



New South Wales

**CORONER'S COURT
OF NEW SOUTH WALES**

Inquest: Inquest into the death of Daniel Leehy

Hearing dates: 3 September 2025

Date of Findings: 3 September 2025

Place of Findings: Coroner's Court of New South Wales, Lidcombe

Findings of: Magistrate Derek Lee, Deputy State Coroner

Catchwords: CORONIAL LAW – death in custody, cause and manner of death

File number: 2024/00119476

Representation: Mr S Chahrouk, Coronial Advocate Assisting the Coroner

Ms G Amal for Justice Health & Forensic Mental Health Network

Ms L Ovens for the Commissioner of Corrective Services New South Wales

Findings: Daniel Leehy died on 31 March 2024 at Long Bay Hospital, Long Bay Correctional Centre, Malabar NSW 2036.

The cause of Mr Leehy's death was ischaemic heart disease with seizure disorder and schizophrenia being other significant conditions contributing to the death but not relating to the disease or condition causing it.

Mr Leehy died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

Non-publication orders: See Annexure A

Table of Contents

1. Introduction	1
2. Why was an inquest held?.....	1
3. Mr Leehy's life.....	2
4. Mr Leehy's medical history	2
5. Mr Leehy's custodial history	2
6. The events of 31 March 2024.....	4
7. What was the cause of Mr Leehy's death?.....	4
8. Care and treatment provided to Mr Leehy.....	5
9. Findings	6
Identity	6
Date of death.....	6
Place of death.....	6
Cause of death.....	6
Manner of death.....	6

1. Introduction

- 1.1 Daniel Leehy was a 47-year-old man who was serving a custodial sentence at Long Bay Correctional Centre following revocation of a previous grant of parole. At around 4:01pm on 31 March 2024, Mr Leehy was seen to be lying on the floor of his cell after having apparently fallen from his bed due to a medical episode. The incident was captured by CCTV cameras and Corrective New South Wales (CSNSW) officers responded by attending Mr Leehy's cell immediately, together with medical and nursing staff from Justice Health and Forensic Mental Health Network (**Justice Health**).
- 1.2 Mr Leehy was found to be unresponsive with an injury to his head. Resuscitation efforts were initiated promptly. However, Mr Leehy could not be revived and was later pronounced life extinct at 4:35pm.

2. Why was an inquest held?

- 2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.
- 2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.
- 2.3 A coronial investigation and inquest seek to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination typically involves consideration of, where relevant, the conduct of CSNSW and Justice Health staff. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Leehy was not appropriately cared for and treated whilst in custody.
- 2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Mr Leehy's life

- 3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.
- 3.2 Mr Leehy was born to his parents, Cheryl and Thomas. He had a brother named Daniel. Mr Leehy spent much of his early life in Scone. Due to his interactions with the criminal justice system, Mr Leehy became estranged from his family members.
- 3.3 Unfortunately, little else is known about Mr Leehy's personal background.

4. Mr Leehy's medical history

- 4.1 Mr Leehy was diagnosed with epilepsy when he was five years old. Despite being prescribed medication for his epilepsy, Mr Leehy was reportedly not always compliant with his medication regime.
- 4.2 Mr Leehy had also previously been diagnosed with schizophrenia. According to his mother, Mr Leehy had previously been admitted to a number of mental health facilities over a period of 10 to 15 years. Again, Mr Leehy was reportedly often non-complaint with medication that was prescribed for his schizophrenia.
- 4.3 Mr Leehy also had a history of illicit drug use, including cannabis and methylamphetamine.

5. Mr Leehy's custodial history

- 5.1 Between 1993 and 2023, Mr Leehy had multiple interactions with the criminal justice system involving property, dishonesty, drug and domestic violence offences.
- 5.2 On 7 January 2022, Mr Leehy entered lawful custody in relation to a serious property offence. He was later convicted and sentenced to a custodial sentence of three years, with a non-parole period of one year and six months, expiring on 6 January 2025.
- 5.3 On 6 July 2023, Mr Leehy was released on conditional parole. However, on 16 August 2023, Mr Leehy's parole was revoked and a warrant for his arrest was issued by the State Parole Authority. On 26 August 2023, the arrest warrant was executed in Scone by the New South Wales Police Force. Mr Leehy was taken into custody and held at Long Bay Hospital after being deemed a mentally ill person in accordance with the provisions of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.
- 5.4 It was noted that Mr Leehy presented with an acute relapse of schizophrenia and that he suffered from seizures due to non-compliance with his epilepsy medication (sodium valproate). It was also noted that Mr Leehy's non-compliance was a result of the psychotic symptoms of his schizophrenia

which led his fixed delusional belief that he did not have schizophrenia and that the sodium valproate was causing his seizures, rather than preventing them. Treatment was focused on assertive treatment of Mr Leehy's psychiatric condition and employing cognitive and psychological strategies to support Mr Leehy's recommencement on his epilepsy medication.

- 5.5 On 18 November 2023, Mr Leehy was admitted to Prince of Wales Hospital (**POWH**) after experiencing a seizure which resulted in a fall and head strike. Following treatment for his injury, Mr Leehy was discharged back to Long Bay Hospital after the risks of not restarting his anti-epileptic medication were explained to him.
- 5.6 On 20 November 2023, anti-epileptic medication was charted for Mr Leehy. During the following week, Mr Leehy declined his medication despite encouragement from medical and nursing staff that the medication could assist in reducing his chance of further seizures. It was noted on several occasions that Mr Leehy was unable to engage in rational conversation and became irritable and visibly agitated. Mr Leehy maintained his belief that sodium valproate caused his seizures.
- 5.7 On 24 November 2023, a Case Review was held during which Mr Leehy and his non-compliance with his epilepsy medication were discussed. A plan was made to continue to offer the medication to Mr Leehy despite his refusal due to delusional reasons.
- 5.8 On the evening of 27 November 2023, Mr Leehy suffered an epileptic seizure and was admitted to POWH. On 28 November 2023, the Long Bay Hospital psychiatry registrar discussed management options with POWH staff regarding Mr Leehy's non-compliance with his epilepsy medication. The possibility of guardianship or parenteral options for medication administration were considered. However, it was determined that parenteral options were unavailable to address Mr Leehy's seizure risk. Mr Leehy was discharged back to Long Bay Hospital later on 28 November 2023.
- 5.9 A plan was subsequently formulated to up-titrate Mr Leehy's sodium valproate consistent with advice provided by POWH. During a subsequent Consultant Multi-Disciplinary Team (**MDT**) meeting on 1 December 2023, it was noted that Mr Leehy had remained compliant with his sodium valproate since 28 November 2023.
- 5.10 The possibility of a referral to the POWH Epilepsy Clinic to build rapport to encourage compliance was discussed. It was determined that such a referral would be very unlikely to be beneficial because only assertive psychiatric treatment was likely to restore Mr Leehy's adherence to his medication. In addition, it was also noted that if a referral was made whilst Mr Leehy was still psychotic, there was a risk that he could incorporate the neurology service into his pre-existing delusions about seizure treatment and worsen his adherence.
- 5.11 During December 2023 and January 2024, Mr Leehy showed continued compliance with his epilepsy medication. Repeat testing during this period showed that Mr Leehy's sodium valproate levels remained within the therapeutic range. It was noted that Mr Leehy remained seizure free until late January 2024.
- 5.12 On 29 January 2024, Mr Leehy was admitted to POWH again following a further seizure. He was later discharged on 30 January 2024. It was noted that Mr Leehy's sodium valproate level indicated that

he had been compliant with his medication. A recommendation was made for Mr Leehy's medication to be up-titrated and he was booked in for follow up with the epilepsy clinic.

6. The events of 31 March 2024

- 6.1 At around 2:20pm on 31 March 2024, Mr Leehy was escorted to his cell by CSNSW staff as part of a routine lock-in process. At around 4:05pm, a CSNSW officer viewing CCTV footage from Mr Leehy's cell saw Mr Leehy lying face down on the floor of his cell after having apparently fallen off his bed. The CSNSW officer attended Mr Leehy's cell and called out to him but received no response. The door to Mr Leehy's cell was opened and, with the assistance of a Justice Health nurse, he was checked on. It was discovered that Mr Leehy was unresponsive and that there was blood on the ground beneath his head.
- 6.2 An emergency call was made for assistance and Justice Health medical and nursing staff attended the cell a short time later. Resuscitation efforts were commenced. A defibrillator was attached to Mr Leehy but no shockable rhythm was detected. Resuscitation efforts continued until 4:35pm when they were ceased and Mr Leehy was pronounced life extinct.

7. What was the cause of Mr Leehy's death?

- 7.1 Mr Leehy was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 9 April 2024. This identified the following relevant findings:
- (a) 60 to 70% focal narrowing of the left anterior descending coronary artery with calcification and up to 70 to 80% focal narrowing of the lumen of the left circumflex coronary artery;
 - (b) early ischaemic changes in the right ventricle;
 - (c) mild chronic congested changes in the liver most likely due to clinically silent early heart failure;
 - (d) no acute and no significant chronic pathology in the brain;
 - (e) blunt injuries involving the front of the nose (with corresponding nasal fracture) and the side around the left eye; and
 - (f) a non-toxic level of benztropine (medication used to treat movement disorders) and a subtherapeutic level of valproic acid, both medications which had been prescribed to Mr Leehy.
- 7.2 Dr Szentmariay noted that two out of three major coronary arteries showed significant, up to 70% and 80%, narrowing of their lumen. Further, histological examination showed changes due to this level of narrowing in the form of early ischaemia of the heart muscle. Dr Szentmariay explained that “[p]atients with schizophrenia have been reported to be three times as likely to experience a sudden unexpected death than individuals from the general population”.
- 7.3 Dr Szentmariay also noted that “recurrent epileptic seizures, particularly tonic-clonic seizures, commonly result in cardiac stress and ischaemia, which may result in acute or chronic myocardial

injury and autonomic dysfunction". Therefore, the possibility of terminal seizure activity cannot be completely excluded in Mr Leehy's case. However, Dr Szentmariay expressed the view that Mr Leehy's facial injuries "*may be more indicative of a terminal fall after a sudden death due to the ischaemic heart disease*" and that the "*post-mortem blood level of various antiepileptic medications may not correlate well with the occurrence of seizures*".

7.4 In the autopsy report dated 26 March 2025, Dr Szentmariay opined that the cause of Mr Leehy's death was ischaemic heart disease with seizure disorder and schizophrenia being other significant conditions contributing to the death but not relating to the disease or condition causing it.

8. Care and treatment provided to Mr Leehy

8.1 The relevant records from CSNSW and Justice Health regarding Mr Leehy's period in lawful custody, and the findings from the post-mortem examination, establish that Mr Leehy died from progression of underlying cardiac disease. It is evident that Mr Leehy had a lengthy history of schizophrenia and epilepsy and that he was frequently non-compliant with medication prescribed for his epilepsy. This non-compliance was a product of the psychotic symptoms of Mr Leehy's schizophrenia which gave him the delusional belief that his anti-epileptic medication was causing, rather than preventing, his seizures.

8.2 On the occasions when Mr Leehy experienced seizures whilst in custody he was appropriately transferred to POWH for management of his condition. Appropriate consideration was given to Mr Leehy's history of non-compliance with his medication regime and continued efforts were made to explain the risks of non-compliance to Mr Leehy and to encourage compliance.

8.3 By December 2023, these efforts resulted in medication compliance from Mr Leehy. This continued until late January 2024 with Mr Leehy remaining seizure-free during this period.

8.4 Given Mr Leehy's history of epilepsy with prolonged periods of medication non-compliance, the post-mortem examination was unable to entirely exclude the possibility of terminal seizure activity on 31 March 2024. However, it is noted that the post-mortem examination identified evidence of significant cardiac pathology sufficient to explain sudden, unexpected death. Further, it is noted that the post-mortem toxicology results demonstrate adherence by Mr Leehy with his anti-epileptic medication. As Dr Szentmariay noted, these results "*may not correlate well with the occurrence of seizures*", making the possibility of terminal seizure activity unlikely.

8.5 Overall, the available evidence indicates that Mr Leehy's medical conditions were appropriately managed whilst in custody. In particular, repeated efforts were made to address Mr Leehy's history of non-compliance with his epilepsy medication. These efforts resulted in relatively sustained periods of compliance including on 31 March 2024. There is no evidence to suggest that any different management of Mr Leehy's epilepsy, or any other medical condition, by CSNSW or Justice Health staff could have materially affected the eventual outcome. There is also no evidence that the cardiac pathology seen at the post-mortem examination could have been identified and treated so as to prevent the eventual outcome.

9. Findings

9.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Samer Chahrouk, Coronial Advocate Assisting the Coroner, for the assistance provided throughout the coronial investigation and the sensitivity shown to Mr Leehy's relatives.

9.2 I also thank Plain Clothes Constable Chloe Bishop for her role in the police investigation and for compiling the initial brief of evidence.

9.3 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Daniel Leehy.

Date of death

Mr Leehy died on 31 March 2024.

Place of death

Mr Leehy died at Long Bay Hospital, Long Bay Correctional Centre, Malabar NSW 2036.

Cause of death

The cause of Mr Leehy's death was ischaemic heart disease with seizure disorder and schizophrenia being other significant conditions contributing to the death but not relating to the disease or condition causing it.

Manner of death

Mr Leehy died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

9.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Leehy's family and loved ones for their loss.

9.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
3 September 2025

Inquest into the death of Daniel Leehy
Coroner's Court File Number: 2024/00119476
Annexure A
Non-publication orders

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (**the Act**), the following material contained within the brief of evidence tendered in the proceedings is not to be published:
 - a) The names, addresses, phone numbers and Visitor Index Numbers of any family member, friend or other person who visited Mr Leehy while in custody (other than legal representatives).
 - b) The direct contact details, Offender Integrated Management System (**OIMS**) usernames (where applicable) and employee identification codes of staff members of CSNSW and other agencies.
 - c) Portions of the '*Escort assessment*' and '*Section 24(1) – Transfer to hospital or other place specified order*' documents contained in Folio 4 of the CSNSW Professional Standards and Investigations Branch report (**PSI Report**), as specified in the attached schedule.
 - d) The shift times of correctional officers contained in the Inmate Accommodation Journal in Folio 5 of the PSI Report.
 - e) CCTV and body-worn camera footage, including any still images from this footage.
 - f) The portions of the CSNSW Custodial Operations Policy and Procedures (**COPP**) specified in the attached schedule.

2. Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to CSNSW documents on the Court file, that material shall not be provided until the Commissioner of CSNSW has had an opportunity to make submissions in respect of that application.

Magistrate Derek Lee
Deputy State Coroner
3 September 2025

SCHEDULE TO SHORT MINUTES OF ORDER

Order 1(d).

Page no. in Folio 4 of PSI Report	Portion of document over which a Non-Publication Order is made
p. 80	The entire contents of the box in section 8 headed ' <i>Additional/special considerations</i> ' in the document titled ' <i>Section 24(1) - Transfer to hospital or other place specified order</i> '.
p. 82	The line in the section headed ' <i>Part 3A. Summary</i> ' starting with the words ' <i>No. of officers...</i> ' in the document titled ' <i>Escort assessment</i> '.
p. 97	The entire contents of the box in section 8 headed ' <i>Additional/special considerations</i> ' in the document titled ' <i>Section 24(1) - Transfer to hospital or other place specified order</i> '.
p. 99	The line in the section headed ' <i>Part 3A. Summary</i> ' starting with the words ' <i>No. of officers...</i> ' in the document titled ' <i>Escort assessment</i> '.
p. 109	The entire contents of the box in section 8 headed ' <i>Additional/special considerations</i> ' in the document titled ' <i>Section 24(1) - Transfer to hospital or other place specified order</i> '.
p. 111	The line in the section headed ' <i>Part 3A. Summary</i> ' starting with the words ' <i>No. of officers...</i> ' in the document titled ' <i>Escort assessment</i> '.

SCHEDULE TO SHORT MINUTES OF ORDER

Order 1(g).

Page no. in document	Portion of document over which a Non-Publication Order is made
<i>COPP section 13.1 'Serious incident reporting', version 1.4</i>	
p. 5	The phone numbers under the heading ' <i>2.5 Telephoning the duty officer</i> '
p. 6	The email address under the heading ' <i>2.6 Briefing note</i> '
p. 7	The phone number under the heading ' <i>3.1 Timeframes for IRM reporting</i> '
p. 9	The email address under the heading ' <i>4.1 Incident and witness reports</i> '
<i>COPP section 13.2 'Medical Emergencies', version 1.5</i>	
p. 7	The email address under the heading ' <i>2.5 SafeWork NSW</i> '
p. 8	The email address under the heading ' <i>2.6 Employee Assistance Program critical incident support</i> '
p. 10	The email addresses under the headings ' <i>2.9 Australian Border Force</i> ' and ' <i>2.10 Federal Offenders Unit</i> '
<i>COPP section 13.3 'Death in custody', version 1.10</i>	
p. 9	The email addresses under the headings ' <i>3.10 Australian Border Force</i> ' and ' <i>3.11 Federal Offenders Unit</i> '
p. 12	The phone number under the heading ' <i>6.1 Aboriginal Strategy and Policy Unit</i> '
<i>COPP section 13.9 'Video Evidence', version 2.1</i>	
p. 11	The email address under the heading ' <i>4.6 Unintentional recordings</i> '
p. 12	The email address under the heading ' <i>4.7 Technical issues with footage or data on evidence.com</i> '
p. 15	The email address under the heading ' <i>5.4 System, licence, and equipment audits</i> '