-known online scammer who accepts orders for drugs such as Nembutal, takes payments for them but delivers nothing. If this is correct it is difficult to know where the Nembutal which Mr Martin seems to have ultimately obtained came from.

42. On 25 August 2016, Mr Martin sent a message to his daughters via Facebook messenger, in which he complained that they had told Ms McAlpine about "*previous breakdowns*". He said they should "*just delete me, forget me*".

43. According to Ms McAlpine from November 2015, Ms McAlpine and Mr Martin began experiencing domestic related issues and slept in separate rooms. After his hospital admission in July, Mr Martin and Ms McAlpine had minimal interaction and eventually decided to sell the house they shared in Greystanes.

44. On 26 August, Ms McAlpine attended the Greystanes property to supervise carpet laying. Mr Martin asked her why they could not "*give it another go*", to which she replied "*I can never come back to what I came home to that day.*" Mr Martin subsequently visited some funeral home websites and sent an email to a funeral director seeking to pre-pay a funeral. He then sent messages to Ms McAlpine which suggested he was contemplating suicide. He finally sent an email to his daughters, which was a suicide note. His daughter Hannah Winter (in New Zealand) contacted her sister Claire Sherwood (in Brisbane), who in turn contacted the police.

45. Soon after, Senior Constable Leiva and Constable Saez from the Holroyd LAC attended Mr Martin's property. They kicked down the door to Mr Martin's room, where he was found unresponsive. Mr Martin had placed photos of Ms McAlpine, his daughters and grandson on the wall in front of him. An ambulance was called and Mr Martin was admitted to Westmead Hospital. He was initially intubated and cared for in the Intensive Care Unit.

46. When Mr Martin regained consciousness, he told doctors he had taken 100 zolpidem (a non-benzodiazepine hypnotic agent, also known as Stilnox) tablets, which he bought online from India. At some point during his admission, Mr Martin told his daughter Bridie that he had taken [redacted] that he had purchased from the internet.

47. On 30 August 2016, Mr Martin was reviewed by Dr Julian Nasti and Dr Soma Devan. Mr Martin said he did not intend to kill himself, only to go to sleep for a couple of days. He wanted to be discharged, but the doctors persuaded him to consider a voluntary admission. Dr Soma Devan spoke with Claire Sherwood, who said Mr Martin had obtained "*euthanasia drugs*" online and had them at his home should he be discharged.

48. Also on 30 August 2016, Claire spoke by telephone to Dr Soma Devan and expressed her concerns about his behaviour. On the night of 30 August 2016, she sent an email to Dr

Soma Devan attaching a series of screenshots of concerning communications between Mr Martin and his daughters.

49. On the morning of 31 August 2016, Dr Soma Devan and Dr Nasti reviewed Mr Martin again and recommended that he be admitted to hospital as a voluntary patient. They indicated that the decision as to how he should be managed was finely balanced and they were concerned about his mood disorder and his suicide risk. They concluded that provided there could be daily follow up by the Community Mental Health team, an appointment made for Mr Martin to see a psychiatrist in the community and that a trusted person could stay with Mr Martin, he could be discharged.

50. After reviewing Mr Martin, Dr Soma Devan was telephoned by Hannah Winter. Hannah expressed her concern that Mr Martin was saying certain things to those treating him in hospital and very different things to his family, with the implication that Mr Martin was saying what he needed to say in order to secure his discharge. At about 11.30 am, Dr Soma Devan spoke by telephone to Ms McAlpine. According to Dr Soma Devan, Ms McAlpine also provided concerning information about Mr Martin engaging in erratic behaviour and sending troubling texts earlier that day.

51. Around the same time, it appears that Dr Soma Devan contacted the Merrylands Community Mental Health Team, who indicated they were unable to see Mr Martin in person for 24 – 48 hours and further, could not guarantee that they could then see Mr Martin daily. Additionally, they informed Dr Soma Devan that the wait for an appointment with a psychiatrist was three weeks.

52. After receiving that information from the Merrylands Community Mental Health Team, and coupled with the information Dr Soma Devan had received from Mr Martin's family, Dr Nasti and Dr Soma Devan returned to review Mr Martin at about 12.00pm and concluded that they should admit him on an involuntary basis pursuant to s. 19(1) of the *Mental Health Act* 2007. In the records of the review, Dr Nasti noted that that Mr Martin was a "*serious risk to himself*" and that the suicide attempt had been "*elaborately planned*", with a clear intent to end his life.

53. Dr Nasti and Dr Soma Devan have indicated that when they informed Mr Martin that he was to be involuntarily admitted, there was a marked change in his demeanour and he became aggressive and somewhat menacing. Mr Martin apparently threatened to make an application in the Supreme Court to challenge the decision and also, to sue the hospital for detaining him.

54. A decision was made to transfer Mr Martin to Cumberland Hospital. The transfer occurred at 9:01pm that evening.

55. The Cumberland Hospital psychiatry team had initially planned to discharge Mr Martin, but his family raised their concerns with the Hospital staff about this occurring and provided them with text messages indicating suicidal plans. This led to Mr Martin being involuntarily detained. Dr Adnan Younus assessed Mr Martin as being at "low" risk of suicide and admitted him at Care Level 3 (with no leave) under the care of Dr Dhawan. It appears that Mr Martin was subsequently transferred back to Westmead Hospital as his prior contraction of ESBL meant he could not be admitted to Cumberland Hospital.

56. On 1 September 2016, a further review was conducted by Dr Tangina Sultana, psychiatric registrar, and Dr Peter Kelly, consultant psychiatrist, at Westmead Hospital. It is unclear what earlier records they had access to. Mr Martin was apparently discussed at a multi-disciplinary team review, and a decision was made to discharge him. Dr Kelly indicates that the multi-disciplinary team concluded that there were no proper grounds upon which Mr Martin could continue to be detained as an involuntary patient.

57. The records indicate that later on the afternoon of 1 September 2016, Hannah Winter telephoned from New Zealand and spoke to Dr Sultana. It is plain from the records that Hannah expressed her significant concerns about Mr Martin being discharged in light of him being verbally abusive and aggressive over the phone and having previously attempted suicide with euthanasia drugs he had bought from overseas.

58. Ms Winter says she asked Dr Sultana what had changed in terms of community mental health resources so that Mr Martin was now safe to be managed in the community. She says she received no satisfactory response and was told that it was not planned that Mr Martin would be discharged into the care of the community mental health team as the treating team at Westmead believed his drug overdose was impulsive and that Mr Martin was not suicidal.

59. Dr Sultana discussed the matter further with Dr Kelly but he ultimately confirmed that Mr Martin was to be discharged.

60. Dr Sultana completed a discharge summary, which recorded a discharge plan as follows:-

- Local medical officer follow up in 2 to 3 days' time;

- Local medical officer to monitor patient's mental state and titrate the antidepressants;
- Local medical officer to initiate a mental health care plan and refer to a psychologist please;
- Local medical officer to limit sedative use;
- Community Mental Health Team referral.

61. Mr Martin was accordingly discharged from Westmead Hospital on 1 September 2016.

Post-discharge care

62. On 3 September 2016, a mental health triage assessment was completed by psychologist Esther Louise Mackie of Macarthur Aged and Mental Health Care, on referral from Cumberland Hospital. According to Ms Mackie's triage notes, Mr Martin "*reported remorse for taking OD*" and was in a "good" mood.

63. Mr Martin was staying with a friend post-discharge, as Ms McAlpine had taken out an Apprehended Domestic Violence Order ("ADVO") against him by this time, preventing him from staying at their Greystanes property. A home visit by the Macarthur Community Mental Health Emergency Team (CoMHET) was conducted with Mr Martin at his friend's home on 3 September 2016. Mr Martin denied any further suicidal ideation and stated that he was "too drunk" – it is unclear from the note whether Mr Martin was referring to his current state or his state at the time of the suicide attempt.

64. Several attempts were later made by CoMHET to contact Mr Martin at his friend's address, on the number Mr Martin had left (which had a missing digit) and through friends and family. Friends stated that Mr Martin was back at work and expressed "nil concerns." On 12 September 2016, the Macarthur CoMHET sent a letter to Mr Martin notifying him that he had been discharged from care as they had been unable to reach him by phone call or home visit.

65. On 4 September 2016, Mr Martin attended his general practitioner, Dr Akhtar, to make a Mental Health Plan. Dr Akhtar recorded that Mr Martin "denies thoughts of deliberate self-harm or suicide."

66. On 6 September 2016, Mr Martin emailed Merrylands Counselling asking to see a psychologist to assist him for a "*relationship breakdown, depression, anxiety, 2x attempted suicide by drug overdose*." Mr Martin made a further inquiry as to sessions available after this, but did not respond further or make an appointment.

Drug purchases

67. Whilst Mr Martin was in hospital, on 30 August 2016, Ms McAlpine received a package which was apparently from India, addressed to Mr Martin. She informed Westmead Hospital and Mr Martin's brother, Kahu Martin, about this. She also told Mr Martin's daughter Claire.

68. On 31 August 2016, Claire rang Merrylands Police Station and spoke to Sergeant Steven Moss. She advised him that Mr Martin had recently attempted suicide by overdose and was likely to be imminently discharged from hospital. Claire stated that the drugs Mr Martin had used in his attempt to commit suicide had been obtained illicitly from overseas and were mailed to him labelled as either vitamins or weight loss pills. She requested that police seize any drugs at his home and expressed concerns that her father would again attempt to commit suicide, upon his discharge from hospital.

69. Sergeant Moss made enquiries on the NSW Police "COPS" records system and read entries concerning Mr Martin's recent suicide attempts. He then telephoned Ms McAlpine, who confirmed that further packages containing imported drugs had recently arrived for Mr Martin at the house.

70. Sergeant Moss arranged for Senior Constable Tonkin and Constable Naddaf of Merrylands Police Station to attend the house to receive the parcels, which they did. At the Greystanes property, Ms McAlpine told them about Mr Martin's recent suicide attempt and expressed concerns for her safety.

71. She handed Senior Constable Tonkin two parcels addressed to Mr Martin from India, which she believed to contain medication. When they returned to the station, Constable Naddaf registered them on the exhibits, forensic information and miscellaneous property system ("EFIMS"). Senior Constable Tonkin inspected the contents, which he described in his statement to be a total of 21 blister packs of "*legal drugs*".

72. On 9 September 2016, Ms McAlpine received a further parcel from overseas addressed to Mr Martin. The customs declaration on the parcel stated it contained dietary supplements.

Ms McAlpine attended Merrylands Police Station and handed the parcel in to Constable Bernhardsson. Ms McAlpine informed Constable Bernhardsson of Mr Martin's recent suicide attempts and stated that he had attempted to overdose on drugs he had obtained from overseas.

73. In consultation with Chief Inspector Peters, Constable Bernhardsson created an entry on the "COPS" system recording the incident and booked the parcel on the EFIMS system. Constable Bernhardsson noted on the EFIMS system that Mr Martin had previously attempted to overdose on medication, including zopiclone, to take his life. The note also recorded that police had been provided similar parcels on 31 August 2016 by Ms McAlpine. Constable Bernhardsson subsequently informed Mr Martin he could collect the parcel. It appears that there was significant uncertainty as to whether police had any power to seize or retain Mr Martin's property in the circumstances.

74. On the morning of 13 September 2016, Mr Martin collected the parcel from the station. He opened it at the request of the police and informed officers it contained diet pills. An "EFIMS – Check Out Receipt" records that the package was collected by Mr Martin from Senior Constable Graeme Sandersan at 7.34 am. A handwritten notation on the receipt form records that it contained "dietary supplements Zoplicon [sic]."

Post-discharge behaviour

75. As mentioned above in [63], during Mr Martin's final admission, Ms McAlpine had obtained a provisional ADVO, which prevented Mr Martin from returning to their Greystanes property or contacting her. Mr Martin breached this order by sending a text message on 4 September 2016, the day on which he was also due at Court regarding the ADVO. He was arrested and convicted of breaching the ADVO at Fairfield Court later that day.

76. On 9 September 2016, Mr Martin again attended Court and the ADVO's conditions were varied such that he could live at the Greystanes property and contact Ms McAlpine. Between 9 and 13 September 2016, according to Ms McAlpine, Mr Martin was "constantly harassing" her via text, including proposing that they should foster a child together.

Mr Martin's death

77. At 8.30 pm on the evening of 13 September 2016, Mr Martin argued with Ms McAlpine at their home. He yelled abuse at Ms McAlpine, calling her a "mongrel dog" and accusing her of contacting other "guys." He left the house with a bottle of wine. About ten minutes later,

he returned, and out of fear, Ms McAlpine locked herself in her room and contacted police, believing that he would again attempt suicide. At some point, Mr Martin left the house again.

78. At 8:50pm, Mr Martin sent a text message to Ms McAlpine stating that he loved her and would always love her, ending the message “Good bye, God bless.” The police Computer Aided Dispatch system (“CAD”) records show that a broadcast was made on police radio in response to Ms McAlpine’s call to police at 8.55 pm. The broadcast stated that Ms McAlpine had informed police that Mr Martin was “suicidal” and had driven away in his car with a bottle of wine. The incident was categorised as a “concern for welfare” on the CAD system and a search for Mr Martin’s vehicle was initiated. A further CAD broadcast entry (at 9.28 pm) states “WORD FROM STN APPROX 8 WEEKS AGO M ATTEMPTED SELF HARM AND HE HAS SAID DAME [sic] THING TONIGHT.” Subsequent communications noted in the CAD records suggest that a triangulation of Mr Martin’s mobile phone was considered at around 9.29 pm. It is unclear whether the triangulation was performed.

79. At approximately 10.01 pm, Sergeant Tracy Duncan found Mr Martin’s body in his car, with a wine bottle, on Eldridge Road, one minute away from the Greystanes property. Attending police performed CPR on him until paramedics arrived and pronounced him deceased.

Autopsy and later analysis

80. An autopsy was conducted by Dr Istvan Szentmariay, forensic pathologist, on 16 September 2016. Dr Szentmariay determined the cause of Mr Martin’s death to be acute pentobarbitone toxicity. Toxicology screening revealed a lethal level of pentobarbitone in Mr Martin’s blood, as well as a level of zopiclone towards the upper end of the toxic range.

81. In addition to the autopsy report, an expert report was obtained from Professor Olaf Drummer, forensic pharmacologist and toxicologist, dated 11 July 2019. In short, Professor Drummer concluded that pentobarbitone (Nembutal) was clearly the most relevant agent to have caused Mr Martin’s death, with a blood concentration of 27mgs per litre indicating the use of a substantial dose. Professor Drummer further indicated that the consumption of such a large dose could lead to death within an hour.

82. Professor Drummer also noted the zopiclone present in Mr Martin’s blood and stated that it could exacerbate the central nervous system depressant effects of other drugs (such as Nembutal). Professor Drummer’s conclusion was that the zopiclone was likely to have contributed to Mr Martin’s death to some extent, though given the much higher toxicity of Nembutal, zopiclone by itself would have been unlikely to have caused Mr Martin’s death.

Was Mr Martin's death self-inflicted?

83. Mr Martin had expressed suicidal thoughts for some time. He made careful plans to obtain lethal drugs over the internet. He sent final messages to his partner and family. In all the circumstances it is established that his death is intentionally self-inflicted.

Was the mental health care provided to Mr Martin adequate?

84. The court heard directly from doctors who provided care in the lead up to Mr Martin's death. While he had a long history of depression, there was also a clear recent exacerbation of his illness, in the context of emotional turmoil and his relationship breakdown.

85. The court focused on the decisions to discharge Mr Martin from involuntary care and the adequacy of the plans made to keep him safe in the community, particularly after his second suicide attempt. While it is not possible to refer to all the evidence within the scope of these brief reasons, I have carefully reviewed all of the material tendered, including the contemporaneous medical records.

86. The court was also assisted by the expert evidence of Dr Eagle and Professor Large. Both are experienced forensic psychiatrists who have worked in psychiatric hospitals and in the community. Professor Large has a particular expertise in the management of suicidal patients. Both doctors reviewed the various medical files and were provided with background information.

87. The court heard from Dr Julian Nasti. At the time of Mr Martin's death, Dr Nasti was a registrar in the final year of his specialist training. Although technically a registrar he was employed in a locum consultant capacity and as such supervised the clinical care provided by more junior registrars. He was responsible for discharging Mr Martin on 29 July 2016 after his first suicide attempt. He also reviewed Mr Martin on his discharge after treatment for respiratory issues on 9 August 2016. After Mr Martin's second suicide attempt, Dr Nasti was called upon to review Mr Martin again and ultimately, as discussed in [52] above, on 31 August 2016, Dr Nasti had Mr Martin detained under the *Mental Health Act* 2007 (NSW) as a mentally ill patient. Dr Nasti's evidence was critical in understanding Mr Martin's mental state in the lead up to his death. He had contact with Mr Martin over a number of weeks and was able to assess his deteriorating condition.

88. Dr Nasti impressed the court as a thoughtful, conscientious and caring doctor. He had good recall of Mr Martin and reflected carefully about the decisions he made. On initial contact with

Mr Martin he formed a preliminary view that Mr Martin was suffering from an exacerbation of a major depressive illness. On discharge on 29 July 2016, it is recorded as "*an adjustment disorder with depressed mood*". Mr Martin was linked to a community health centre and his medication was to continue. Mr Martin's general practitioner was to review his medication going forward.

89. Both Professor Large and Dr Eagle were asked to comment on the adequacy of care offered at this point. I note that while Dr Eagle thought Mr Martin could have been involuntarily detained on 29 July 2016, it was "not unreasonable" to discharge him on the expectation that a safe and effective discharge plan was capable of being implemented.[6] Nevertheless, she felt the plan lacked specific details and confirmation of follow up arrangements.[7] In oral evidence Dr Nasti remained comfortable with his diagnosis and the decision to discharge. However, with the benefit of hindsight he agreed that given the complexity of the case, there could have been consideration of further documentation being sent to Mr Martin's general practitioner.[8]

90. I have taken into account the views of both experts and reviewed Dr Nasti's oral evidence and I have no criticism of the care he provided at this juncture.

91. The next time Dr Nasti saw Mr Martin was when he reviewed Mr Martin with Dr Soma Devan on 9 August 2016. This review was undertaken at the request of the respiratory team, as Mr Martin had been re-admitted to hospital with pneumonia following the earlier suicide attempt.

92. Dr Soma Devan also gave evidence before me. At the time of the events under review she was a psychiatric registrar. She impressed as a thoughtful, conscientious and caring doctor. Her concern for Mr Martin was genuine and she recalled him easily.

93. I have had the opportunity to review the comprehensive notes made by Dr Soma Devan in relation to this consultation. I am confident that proper care was taken. Dr Nasti was of the view that while there were ongoing concerns, there were no clinical grounds upon which Mr Martin could be detained as an involuntary patient pursuant to the *Mental Health Act* 2007.

94. In oral evidence Dr Nasti noted that at this time Mr Martin was still physically unwell. For that reason he had only a very limited opportunity, since his initial discharge, to engage in mental health care in the community. Nevertheless, Dr Nasti was of the view that Mr Martin was

[6] Dr Eagle Report, Vol 6, Tab 103 page 24
[7] Dr Eagle Report, Vol 6,Tab 103 page 25
[8] Transcript, 26/9/19, page 41, line 6

being transparent with his medical team and he believed that they had established a good rapport. This helps explain why further corroboration was not sought at this time. I am satisfied by Dr Nasti's explanation of his decision at this time.

95. Dr Nasti's final contact with Mr Martin occurred on 31 August 2016. Dr Nasti had good recall of the events of that day, having spent considerable time involved in Mr Martin's care and management. Dr Nasti and Dr Soma Devan reviewed Mr Martin together. It is clear that Dr Nasti gave the difficult decision he needed to make regarding Mr Martin's possible involuntary admission considerable thought. He describes Mr Martin as neither delusional nor suicidal. He showed no formal thought disorder and was able to establish a good rapport. Dr Nasti noted that Mr Martin described a number of positive future plans and was highly motivated to be released. While there was clearly some risk, it was his initial view that Mr Martin's "*disturbance of mood and need for protection from harm [were] not so severe as to warrant detention*."[9] Dr Nasti spoke of having to balance the "least restrictive means consistent with safe and effective care". He also carefully considered the risk that involuntary detention could itself make Mr Martin's symptoms worse. The risk of iatrogenic harm was real in these circumstances. Mr Martin's history as a psychiatric nurse made him particularly resistant to the idea of being an involuntary patient. He would feel a serious "*moral affront*" if detained. Mr Martin expressed concerns that he "*would lose everything*." On balance, Dr Nasti formed the view that if appropriate arrangements could be put in place, then Mr Martin could be discharged.

96. However as the day wore on, it became clear that appropriate arrangements could not be made. Dr Soma Devan received further information from Mr Martin's family about the delivery of pills to his home. Dr Soma Devan also obtained information directly from the Merrylands Crisis Team that Mr Martin would not be seen for 24 to 48 hours after release and may not have a psychiatric appointment for three weeks. Further troubling collateral information was received from Mr Martin's partner and his daughter Hannah Winter. There was also evidence from a urine screen indicating the presence of certain drugs which were inconsistent with the history of drug use Mr Martin had given to medical staff. Dr Soma Devan and Dr Nasti gave careful attention to the new information that was received over the course of the day. Taking the new information into account Dr Nasti "*realised …that Mr Martin had not been transparent with us and that the therapeutic relationship or rapport that we thought existed perhaps didn't and that he had been withholding information and he had been guarded*."[10]

[9] Statement of Dr Nasti, quoting contemporaneous medical record Volume 5A, Tab 84 [34]
[10] Transcript 26/9/19 page 48, line 9 onwards

97. It became clear to Dr Nasti, in consultation with Dr Soma Devan that the delicate balance in relation to discharging Mr Martin had swung. It was now apparent, with the benefit of new information that "*the risk of detaining Mr Martin was now outweighed by the risk of not detaining him*."[11] It was not a decision made lightly. Dr Nasti had seen Mr Martin a number of times over a period of some weeks. He was keenly aware that there was a real risk of iatrogenic harm.

98. Dr Nasti and Dr Soma Devan informed Mr Martin of the revised decision at noon on 31 August 2016. Mr Martin became extremely angry.

99. The reasons for detaining Mr Martin are clearly recorded on the Form 1 document. In particular it was noted that the recent overdose was "*elaborately planned*".

100. I note that Dr Eagle supports Dr Nasti's decision to detain Mr Martin on 31 August 2016. The decision was made after a comprehensive assessment and proper exploration of what was actually available in the community for Mr Martin.

101. I have no criticism of either Dr Nasti or Dr Soma Devan. On the contrary, their decisions are clearly recorded and their consultation was obviously thorough. They took into account collateral information provided by family members in a proper manner. Their concern for Mr Martin was genuine and they offered him appropriate care.

102. Mr Martin was subsequently taken to Cumberland Hospital on the evening of 31 August 2016, before being returned to Westmead on the morning of 1 September 2016. At Cumberland Hospital, he was seen by Dr Adnan Younus. As mentioned in [55] above, he was ultimately returned to Westmead Hospital due to his ESBL infection, which meant he could not be admitted to Cumberland Hospital. He remained under schedule. Once back at Westmead Hospital he was seen by Dr Peter Kelly, in the company of Dr Tangina Sultana, who was a psychiatric registrar at the time. Both doctors gave evidence before me. Neither had any memory of Mr Martin and relied on their "usual practice" and what was contained in the notes to explain their decision making.

103. Dr Sultana, as the junior doctor, was the scribe during the relevant consultation with Mr Martin on 1 September 2016. She had no memory of Mr Martin and relied entirely on the notes and her usual practice. Dr Sultana gave evidence that it was her usual practice to look at previous medical records but she could not recall whether she did so in this case.[12] She

[11] Statement of Dr Nasti, quoting contemporaneous medical record Volume 5A, Tab 84 [42]
[12] Transcript 25/9/19, Page 34, line 47

gave unimpressive evidence, which was at times confusing and unhelpful. Her notes largely reflected the history recorded in the initial progress notes by Dr Younus at Cumberland Hospital, but did not reflect her having seen any earlier notes. She had no plausible explanation for why there was a failure to record discrepancies in the account she was given by Mr Martin, if she had in fact seen the earlier conflicting records. Her lack of care is apparent in her final note. She appears to have made no proper attempt to find a contact number for Mr Martin's general practitioner who was an integral part of the discharge plan. Signing off with "*attempted to contact Pt – no luck*".

104. Dr Kelly is a consultant psychiatrist employed by the Western Sydney Local Health District. At the time he saw Mr Martin he was an experienced senior specialist. In oral evidence Dr Kelly conceded the notes taken by Dr Sultana during his consultation with Mr Martin on 1 September 2016 were deficient. I note that the records of his consultation do not record a diagnosis or express his reasoning for believing that Mr Martin "*could no longer be detained involuntarily under the Act*."

105. Dr Kelly stated that it was his "*usual practice to review available Progress/Clinical Notes prior to review of a patient. In a case where a patient has been admitted involuntarily, this practice includes reviewing the Schedule 1 and Form 1 prior to conducting psychiatric review*."

106. There was a multidisciplinary meeting held that day. Dr Kelly notes "*It is apparent from the note that the team concluded that there were no proper grounds upon which Mr Martin could continue to be detained involuntarily under the Mental Health Act*."[13] A plan was then formulated for his discharge. Although there may have been discussion at the team meeting, I do not accept that a "team decision" was made. Clearly, as the consultant the responsibility for the decision to alter Mr Martin's status rests with Dr Kelly. It is apparent that even after further contact with Mr Martin's family, where very significant ongoing concerns regarding Mr Martin's mental health were raised, Dr Kelly did not change his view.

107. Dr Sultana's note of the following day records "*Spoken to Dr Kelly about it- Acc[according] to Dr Kelly - pt [patient] will be D/C [discharged]*". A brief discharge plan is recorded by Dr Sultana. There was no attempt to telephone the local mental health team, however a referral was apparently faxed to Campbelltown Community Mental health Team. The final note recorded by Dr Sultana is particularly troubling. She records "*there are no front sheet LMO details to fax the D/C summary, attempted to contact Pt [patient] – no luck. Pt has been provided mental health life line number*".[14] I note that there was no attempt to contact

[13] Statement of Dr Kelly Vol 5A, Tab 87
[14] Annexed to Statement of Dr Kelly Vol 5A, Tab 87

members of Mr Martin's family to advise them he would be discharged, even though they had been actively involved in his care.

108. The court has very serious concerns about the thoroughness of the consultation process and the quality of the notes taken.

109. Dr Kelly stated that it was his usual practice to review the clinical notes of a patient he was called upon to review. However, it is difficult to accept that a full review of the medical notes actually took place. Dr Kelly was taken to a number of significant inconsistencies between the notes taken by Dr Sultana during the consultation with Mr Martin on 1 September 2016 and the facts set out in the Form 1 document, signed the day before by Dr Nasti. Dr Kelly had no plausible explanation for why the discrepancies in what Mr Martin told Dr Nasti and what he told Dr Kelly were not identified or explored.

110. Dr Kelly stated that "*nil self harm before*" as recorded in the notes taken during the consultation he had with Mr Martin may have reflected the fact that both suicide attempts could have been seen as occurring as "*part of the same episode*". I do not accept that explanation. It is also clear that there is no documentation to indicate that past information from family and friends was taken into account, as one might expect if past records had been examined. While Dr Kelly conceded it was not recorded that this information had been reviewed, he maintained that it would have been considered as it was "*his usual practice*".

111. There were other significant differences in what Mr Martin apparently told Dr Sultana and Dr Kelly and what was recorded on the file including in relation to the number of pills he had taken and whether the suicide attempt was impulsive or planned. Each of these issues, if known to Dr Kelly should have triggered further investigation. There is no evidence of this. I note that Dr Kelly stated that even with hindsight, he was "still comfortable with the diagnosis and decision he made."[15] His lack of insight and reflection is alarming.

112. Dr Eagle states "*the decision to discharge Mr Martin appeared to have been based largely on a cross-sectional assessment of Mr Martin's mental state and a reliance on Mr Martin's account of events without regard to collateral information or a consideration of the overall circumstances of Mr Martin's presentation. The decision also appeared to be overly influenced by incorrect information provided by Mr Martin, including that the suicide attempt was impulsive and had occurred in the context of alcohol use*".[16] I accept her view.

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[15] Transcript 25/9/19, Page 109, line 12
[16] Dr Eagle Report, Vol 6, Tab 103 page 27,

113. Professor Large expressed the view that he was "*not necessarily critical*" of the decision to discharge Mr Martin on 1 September 2016 , "*particularly if the treating team reached the view, based on the mental state of Mr Martin, that he did not have a severe disturbance of mood and therefore was not a mentally ill patient*."[17] However, he expressed concerns that the decision was likely to have been made in the absence of all the available information. This seems to me to be the nub of this matter. The records indicate that on 1 September 2016, the treating team placed great emphasis on the misleading account given by Mr Martin that he had taken "*an impulsive overdose*" in order to sleep after becoming intoxicated and having a fight with his ex-partner. In doing so they appear to have relied heavily on the electronic record made at Cumberland Hospital the previous evening. There is nothing to suggest that they actually reviewed the extensive material prior to this admission, including the paper records made by Dr Soma Devan and Dr Nasti the previous day. There is also no evidence that in absence of the records they made an effort to contact the doctors directly. If this is the case, the decision to discharge was made hastily and without appropriate regard for the information that was potentially available. There was a total lack of curiosity about the past. There was no documented attempt to find out what had happened on previous admissions or explore the reasons for Dr Nasti's careful decision just the day before.

114. Professor Large indicates that in his experience it is certainly possible that the paper records may have been in transit on the morning of 1 September 2016. Professor Large expresses concern about the possibility that this loss of continuity of care may have had an impact on the decision to discharge. He also expresses the view that there were deficiencies in the discharge planning.

115. In oral evidence both Dr Nasti and Professor Large indicated that they think it likely Dr Kelly did not see a full medical record, notwithstanding Dr Kelly's belief that he would have, as it accords with his usual practice. I accept their view.

116. I have had the opportunity to review the medical records and to have heard from both Dr Kelly and Dr Sultana. I accept the decision to detain someone under the *Mental Health Act* is often a finely balanced and difficult decision. There will be many instances where competent doctors differ in their views or where hindsight throws up matters which were not at the time clear. This is a different situation. In my view there are clear deficiencies in the care Dr Kelly and Dr Sultana provided. The decision to discharge was made without a proper review of Mr Martin's history. Inadequate notes were taken and the discharge process was conducted in a careless and inappropriate manner. Neither doctor showed any insight or regret. In my view

[17] Professor Large Report, Vol 6, Tab 103 B

the conduct of both doctors requires further professional investigation and I intend to refer them both to the NSW Medical Council.

117. The deficiencies that emerged in relation to the note taking of clinical staff at Westmead Hospital also require further consideration. Dr Kelly conceded the notes of his critical decision were inadequate. It is commendable that the Western Sydney Local Health District acknowledge the need to review or audit the note taking of clinical staff working in consultation-liaison psychiatry at Westmead Hospital during the relevant period and up until today. I accept the efforts they have outlined[18] will now occur as a result of the recommendations I will make.

How did Mr Martin obtain the drug?

118. The evidence establishes that Mr Martin had researched suicide methods on the internet for some years. The first contact with Exit International was in 2013[19], however his research may have pre-dated that.

119. Exit International[20] is an organisation which "*aims to ensure that all rational adults have access to the best available information so that they may make informed decisions over when and how they die*." Exit International ePublishing BV is a privately held company registered and headquartered in the Netherlands.[21]

120. The court heard directly from Philip Nitschke. Dr Nitschke is the director of Exit International. He outlined the distinction between Exit International, which is an Australian registered company that runs workshops and [redacted] [redacted], and Exit International ePublishing BV ("Exit Publishing"), which is a publishing company that distributes the [redacted] by way of subscription. Members of both Exit International and Exit Publishing can request access to the [redacted] [redacted] administered by Exit International.

121. Dr Nitschke confirmed that Mr Martin was not a member of Exit International, however Mr Martin did take out a subscription to the [redacted][22] According to Dr Nitschke, Mr Martin first contacted Exit International in 2013 and then again in August 2016 regarding

[18] See Submissions provided by the WSLHD
[19] Statement from Philip Nitschke, Vol 6, Tab 105
[20] Final Exit (Australia) Ltd is a non profit company, registered in Darwin. It trades as Exit International. See Statement from Philip Nitschke, Vol 6, Tab 105
[21] Dr Nitschke's response provided by Tania Evers on 6 September 2019. Vol 6, Tab 107
[22] Transcript 26/9/19, Page 71, line 38 onwards

access to the . Mr Martin was directed towards the , and presumably Exit Publishing, taking out a subscription to the . On the basis of that subscription, Mr Martin contacted Exit International by email on 13 August 2016 and requested immediate access to the Exit International .

122. Dr Nitschke explained that there is generally a one month waiting period before . This waiting period is purely for administrative reasons and allows the to verify the identity of the person requesting access. The waiting period is not intended to rule out impetuous acts.

123. In his email to Exit International on 13 August 2016 requesting immediate access to the , Mr Martin stated that he had a brain tumour and because of the terminal nature of his disease, was seeking urgent access to . Mr Martin uploaded a copy of his Medicare card, driver licence and passport onto his computer before sending a copy to Exit International by email. Mr Martin was granted access to the the very same day.

124. Although the do not allow persons to post information about where to obtain drugs that can be used for assisted suicide or euthanasia, the , which is regularly updated, does reference reliable sellers of such drugs.[23] The also provides details regarding gases and the preparation of an Mr Martin had downloaded a copy of the instructions onto his computer.

125. Dr Nitschke was asked about the processes Exit International implemented to ensure that persons requesting access to the do not have a mental illness. He outlined that Exit International did not have a formal process for identifying someone with a mental illness, but that someone with a serious psychiatric condition would be readily identifiable. Dr Nitschke expressed the view that the mental capacity of a person should be assumed and that "*if a person is able to carry out a conversation*" and "*can read communications*" then they should be assumed to have mental capacity like everybody else in society.[24]

126. Ultimately the philosophy of Exit International is that rational suicide is a human right and that no reason is required should a rational person decide to end their life. That person's

[23] Transcript 26/9/19, page 75, line 31 onwards
[24] Transcript 26/9/19, page 80, line 44 onwards

decision to undertake this step should be respected and accordingly information would be provided to that person, provided that they have the requisite mental capacity.[25]

127. Dr Nitschke's views would have been very painful for Mr Martin's family members to hear. At the time that Mr Martin was in contact with Exit International and researching methods of death on the internet he was seriously unwell. However, he had survived periods of depressive illness before. His family and friends were doing everything they could to keep him alive and delay a fatal decision being made while he was in a depressive state. I have no doubt they find the approach taken by Dr Nitschke difficult to bear. While it is true that suicide can be achieved in many obvious and easy ways, one might hope that organisations committed to euthanasia would make some effort to encourage those likely to be experiencing transitory illness to delay a decision and seek assistance. Dr Nitschke did not appear to see these kinds of concerns as part of his responsibility.

128. Between June 2016 and August 2016, Mr Martin accessed a variety of websites that sell drugs online. It appears that some websites he visited resulted in purchases.[26] There is also evidence of parcels addressed to Mr Martin being intercepted by the Therapeutic Goods Administration. On 6 May 2016, 100 Stilnox (zolpidem) tablets sent to Mr Martin from Romania were intercepted and detained by the Therapeutic Goods Administration. On 2 September 2016, 90 tablets of zopiclone sent to Mr Martin from India were intercepted by the Therapeutic Goods Administration, before eventually being released to Mr Martin some time after 7 December 2016.[27]

129. Dr Nitschke was also asked about Jorge Hernandez and the email correspondence Mr Martin had with Mr Hernandez, which appeared to result in the purchase of $630 worth of Nembutal. Dr Nitschke explained that Mr Hernandez was a well-known scammer and that he did not know of an instance where the purchase of Nembutal from Mr Hernandez was successful.[28]

130. Unfortunately, despite police investigation it is impossible to know precisely where the pentobarbitone came from.

[25] Transcript 26/9/19, page 83, line 43 onwards
[26] Summary of material extracted from laptop of deceased, Vol 3, Tab 66B
[27] Therapeutic Goods Administration records, Vol 2, Tab 50
[28] Transcript 26/9/19 , page 87, line 11

Was the medication handled by police correctly?

131. The primary drug that killed Mr Martin was pentobarbitone (Nembutal). As I have already stated, it has not been established exactly where Mr Martin obtained that drug, however there is evidence that he had extensively researched the drug and was attempting to buy it overseas in the lead up to his death.

132. Also present in his system at a toxic level was the drug zopiclone. Professor Drummer was of the view that while the quantity in his post mortem blood was greater than a therapeutic dose it is unlikely to have caused Mr Martin's death if taken alone.[29] Nevertheless, it may have hastened death by exacerbating the central nervous system depressant effects of the Nembutal.[30]

133. From July 2016 onwards, Mr Martin's partner and family were extremely concerned about his capacity to buy lethal drugs over the internet. Mr Martin's daughter Claire had contacted Merrylands Police Station on 31 August 2016 requesting police assistance to seize a package which had arrived from India. This call was recorded on the COPS system. Two officers were later dispatched to retrieve the package. On return to the station, Constable Naddaf recorded the property on the EFIMS system. He stated the package contained 21 blister packs of "legal drugs". Unfortunately, this drug was destroyed prior to the inquest commencing and does not appear to have been photographed or tested.

134. On 9 September 2016, Ms McAlpine attended Merrylands Police station herself and gave another parcel containing drugs to Constable Bernhardsson. She explained Mr Martin's history of attempted suicide using drugs he had obtained from overseas. The parcel was addressed to her husband Ross Martin. It appeared to have originated from Spain and was declared as a "dietary supplement".[31] There is little doubt that Ms McAlpine gave a full account of Mr Martin's mental health issues and his history of purchasing drugs for suicide over the internet.

135. Constable Bernhardsson stated that the parcel felt like it contained blister packs. He did not believe the parcel contained anything "illegal"[32] and did not believe he had legal justification for opening the parcel. He was unsure of how to proceed and sought the advice of more senior officers. Apparently he saw Sergeant Vouden, Detective Senior Constable Thompson

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[29] Transcript 25/9/19 , page 8, line 30
[30] Transcript 25/9/19 , page 8, line 20 onwards
[31] Statement of Constable Bernhardsson, Vol 1 Tab 15 [2]
[32] Statement of Constable Bernhardsson, Vol 1, Tab 15 [2]

and Chief Inspector Peters in a common area of the police station and they had a fairly informal discussion about the issue.

136. Detective Senior Constable Thompson remembered an informal discussion she had with Constable Bernhardsson about what should be done, focussing on whether police had the power to open the parcel. In her view, it was appropriate in all the circumstances to open the parcel and check what was inside.[33] At some stage, Chief Inspector Peters joined the conversation. She did not remember a consensus about what should be done being reached and left the discussion before it concluded.

137. Both Detective Senior Constable Thompson and Chief Inspector Peters' account of the conversation indicates that it was "advice on the run". Neither seems to have clearly understood the facts as they were available at the time. Both appeared to think the conversation revolved around "illegal drugs" rather than turning their minds to pharmaceutical drugs which may have been illegally obtained.[34] Chief Inspector Peters stated he knew nothing about the fact of the prior overdose, or the previous importation of "*euthanasia drugs*".[35]

138. Chief Inspector Peters stated that he had considerable doubts about whether police had the power to open a parcel addressed to Mr Martin, on the information provided by his wife. He seemed to place some weight on the fact that the parcel had been "*lawfully delivered*" and would have gone through the normal screening processes conducted by Australian Border Force.[36]

139. He states that he advised Constable Bernhardsson to secure the parcel and enter it as miscellaneous property. Mr Martin should then be advised to come and collect it. "*He would then be asked to open the parcel in front of police who could then examine the contents and determine if anything appeared to be illegal. Any substance which was not over the counter type medicine or appeared to require a prescription in Australia would be seized and examined. If Mr Martin refused to open the parcel, the parcel would not be returned and I would arrange to have the contents examined.*"[37] Chief Inspector Peters was unable to adequately explain how simply viewing a substance would allow an officer to decide whether it was "illegal".

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[33] See discussion at Transcript 24/9/19, Page 7, line 8 onwards
[34] See for example Transcript 24/9/19, Page 21, line 37 onwards
[35] See for example Transcript 24/9/19, Page 24,
[36] Statement of Chief Inspector Peters, Vol 1, Tab 16 [7]
[37] Statement of Chief Inspector Peters, Vol 1, Tab 16 [11]

140. It appears that Constable Bernhardsson may not have understood the advice given to him by Chief Inspector Peters, or alternatively, the advice that was given may have been unclear. In any event, Constable Bernhardsson ultimately created a COPS Event[38] and booked the parcel into the EFIMS system. Constable Bernhardsson stated that Chief Inspector Peters later advised him that "*we should return the parcel to Mr Martin and when doing so, ask if he would open it in front of the police to insure(sic) there was nothing illegal contained in it*."[39]

141. The following day Constable Bernhardsson did an internet search and was able to confirm minimal information about the medications Ms McAlpine had mentioned were used by Mr Martin in his suicide attempt. One of those medications was zopiclone. He then telephoned and advised Mr Martin that he could collect his parcel.

142. Later that evening Constable Bernhardsson was working at Merrylands Police Station when Mr Martin came in and enquired about collecting the parcel. As the Exhibits Office was closed, Constable Bernhardsson told Mr Martin to return the following day. Constable Bernhardsson asked what the parcel contained and Mr Martin apparently replied "*dietary supplements required due to his recent weight loss and that it was cheaper obtaining them from overseas*."

143. At 10.26pm that evening, Constable Bernhardsson emailed the Exhibits Officers, Senior Constable Kuman and Senior Constable Sandersan advising them that Mr Martin would likely return to the Police Station the following morning to collect his parcel. The email states "*Hey guys, [the exhibit] can be returned to Ross Martin. He attended station at 7.30pm on 12/9/16 however could not return the property as it has been transferred downstairs. I advised him to come back during a week day and speak with an exhibit officer to have it returned. When he does come to collect, can I please ask if you could ask him to open the parcel in front of you, just to make sure there's nothing illegal in there. If he refuses that's fine. Please just put a quick narrative in the event with the outcome. Thanks a lot*".[40]

144. The email was confusing at best. It is difficult to understand the purpose of getting Mr Martin to open the package to see if there is something "illegal" inside, and then letting him have it anyway even if he refuses. There is no consideration of the complex issues at hand. That is, that the package may obtain a potentially lethal drug, imported without a prescription, or that Mr Martin may be at imminent risk of suicide.

[38] E63916680
[39] Statement of Constable Bernhardsson, Vol 1, Tab 15 [13}
[40] Statement of Constable Bernhardsson, Vol 1, Tab 15 [17]

145. On 13 September 2016, Senior Constable Sandersan was on duty. When Mr Martin came in, on the basis of the email Senior Constable Sandersan had received from Constable Bernhardsson, he was asked to open the package, and the pills were promptly returned. Mr Martin showed his licence and signed a check-out form. Senior Constable Sandersan had not read any COPS records or the relevant EFIMS records and, in accordance with his usual practice, returned the property on the basis of an instruction from the Officer in Charge.

146. Both Senior Constable Kuman and Senior Constable Sandersan stated that the decision as to whether an item is to be returned is generally made by the Officer in Charge, not the exhibit officer. It would not be usual practice to go behind a decision made by an officer who had more detailed information about the event. I understand that approach.

147. Later that day, Mr Martin died from a drug overdose, his death was caused by acute pentobarbitone toxicity. However, there was also a toxic quantity of zopiclone in his system. For this reason the court was particularly concerned to examine the circumstances whereby police returned a quantity of drugs, likely to have been zopiclone to Mr Martin on the very morning of his death.[41]

148. The court was also troubled by the fact that none of the involved police officers appeared to have properly turned their minds to the risk involved in returning the drugs to Mr Martin. NSW Police had been informed by family members that he had recently used prescription drugs, purchased from overseas, in contravention of Australian law to attempt suicide. In these circumstances, at the very least, one would have expected Mr Martin to be asked to provide proof that the drug had been provided pursuant to a valid prescription.

149. The court was concerned about the poor communication between Chief Inspector Peters and Constable Bernhardsson. According to Chief Inspector Peters, the advice he gave was more detailed than that recorded by Constable Bernhardsson in his COPS event E 63916680. Chief Inspector Peters told the court that he advised, among other things, that if the package contained a substance that appeared to require a prescription it should be seized and examined. If Chief Inspector Peters' memory serves him correctly and this is the advice he actually gave, it was not understood by Constable Bernhardsson. The advice Constable Bernhardsson emailed the exhibits officers had quite a different flavour. It is difficult to even understand what he meant by "*If he refuses that's fine*".

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[41] The drugs returned were labelled zopiclone. However, it is impossible to know with absolute certainty, given that Mr Martin obtained drugs from overseas on a number of occasions whether these were the ones he used on the day. It is also impossible to know whether the drugs he took were correctly labelled.

150. The confusion evident prompted the court to consider making a recommendation which would require a senior officer in Chief Inspector Peters' supervisory position to create or confirm an accurate COPS Event capturing relevant information when giving advice in these kinds of circumstances. However, having taken into account the Commissioner's submissions on this issue I accept that it would be extremely onerous for a supervising officer to create a COPS event for every instruction that was provided to junior officers. Nevertheless, it is incumbent and should be impressed upon Senior Officers such as Chief Inspector Peters to confirm their advice is clear and well understood.

151. The court was also concerned about the real lack of clarity and guidance available for the officers involved in this matter in relation to their power to open and retain a package in the circumstances of this case. Different views were expressed and all officers stated, to one degree or another, that they were unsure of their precise legal rights in this area. I note that the Commissioner supports a recommendation that would provide greater guidance to Police Officers in the circumstances of this case.

152. The court was also concerned that the apparently common practice of using an email to inform the exhibits officers that an item could be returned, may mean that useful information which could be stored centrally on the EFIMS system might be bypassed or missed. In my view a review of the way this system works may enhance future safety.

153. The court was surprised to learn that various local procedures exist for the disposing or retaining of exhibits and miscellaneous property. In this case it was most unfortunate that drugs obtained from Ms McAlpine on 1 September 2016 were disposed of prior to the coronial proceedings and thus could not be examined or tested. No photograph was taken of the drugs or package which may also have provided useful information about its provenance. In my view the evidence in this inquest raised a number of issues with the EFIMS system which would benefit from review.

Efforts by Mr Martin's family and partner to save his life

154. Tragically, those grieving Mr Martin remain divided in their understandings of the events leading up to his death. Two of Mr Martin's daughters and his former partner Ms McAlpine attended each day of the inquest. While they remain estranged, it is clear to this court that each undertook enormous efforts to obtain help for Mr Martin in the lead up to his death.

155. Mr Martin's daughters and Ms McAlpine contacted police and medical staff on numerous occasions to warn them of the severity of the emerging situation and of the real risk that Mr

Martin faced in the community. They warned that he had the ability and desire to obtain drugs that would kill him. I have no doubt they felt helpless and betrayed by those they looked to for help. I acknowledge their great efforts and offer my sincere condolences for their ongoing loss.

Findings

156. The findings I make under section 81(1) of the *Coroners Act* 2009 (NSW) are:

Identity

The person who died was Ross Martin

Date of death

He died on 13 September 2016

Place of death

He died in his car, outside 18 Eldridge Road, Greystanes NSW

Cause of death

He died of acute pentobarbitone toxicity. There were a number of other drugs in his system, including zopiclone, which was detected in the upper end of the toxic blood level range.

Manner of death

His death was intentionally self-inflicted. He died less than a fortnight after premature discharge from a mental health facility.

Recommendations

157. I have carefully considered the need for recommendations in this matter. For reasons set out above I make the following recommendations pursuant to section 82 of *the Coroners Act* 2009 NSW.

To the Commissioner of Police

- That the Commissioner of Police undertake a review of the Exhibits Procedures Manual and the Police Handbook chapters entitled Exhibits, Forensic Information and Miscellaneous Property System (EFIMS), Exhibits and Miscellaneous Property and consider revising them so as clarify police powers to open and retain property where it is

suspected on reasonable grounds of containing something that may cause harm to police or any other person.

- That the Commissioner of Police undertake a review of the Exhibits Procedures Manual and the Police Handbook chapters entitled Exhibits, Forensic Information and Miscellaneous Property System (EFIMS), Exhibits and Miscellaneous Property and consider revising them so as to require that where any officer obtains advice as to the retention of or the return of an exhibit or miscellaneous property, a record of the advice is made within EFIMS.

- That the Commissioner of Police undertake a review of the Exhibits Procedures Manual and the Police Handbook chapters entitled Exhibits, Forensic Information and Miscellaneous Property System (EFIMS), Exhibits and Miscellaneous Property so as to:

    - consider creating a single system and common procedure across NSW for the retention and disposal of exhibits and miscellaneous property;

    - require that a notification is logged on EFIMS where a Coronial Investigation has been commenced and an exhibit or miscellaneous property is held that relates to the deceased person the subject of the Coronial investigation;

    - require that photographs are taken and retained for all exhibits and miscellaneous property booked onto EFIMS.

To the Western Sydney Local Health District

- That Western Sydney Local Health District undertake a review or audit of the note taking of clinical staff working in consultation-liaison psychiatry at Westmead Hospital for the period September 2016 to the present.

- That Western Sydney Local Health District consider organising supplementary training for clinical staff working in consultation-liaison psychiatry at Westmead Hospital in relation to clinical note taking.

Referral to the NSW Medical Council

158. For reasons stated above I also make the following referrals:

a. Pursuant to section 151A of the *Health Practitioner Regulation National Law*, I refer Dr Peter Kelly to the NSW Medical Council for investigation of his management and care of Mr Ross Martin on 1 September 2016.

b. Pursuant to section 151A of the *Health Practitioner Regulation National Law*, I refer Dr Tangina Sultana to the NSW Medical Council for investigation of her management and care of Mr Ross Martin on 1 September 2016.

Conclusion

159. I thank Mr Martin's daughters and former partner Ms McAlpine for their attendance at this court and for their participation in this inquest. Once again I offer them my sincere condolences for their profound and ongoing loss.

160. I thank counsel assisting Mr Jason Downing and his instructing solicitor, Ms Lena Nash for the great assistance in the preparation of this matter.

161. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
NSW State Coroner's Court
21 November 2019