CITATION: *Inquest into the death of Martin Leach* [2026] NTCC 03

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0197/2024
DELIVERED ON:	10 February 2026
DELIVERED AT:	Darwin
HEARING DATE(s):	10 February 2026
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Death in custody; natural causes; Atrial Fibrillation; Advance Personal Plan; Advance Consent Decision; who is bound by an Advance Personal Plan; information sharing between NT Correctional Services and NT Health; 'At Risk'**

REPRESENTATION:

Counsel Assisting:	Chrissy McConnel
Counsel for Health:	Zachary Cleal
Counsel for Corrections:	Taylah Cramp

Judgment category classification:	A
Judgement ID number:	[2026] NTCC 03
Number of paragraphs:	171
Number of pages:	53

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0197/2024

In the matter of an Inquest into the death of
MARTIN LEACH

ON: 03 AUGUST 2024
AT: ROYAL DARWIN HOSPITAL

FINDINGS

Judge Elisabeth Armitage

Introduction

1. When he passed away on 3 August 2024, Martin Leach was serving a life sentence at the Holtz Darwin Correctional Precinct (DCC) for two murders and a rape and was not eligible for parole.

Background

2. Background information concerning Mr Leach was obtained from records held with Department of Corrections, personal documents and property of Mr Leach, court documents, and the personal recollections of a younger brother of Mr Leach.

3. Mr Leach was born in Wellington, New Zealand on 11 January 1957 to parents Margaret and Geoffrey Edward Leach.

4. Margaret grew up in Scotland with her grandfather. At just 15 years of age, during World War 2, she travelled unaccompanied on a ship to New Zealand and commenced a new life. Geoffrey was born in Sydney Australia and moved to New Zealand and is recorded as being a Motor

Driver. The couple met and married and began a family. Mr Leach was one of nine siblings. Seven of his siblings survived into adulthood and two passed away at an early age.

5. Mr Leach's younger brother described a distressing childhood of complex trauma at the hands of their father who was a violent alcoholic who often beat his wife and children. The father had a home-made distillery beneath a trap door underneath the family's kitchen fridge. In his drunken rages he forced his children to consume the alcohol. One time his mother produced a handgun and pointed it at his father's head. There were also reports of sexual violence within the family. Prison health records maintained by a prison psychologist, corroborate this background information and contain references to Mr Leach having experienced "a dysfunctional childhood, reporting poor attachment, neglect and physical abuse from and between both of his parents."

6. The family were transient residing in both Australia and New Zealand, with Margaret escaping the violence from time to time but later returning to the relationship. Margaret finally left the relationship in 1972 and returned to New Zealand with some of the children, including Mr Leach.

7. Mr Leach commenced his early schooling in about 1964 in Bella Vista, New South Wales, a transient town that was part of the Snowy Hydro project. Later, when living in New Zealand with his mother, he attended Porirua High School but left at the age of fifteen after reaching Form 3 - now known as Year 9.

8. On her return to New Zealand his mother commenced a new relationship, and the children did not get on with their new stepfather. The children were left to fend for themselves and they all got into trouble with the law. Mr Leach's brother recalled witnessing a physical fight between their stepfather and Mr Leach. During the fight Mr Leach was thrown through a glass door. After that fight Mr Leach left home and never returned. It was likely this incident also led to him leaving school. Mr Leach later described this time to health professionals, telling them that after leaving

home, in the absence of any income or support, he spent the next 6 months living out of a vehicle, and stealing clothes and food.

9. This period coincides with the commencement of Mr Leach's New Zealand criminal history which reveals numerous convictions for theft in 1973 and burglary in 1975. His brother also recalled that Mr Leach was in a juvenile correctional facility in New Zealand at some stage.

10. At about this same time, Mr Leach commenced a relationship with a young woman, also aged fifteen, and they had a child in 1976. The couple separated and Mr Leach did not contribute to the upbringing of this child but reconnected with her when he was incarcerated in Alice Springs. Mr Leach reported that this child passed away from cancer at age eighteen.

11. When he was sixteen Mr Leach took up with another girl and they went onto marry in 1979. They had two children born in 1979 and 1983. Mr Leach worked as a self-taught mechanic during this period.

12. His younger brother last saw Mr Leach in New Zealand, when the younger brother was thirteen and Mr Leach was seventeen years of age. Later, when Mr Leach was in prison, there were some telephone calls and correspondence between them. Mr Leach also kept in contact with his parents from prison.

13. At the age of eighteen, Mr Leach and his girlfriend travelled to Australia, arriving in August 1978. He worked for a two week period as a metal polisher in Victoria, before the pair hitchhiked to Darwin seeking employment. Unable to find work they commenced hitchhiking back to Melbourne. On 4 November 1978, a car they were travelling in was involved in an accident south of Mataranka, and Mr Leach was seriously injured. After receiving medical treatment in the Northern Territory, he travelled to Victoria for a brief time before returning to the Northern Territory with his girlfriend.

14. In May 1979, Mr Leach was living at an inner city boarding house with his girlfriend, who was now pregnant with their first child.

Imprisonment for rape

15. On 3 May 1979, Mr Leach raped a nineteen year old fellow boarding house female resident at knife point. He broke into and entered the victim's bedroom in the middle of the night, by slipping the catch on the bedroom door with the aid of a knife. He later admitted to police that the victim had submitted to sexual intercourse because he had the knife in his hand. He was arrested shortly thereafter and remanded to await trial.

16. In September1979, while in prison on remand, Mr Leach married his pregnant girlfriend.

17. On 4 October 1979, for the offences of rape and breaking and entering with the intent to commit the felony of rape in a dwelling house, Mr Leach was sentenced to 3 years imprisonment with hard labour. He was conditionally released on the same day, to be of good behaviour, with a $500 recognizance.[1]

18. The Crown Prosecutor lodged an appeal against the sentence and on 23 November 1979, the Federal Court of Australia upheld the appeal. A new sentence was given of concurrent sentences of three years imprisonment with hard labour on each charge, with a non-parole period of one year and six months.[2] Mr Leach was returned to Darwin Prison to serve out his sentence.

19. Mr Leach was released from prison in June 1982. He resumed his relationship with his wife and held short term employment for a period of several months with a cleaning company and as a printer. His wife was in full time employment.

He commits a rape and murders two young women and is imprisoned for life.

20. On 20 June 1983, at the age of twenty-four, Mr Leach murdered two

[1] Recognizance upon conditional release dated 4 October 1979
[2] Warrant of Apprehension dated 23 November 1979

young women, (aged eighteen years and fifteen years respectively), one of whom he raped, at Berry Springs. He provided a detailed account of events leading up to the deaths to police during an interview on 27 June 1983.

21. Mr Leach admitted that he was at the Berry Springs Nature Reserve where he watched the two victims, who were unknown to him, for some time. When other people present at the Nature Reserve departed the location, he armed himself with a fishing knife and approached the victims who were swimming. Under threat of the knife, he held the wrist of the younger victim and led her away from the waterfall area, compelling the elder victim to follow. He directed the victims to a gully, where he cut their clothing and bound and gagged the younger with the clothing. The elder attempted to grab the knife. Mr Leach stabbed her in the abdomen, and left the knife embedded. He then bound and gagged the elder and raped her in the presence of the younger victim.[3]

22. He then turned his attention back to the younger victim and stabbed her in the chest, penetrating her heart, resulting in her immediate death. He then stabbed the elder victim in the chest, puncturing her left lung. He walked away leaving her alive but writhing on the ground. It is estimated that she remained alive for a further 5 to 10 minutes before succumbing to her injuries. The elder victim's cause of death was due to blood loss and a collapsed lung.[4]

23. Immediately after, and in the days following the murders, Mr Leach discarded the murder weapon, cleaned himself and his motorbike (which he had ridden on the day of the incident), and altered his appearance by shaving his beard. Neighbours, suspicious of his activity, reported him to the police as a person of interest relevant to the murders. This led to his arrest and imprisonment on remand on 28 June 1983.

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[3] *R v Leach* [2004] NTSC 60 at p 38-39
[4] *R v Leach* [2004] NTSC 60 at p 36-37

24. For each of the two counts of murder, and the count of rape, he received imprisonment for life.[5]

25. In the years following, the Sentencing *(Crime of Murder) and Parole Reform Act 2003*, commenced operation on 11 February 2004.

26. When Mr Leach was sentenced, the mandatory sentence for murder was imprisonment for life and the Court was not empowered to fix a non-parole period. However, under the new legislation prisoners who were serving life sentences for two or more murders were given non-parole periods of 25 years.

27. The Director of Public Prosecutions applied to the Court to revoke the statutory 25 year non-parole period fixed by Section 18, and further, to refuse to fix a non-parole period. The Supreme Court was satisfied that Mr Leach's level of culpability in the commission of his crimes was so extreme that the community interest in retribution and punishment could only be met if he were imprisoned for life without the possibility of release on parole. On 12 November 2004, the Court ordered that his non parole period of 25 years (fixed by Section 18 of the Act) be revoked and refused to fix a non-parole period.[6]

28. Mr Leach was destined to spend the rest of his life in goal. When he passed away, he had been a prisoner for over forty years. He had a low-restricted security classification, and he was housed in Sector 7 of the Darwin Correctional Centre (DCC). He maintained employment throughout his incarceration, working in numerous areas. From 19 June 2023 he was employed as a Peer Educator.

29. During his imprisonment, commencing in 1995, he undertook and successfully completed studies in many courses. Most notably, he studied by correspondence to obtain two pre-graduate degrees in Information Technology and Applied Science (Library Technology). He used the

[5] *R v Leach* [2004] NTSC 60 at p 43
[6] *The Queen v Leach* [2004] NTSC 60 p106

skills acquired through his studies and became involved in the Correctional Centre Library (and his contributions were said to be significant). He also assisted in developing a database for a Northern Territory community organisation.

30. His further contributions while in prison included: involvement in the Berrimah Braille Program; making wooden toys; tutoring and assisting fellow prisoners; and starting the 'Lifers BBQ' where families of 'lifer' prisoners could attend a BBQ hosted at the facility by prisoners sentenced to life, to help those prisoners remain connected with their families.

31. Although he had little formal academic achievements, many who were acquainted with him during his incarceration, particularly in his early years, considered him to be intelligent, well-read, and articulate.

Prison Health History and his First Advance Personal Plan

32. Mr Leach was known to NT Health and was diagnosed with numerous medical conditions while incarcerated including:

    - Congestive Cardiac Failure - diagnosed 10 April 2024
    - Cataract surgery - conducted 14 June 2023
    - Atrial Fibrillation - diagnosed 14 March 2023
    - Arthritis - recorded 19 April 2012
    - Diverticular disease - diagnosed 8 November 2010
    - Asthma - recorded 1 January 2010
    - Arthropothy / Spondylitis - recorded 1 January 2010
    - Personality Disorder I Depression - recorded 1 January 2010

33. In the period leading up to his death, Mr Leach was prescribed or provided the following medications:

    - Paracetamol 775mg PRN (as needed)
    - Duloxetine 6mg oral in the morning

- Spironolactone 25mg/daily
- Candesartan 4mg oral in the morning
- Digoxin tablet 250mg daily
- Bisoprolol 5mg once daily
- Rosuvastatin 20mg once daily
- Dapagliflozin 10mg tablet oral in the morning
- Apixaban 5mg tablet twice a day
- Furosemide 40mg oral once daily

34. Mr Gregory McGrath, Executive Director Population and Primary Health Care Top End NT Health, provided a detailed affidavit dated 23 January 2026[7] and was NT Health's institutional respondent. Having carefully reviewed the medical records he noted that for about 15 years before his death Mr Leach had consistently refused treatments and diagnostics for his underlying conditions, including for his Atrial Fibrillation (AF). Details of these refusals are listed in Mr McGrath's affidavit and annexures. As a result, Mr Leach's AF was not diagnosed until 2023 by which time there was no cure and only treatments that could ease the symptoms.

35. Before administering health care to a person, a health care provider must gain consent from the person or other person with legal authority (except in an emergency). It is the responsibility of the health care provider to determine the person's decision making capacity, follow any directions provided in an Advance Personal Plan (APP) and contact the health care decision maker(s) when the person cannot consent for themselves.[8]

36. In the Northern Territory, an APP is a legal document which allows an individual to consent to or refuse specific treatments in advance via an

[7] Together with a further short affidavit dated 6 February 2026
[8] *Health Care Decision Making Act 2023*

Advance Consent Decision. An APP does not replace a Will and only applies while the maker is still alive. In 2014, APPs replaced the Enduring Power of Attorney formerly used for similar purposes in the Northern Territory.[9]

37. In October 2019, Mr Leach completed an Advance Personal Plan (First APP) containing Advance Consent Decisions. While an Advance Consent Decision is binding on health care providers, Correctional Services is not a health care provider and is not legally bound to follow an Advance Consent Decision. Mr Leach did not appoint a substitute decision maker.

38. It is important to understand what Mr Leach prepared and signed so relevant parts from the original document are extracted below: [10]

Section 1: Your details

This is a compulsory section

Complete this section by writing on the lines.

I, Martin Leach
(Full name here)
Of, Corrections Berrimah NT
(Address here)
Born on, 11/01/1959
(Date of your birth)

being over the age of eighteen years, who has decision-making capacity and who does not have an adult guardian appointed under the *Adult Guardianship Act* or manager appointed under the *Aged and Inform Persons' Property Act*, make this Advance Personal Plan after careful consideration, voluntarily and without coercion or other undue influence.

If at any time I am unable to take part in decisions about my care or welfare (including health care) or property or financial affairs, let this document stand as evidence of my health decisions, my views, wishes and beliefs and/or who I nominate as my substitute decision maker/s.

This Advance Personal Plan should not be used if I have the capacity to speak competently for myself or if there is evidence that it has been revoked.

I request that all who are responsible for my care respect the decisions and directions given in this document.

[9] *Advance Personal Planning Act 2013*
[10] Advance Personal Plan of Mr Leach dated 10 October 2019

Section 2: Advance Consent Decisions

This is not a compulsory section

Note: It is strongly recommended that before completing this document you discuss your options with your doctor who knows your medical history and views. The doctor will also be able to explain any medical terms that you are unsure about and will confirm that you were able to understand the decisions you have made in the document and that you made those decisions voluntarily. You can also ask your doctor to witness your signature.

Advance Consent Decisions are legally binding on your health care provider and can include decisions about organ transplants, palliative care, instructions not to be put on life support or direction about not receiving blood transfusions.

An Advance Care Decision is an express statement of your consent or refusal for specific treatments or future health care. You can either select a box below that you agree with or write the statements in your own words below each option.

For example, a statement that "I do not want to be given a blood transfusion in any circumstance" is an express statement for refusing consent for a blood transfusion. A statement that "If I have a terminal illness and am going to die soon, I do not want to be given treatment just to keep me alive for a little bit longer – just keep me pain free" may constitute consent for a terminally ill person to be given pain relief and for other treatment to be discontinued.

a. Specific health care treatment directions
(You can select your preferred option by marking the box with an 'X'. You can add more information about your own decisions in part b. below)

(i) Life support

☐ I would like life prolonging treatments to be commenced and continued, including CPR, while they are medically appropriate and remain in my best interests.

X If I am acutely ill and unable to communicate responsively with my family and friends, and it is reasonably certain that I will not recover, I want to be allowed to die naturally and be cared for with dignity. I do not want to be kept alive by extraordinary or overly burdensome measures that might be used to prolong my life (e.g. Cardio-Pulmonary Resuscitation (CPR)). If any of these treatments have been started, I request that they be discontinued.

Please provide any further information below
Note: *You may attach more pages if required.*

Relief of pain paramount - manage symptoms
NOT WANT ACTIVE CPR

b. Other specific health care treatment directions
(Detail here any treatment you would or would not want to have provided e.g. blood transfusions or antibiotics) **Note:** You may attach more pages if required.

Antibiotic OK - not blood transfusion – operations under advice with discussion - case by case discussion with DR nursing staff

MARTIN LEACH

Section 5: Signing and witnessing

This a compulsory section

Adult making the Advance Personal Plan

Martin Leach _____ 10 October 2019
(Name) (Adult signs here or, if the adult is unable to sign a person acting on the direction, and in the presence of the adult, must sign)

If you are signing for the adult
I,
_____
(Full name)

Am at least eighteen years old and not appointed as a decision maker for the adult.

Witness

I, Dr BARBARA ALLEN
of
(Full name)

DCC HOLTZE.
(Address)

A qualified witness MBBS FRACGP
(State qualifications as authorised witness)

certify that the person making this document is who they purport to be, has attained the age of eighteen years, appears to understand the nature and effect of the Advance Personal Plan, appears to be acting voluntarily without coercion or other undue influence and that the plan was signed by the adult making it, or by their representative, in my presence.

_____ 10 OCT 19
(Witness signs here) (Insert date)

If the Advance Personal Plan authorises dealings in property, the plan must be registered with the Land Titles Office for any dealings to occur.

The following people are authorised witnesses and are able to witness the making of an Advance Personal Plan:
Commissioner for Oaths, including legal practitioners, Justices of the Peace and Police Officers. Doctors, Nurses and other health professionals
Accountants
Chief Executive Officers of Local Government Authorities Social Workers
Principals of Northern Territory schools

39. A copy of this APP was in Mr Leach's Primary Health Records.

40. There was never any real question as to Mr Leach's competency or capacity to make decisions or an APP. Mr Leach saw a psychologist on 1 and 16 February 2023 and again on 8 March 2023. On each occasion he was found to have good insight, he was not suicidal, and he remained adamant that he did not want life prolonging medical interventions.

41. On 12 March 2023 Mr Leach was diagnosed with AF. Throughout various appointments and attendances that followed he refused investigations, reviews, and treatments. Medical professionals regularly re-assessed his competency and re-confirmed his decision to decline treatment.

Medical treatment throughout 2024 and a Second APP dated 22 June 2024

6 - 7 February 2024 RDH and 'At Risk'

42. Mr Leach's Client Summary Report (NT Health records) contained the following alerts, including as to his APP (referred to as an Advanced Care Plan/Directive):

> ***Other Alerts***
>
> ***Activate Date Alert Type Notes***
>
> *21/05/2019 Treatment Alert client does NOT want to be resuscitated in the event of an arrest or other - he is adamant he will die in prison + has written letters requesting this in about 2013/2014 - 21 May 19 his decision remains the same-*
>
> *06/02/2024 Medical Alert in spite of patient preference - to be resuscitated as per*
>
> *Corrections Act - Advanced Care Plan not accepted by Corrections - see notes 6 Feb 24*
>
> *30/07/2024 Treatment Alert scanned copy of Signed Advanced Personal Plan in documents dated 10/10/2019*
>
> *31/07/2024 Treatment Alert Legal Services supports the position that health staff should honour the client's wishes as set out in his Advanced Care Directive.*
>
> *Sections 92 and 93 of the Corrections Act 2014 (NT) do not empower the General Manager or other Corrections staff to compel a health worker to provide health care or medication without consent.*

43. On the morning of 6 February 2024, (approximately 6 months prior to his passing) Mr Leach presented to DCC clinic complaining of visual disturbances, headaches, dizziness, shortness of breath and chest discomfort. He had an ECG which measured his AF at 154. He "declined treatment" but "accepted" transfer to the hospital. At 11.50am he was handed over to St John Ambulance for transfer to the Emergency Department (ED) of Royal Darwin Hospital (RDH).

44. He arrived at ED at 12.44pm. His clinical assessment records that: he was brought in with chest pain and sudden onset of palpitation; he had a history of uncontrolled AF; he had never taken medication for the condition; and his APP with 'Do Not Resuscitate' (DNR) was noted.

45. At 2.02pm, he was escalated to the ED Consultant Dr Harrington. Both Dr Harrington and Professor Didier Palmer OAM, Director Emergency &

Trauma Centre, discussed his circumstances with Dr Barbara Allen of the DCC clinic. The RDH ED doctors advised that Mr Leach was of sound and competent mind and did not consent to and had declined medical treatment. As he was not accepting treatment he was being discharged back to DCC with medication (should he change his mind and decide to take it). They recommended that he should return if his condition deteriorated.

46. Dr Allen told the ED doctors that Mr Leach could not be effectively monitored or managed at DCC (as there were no medical staff overnight), prison protocols precluded him from remaining at the prison unsupervised in his present condition, and it was likely that prison protocols, when followed by prison health staff, would also place Mr Leach in a category that would require him to be taken back to a health facility outside of the prison. In other words, applying prison protocols he was too sick to be at the prison when there were no medical staff on duty.

47. At 3:08pm, Joanne Hobday, Acting Professional Practice Nurse DCC clinic, emailed David Gordon, DCC General Manager, Michael Cox, Acting Superintendent, and Ted Murphy, Acting District Manager Prison Health, copying in NT Health staff and the DCC clinic staff:

> *We just need to know where we stand in terms of his treatment or him refusing treatment, as he is a lifer and this would be a death in custody. He does have an advance care directive, not for resuscitation here.*

48. Mr Murphy responded requesting further information and Mr Gordon responded that he would attend the DCC clinic.

49. At 3.46pm, Mr Leach was discharged from ED back to DCC. At 4:01pm Dr Allen emailed Mr Gordon to advise him that Mr Leach was returning to DCC. The email included the following (emphasis added):

> *IF he returns he would be admitted to medical which we all are aware does not have medical staff from 2130 to 0700 hours.*
>
> *If able to be released ED have agreed they will provide us with a plan and the relevant medications to administer if he changes his mind as we do not stock them (Digoxin).*

Our medical staff are also conflicted as it goes against our medical ethics to make someone who is cognitively able to refuse care.

We will resuscitate him if required - again against our principles and against his will.

For future episodes, are there any plans for the act to be revised? I have been informed that there is a similar Act in all states.

We have just been informed the Officers are on their way back to the prison.

He will be placed at risk in the medical centre when he returns.

50. At 4:47pm Mr Gordon responded (emphasis added):

> ***…I have both a moral and legal obligation to preserve life and as such I am authorizing the administration of relevant healthcare to preserve life albeit against Mr Leach's wishes. I authorise this under the Corrective Services Act 2014 section 92 Provision of Health Care without consent and section 93 Administration of medication to prevent harm. …***
>
> ***I still consider Mr Leach a heightened risk and as such he will be placed in "at risk" accommodation*** *in medical and I have authorised 2 officers to have continued observations of the prisoner. If there is a visible deterioration in his condition observed or reported, I have instructed that a CAT 1 ambulance be called and he again be transported to RDH with the 2 x officers I have placed on him for observation.*

51. At 4.49pm, Mr Murphy wrote to Mr Gordon confirming NT Health had developed and communicated a 'preservation of life plan' and had placed a 'Medical Alert' on Mr Leach's file as follows (emphasis added):

> ***In spite of patient preference – to be resuscitated as per Correction Act – <u>Advanced Care Plan not accepted by Corrections.</u>***

52. At 4:55pm, Professor Palmer replied to Mr Gordon (emphasis added):

> ***From a medical perspective M. Lynch has been assessed*** **as** ***competent to make a decision to refuse treatment (which may save life) after the consequences*** **of** ***that refusal were explained to him. Further it was judged during that assessment that he understood those consequences and made*** **a** ***reasoned choice (we don't have to agree with that choice). This fulfils the four standards*** **of** ***decision making capacity in medical ethics.*** *This assessment was made by* a *senior consultant emergency physician. From* a *medical perspective* ***the treating consultant regarded it as unethical to force treatment upon M. Lynch and further would not do*** **so** ***under any condition (e.g. court order) unless M. Lynch were to consent himself.*** *The treating consultant came to me to discuss the situation and I concurred with his judgement. I* ***appreciate section 92*** **of** ***the [A]ct gives legal protection to the medical officer to treat against the person's will (which would otherwise be an assault)*** *....* ***But that does not trump the ethical duty*** **of** ***the doctor*** *....* ***And the Act is reflective*** **of** ***this*** *.....* ***"requests*** **a** ***medical practitioner to examine the prisoner and, if appropriate, provide health care".*** *M. Lynch has been discharged from the*

Emergency & Trauma Centre with a medical discharge letter providing guidance on treatment and a supply of the medication for that treatment.

53. After this email Mr Gordon and Professor Palmer spoke on the phone and Correctional Services submitted that Mr Gordon acknowledged that he could not force a doctor to act against a prisoner/patient "interest."[11]

54. It is not clear, however, that Mr Gordon's 'softened position' was communicated to the DCC clinic staff at that time because, for example, at 4:56pm, Mr Murphy emailed Dr Sharon Miskell, then Acting Director of Medical Services in relation to Mr Leach's 'At Risk' episode, stating that NT Health staff "... **have been advised to preserve life** and will attend to any code blue called for Mr Leach. Corrections staff have been advised to arrange medical evacuation (with or without his consent), should he deteriorate overnight." The email also sought Dr Miskell's advice on how to manage Mr Leach's refusal of treatment.

55. At 8:45pm, Dr Miskell replied to Mr Murphy stating that it would be "... advisable to develop a management plan for Mr Leach given there have been previous occasions where he has refused care."

56. On his return to the prison, Mr Leach was marked 'At Risk' and housed in an 'At Risk' cell under the supervision of Correctional Officers. This 'At Risk' episode will be discussed in more detail later in these findings.

57. He was removed from 'At Risk' on 7 February 2024. Mr Gordon told Mr Leach that in the event of a medical emergency Corrections staff would "conduct first response" until medical arrive who will abide by their own processes.

18 February – 31 July 2024: A period of AF deterioration and continued treatment refusal

58. On 18 February 2024 he told a nurse that his wishes regarding his care remained unchanged, and he declined to speak to a psychologist.

59. Dr Sewell saw him on 23 February 2024. He continued to decline

[11] Department of Corrections submissions dated 9 February 2026 [12]

treatment and signed a 'Refusal to Treat' form. He spoke to the psychologist who documented their discussion which included the following:

> *…Martin presents with good insight and judgement; and seems to understand his situation well. At the time of session, and all prior sessions with Martin; he appeared strongly oriented to time, place, person and situation and no overt indicators of poor mental health noted or reported, other than reports of depression which presents as lack of motivation, desire to withdraw and lethargy. Rumination within an anxiety context was also reported….*
>
> *RISK ASSESSMENT: Risk was explored at varying intervals during the session. Martin repeatedly acknowledges that he had received indefinite prison sentences and understands that he will die in prison. However, he reports that he does not want to prolong his life if he were to become sick. Martin has signed a "do not resuscitate" order but understands that this may not be relevant / the order is suspended while he is in custody. He remains adamant that he does not want medical intervention should he became sick or unwell…*
>
> *…*
>
> *He recognised repeatedly that death is a normal part of living, and nobody including himself was exempt from death. He expressed anger around his lack of control of his situation, and how his death should be about dignity and not "a shit show". The lack of control was something that Martin repeatedly circled back to...*

60. On 5 March 2024 he was seen by a nurse and the psychologist after he had allegedly been struck by another prisoner. He was "still declining treatment." Dr Allen saw him on 28 March, and he was still declining treatment.

61. On 4 April 2024 a registered nurse saw him and noted:

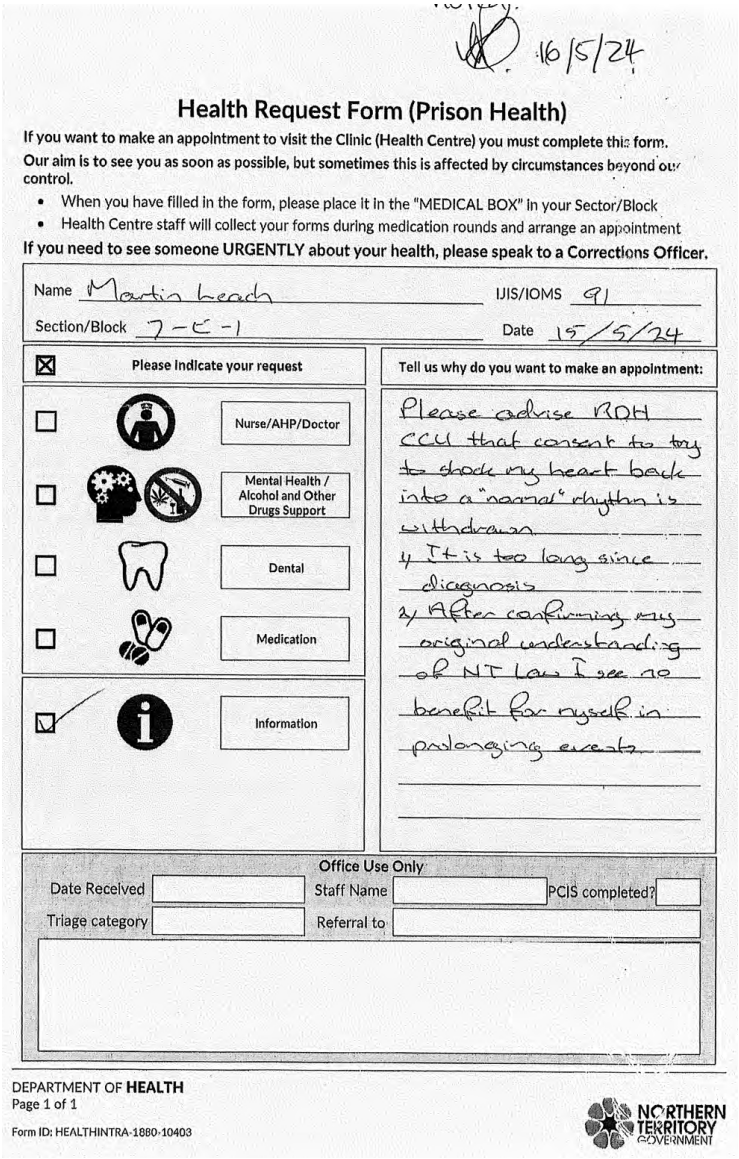
> *..He has previously written an advanced care directive in 2019 which Martin advises NTC apparently do not recognise under the Correctional Service Act 2014.*
>
> *He has consistently declined medications for AF & rejects the notion that NTC officers may be able to use 'force that is reasonably necessary' under the Act to make him comply with treatment.*
>
> *His cognition is intact, given he is able to quote the Act word for word.*
>
> *Major issue for him is that anything that brought him any joy has been systematically removed in the last 10 years. This includes art, reading, studying, his computer...*

62. On 5 April 2024 he presented at the DCC clinic short of breath with rapid AF. He consented to go to RDH in an ambulance "in handcuffs but not in shackles." At RDH he was managed with medication changes "Bisoprolol was up titrated to 5mg. Digoxin was commenced" and he was discharged back to DCC.

63. On 10 April 2024 he saw Dr Sewell who reported:

> *..has written to coroner regarding his wishes for DNR as in his advance care plan now wants commissioner to accept this also..*

64. On 15 May 2024 he completed a Health Request Form "wishing to advise RDH that consent to try to shock my heart back into a 'normal' rhythm is withdrawn:"



16/5/24

Health Request Form (Prison Health)

If you want to make an appointment to visit the Clinic (Health Centre) you must complete this form.
Our aim is to see you as soon as possible, but sometimes this is affected by circumstances beyond our control.

- When you have filled in the form, please place it in the "MEDICAL BOX" in your Sector/Block
- Health Centre staff will collect your forms during medication rounds and arrange an appointment

If you need to see someone URGENTLY about your health, please speak to a Corrections Officer.

Name Martin Leach IJIS/IOMS 91

Section/Block 7-E-1 Date 15/5/24

Please indicate your request	Tell us why do you want to make an appointment:
☐ Nurse/AHP/Doctor	Please advise RDH CCU that consent to try to shock my heart back into a "normal" rhythm is withdrawn. 1/ It is too long since diagnosis 2/ After confirming my original understanding of NT Law I see no benefit for myself in prolonging events
☐ Mental Health / Alcohol and Other Drugs Support	
☐ Dental	
☐ Medication	
☑ Information	

Office Use Only

Date Received | Staff Name | PCIS completed?

Triage category | Referral to

DEPARTMENT OF **HEALTH**
Page 1 of 1
Form ID: HEALTHINTRA-1880-10403

NORTHERN TERRITORY GOVERNMENT

65. On 6 June 2024 Mr Leach told the DCC pharmacist that he had ceased taking some medications and that he removes and discards these medications from his pack every day. He said he was only taking Paracetamol, Duloxetine, Frusemide, Spironolactone.

66. In April 2024 he sought assistance drafting a new Advance Care Plan and wished to update his Will. On 22 June 2024 he completed a further APP (Second APP) which was witnessed by his legal practitioner who he also appointed as his decision maker for "all matters." In this APP he made Advance Consent Decisions:

    - "Please allow me to die a natural death. Do not restart my heart or breathing (No CPR)."
    - He did not want artificial feeding/tube feeding.
    - He did not want blood transfusions.
    - He did not want "any sort of medical intervention or treatment. I just wish to receive pain management."
    - "Because of my religious beliefs, I do not want to receive any blood transfusions or organ transplants."

67. On 22 July 2024, following review by a cardiologist and considering his APP, it was determined that there would be no further cardiology appointments and instead the palliative care team should be involved for comfort care in the event of deterioration.

68. He attended the DCC clinic on 24 July 2024 with worsening symptoms. He declined treatment/medication, said he was "old and grumpy" but agreed to go to RDH, and he was handed over for ambulance transfer at 11:10am. His RDH discharge summary on the same day documented that he was cognitively intact, capable of making his own decisions, was not suicidal, and his continued refusal of treatment. He accepted Oxycodone and Fentanyl (palliative analgesia) and was discharged with Tramadol. On return to the prison, he refused the Tramadol but accepted Brufen.

69. On 26 July 2024 he attended the satellite clinic in DCC Sector 7. His symptoms had worsened. The nurse said she would call Code Blue, but Mr Leach refused. He refused a wheelchair but agreed to walk to the clinic. At the clinic he refused oxygen and an ECG, and he was transferred to RDH. At RDH Mr Leach consented to investigation of the

'episode,' refused life prolonging treatment, but accepted pain relief of Endone and Paracetamol. The following is recorded in his progress notes.

> *client does NOT want to be resuscitated in the event of an arrest or other - he is adamant he will die in prison + has written letters requesting this in about 2013/2014 - 21 May 19 his decision remains the same*
>
> *in spite of patient preference- to be resuscitated as per Corrections Act - Advanced Care Plan not accepted by Corrections -*
>
> *transferred to RDH*

70. On 29 July 2024 he was seen by Dr Sewell, who was satisfied as to his mental competence, and she noted:

> *says [he] has written to the coroner and commissioner regarding his wishes to refuse treatment and DNR + Anti-Discrimination Commission. [He] is adamant about his wishes, says he will not change his mind. [He] doesn't want to keep going back and forward from RDH [and] would like a higher threshold before he gets sent in.*

71. Dr Sewell saw him again on 30 July 2024 and he agreed to be transferred to RDH as he was not well enough to be returned to the block. At RDH he was referred to the palliative team, he was chartered for MS Contin 5 mg for chest pain and shortness of breath to be administered at the DCC clinic, and he was discharged to DCC.

NT Corrections correspondence about the APP

72. On 25 July 2024, at 7.46am, A Jeffers, Acting Senior Correctional Officer DCC, sent an email to DCC management requesting directions:

> Could I please have any information in writing in regards to prisoner Leach's wishes and our stance in how we respond to his resuscitation? He returned from hospital yesterday stating that he has been informed that he will have a
> Catastrophic heart attack at any moment and reiterated his wishes to us that he is not to be resuscitated.

73. At 7.50am, G Hirschausen, Acting Superintendent, DCC, replied:

> As first responders we will administer first aid as trained.
> Once handed over to medical they will then abide by their own ethical standards.

74. At 11.15am, D Gordon, General Manager, DCC, further responded:

Hi there...to give everyone comfort...

While it is acknowledged that Mr LEACH has expressed his desire to not be resuscitated, I have both a moral and legal obligation to preserve life and as such I am authorising the administration of relevant healthcare to preserve life albeit against Mr LEACH'S wishes. I authorise this under the Corrective Services ACT 2014 section 92 Provision of Health Care without consent and section 93 Administration of medication to prevent harm. I have attached the relevant sections of the ACT.

As Mr Hirschausen has stated, once handed over to medical they will abide by their own processes.

75. At 11.47 am, J Hobday, Acting Health Centre Manager DCC clinic, sent an email to several recipients within DCC management, and copied management within NT Health:

As you will be aware Martin Leach was recently in hospital for his heart issues. He continues to decline treatment and several medications.
Medical wish to advise that if Mr Leach raises any issues or concerns, then they are to be escalated to medical immediately.
If there are any issues out of staffed medical hours, we recommend an ambulance be called immediately, and the on-call nurse to be notified of what has occurred.
He is high risk, and he is actively declining medical intervention.
As per his recent hospital admission, as part of his discharge plan it was recommended that if his pain or symptoms worsen then he is to return to emergency.

I would greatly appreciate if you could disseminate this information to your staff.
Symptoms to be aware of are increased/new pain, cheat pain, shortness of breath / difficulty breathing.
If Martins expresses that he feels unwell in anyway, or others raise concern for him, then this needs to be escalated to medical staff.

I think when our district manager Ted is back next week, we need to arrange a meeting between health and corrections about the ongoing care plan for Mr Leach.

NT Health obtain legal advice about the APP

76. Following the 'purported' authorization of the administration of health care without consent pursuant to sections 92 and 93 of the Correctional Services Act 2014, NT Health consulted extensively with NT Correctional Services and obtained legal advice. On 31 July 2024, the progress notes record that advice was received from NT Health Acting Director Legal Services as follows (emphasis added):

> *We have received the following advice from the A/Director, Legal Services:*
>
> ***Legal Services supports the nurses' position that they should honour the client's wishes as set out in his Advanced Care Directive (attached for convenience).***
>
> ***Sections 92 and 93 of the Corrections Act 2014 (NT) do not empower the General Manager or other Corrections staff to compel a health worker to provide health care or medication without consent.***
>
> *Practical steps should be taken to ensure that the Advanced Care Directive is brought to the attention of relevant staff during handovers and is notified to any third party health providers (e.g. St Johns) that may be called upon to assist in the client's care.*

Legal services will seek further advice from the Solicitor for the Northern Territory in relation to this matter.

77. On 31 July 2024 at 9.08am, E Murphy, District Manager Prison Health forwarded an email to several NT Corrections recipients including Mr Gordon:

> Please be advised we have received advice concerning the status of the Advanced Care Directive of Martin LEACH as it relates to health staff at Holtze clinic:
>
> *Legal Services supports the nurses' position that they should honour the client's wishes as set out in his Advanced Care Directive (attached for convenience).*
>
> *Sections 92 and 93 of the Corrections Act 2014 (NT) do not empower the General Manager or other Corrections staff to compel a health worker to provide health care or medication without consent.*
>
> As you will recall, RDH medical staff were clear on what their obligations were, however this is less clear for nursing staff responding in good faith to a code blue.
>
> We will continue to respond to a code blue called for him (as we would in any other circumstance, but we will be providing comfort measures only and not active treatment.

78. On 31 July 2024, at 9.49am, M Cox, Acting Superintendent DCC, forwarded the above email to DCC management and commented:

> Attached for future reference, noting PHC staff respond to a code blue, however will provide comfort measures only.
>
> Mr Gordon has already provided clear direction that NTCS staff will be obligated to provide first aid and commence lifesaving actions as per our training.

Final Hospital admission - 2 August 2024

79. On 1 August 2024, Mr Leach attended the DCC clinic with worsening shortness of breath, vomiting and dizziness.

80. The on-call Doctor was consulted, and it was decided to transfer him to RDH. He was conveyed to RDH during the early hours of 2 August 2024. After initial triage in ED, he continued to refuse investigation or treatment and in accordance with his stated wishes he was admitted into the Palliative Care Unit. The medical records included his First APP and a reference to his Second APP (but RDH did not hold a copy). His nominated decision maker was emailed in case NT Health required her assistance with a decision. The nominated decision maker emailed a copy of the Second APP to the DCC Health clinic general email address at 2.35pm and this was forwarded to staff at the DCC clinic, with a request

that it be forwarded to St John Ambulance. It was not provided to Correctional Services.

81. At 1.37pm, M Rahman, Acting Chief Correctional Officer, sent an email to DCC management and the DCC clinic requesting that he be housed in 'medical' if he returned from RDH. At 2.07pm, J Hobday responded that while ordinarily the request would be fulfilled, all the beds in the clinic were full, and would not be available over the weekend period. She further advised that "discussions are planned between Martin, health, palliative care, and NTCS regarding plans for his medical management. This is due to occur next week as far as I know."

82. About 6.30pm on 2 August 2024, there was a change of escorting Correctional Officers and nightshift Officers JW and HN commenced monitoring Mr Leach. Mr Leach engaged in short conversations with the Correctional Officers.

83. At about 6.50pm he needed to use the bathroom and declined help from the Correctional Officers.

84. Following his return to bed, he appeared breathless and was huffing and puffing before falling asleep. During the night he hiccupped but did not wake. The Correctional Officers notified medical staff who, following assessment, believed the hiccup was due to a fizzy drink he had consumed earlier in the night. Mr Leach continued to sleep.

85. About 6.03am on 3 August 2024, Officer HN got up to use the bathroom. Officer JW was updating the bedsit register when he noticed Mr Leach's breathing had changed. Officer JW called for the nurses. The nurses entered and saw Mr Leach take two more breaths before he stopped breathing. He was declared deceased at 6:10am. His death was reported to the Joint Emergency Services Communication Centre at 7.46am by a Correctional Officer.

86. The discharge summary prepared by the Palliative Medicine specialist recorded:

Martin Leach, a 65-year-old man, presented to RDH ED on 2 August 2024 with increasing dyspnoea and tachycardia. He was found to have congestive cardiac failure in the setting of AF with RVR, with evolving cardiogenic shock. Martin was adamant he did not want further investigation or treatment. Martin was admitted under Palliative Care for symptomatic management only. Subcutaneous medications were utilised to manage his symptoms. He rapidly deteriorated and died in the Hospice at 0610 on 3 August 2024. Given this was a death in custody, his case was referred to the Coronial Investigation Unit.

Autopsy

87. Forensic pathologist Salona Roopan conducted an autopsy on Sunday the 4 August 2024. His cause of death was:

    I (a). Congestive cardiac failure

    Morbid conditions giving rise to the above cause:

    I (b). Dilated cardiomyopathy (not otherwise specified) and atrial fibrillation.

    Other significant conditions contributing to death but not related to the condition causing death:

    Chronic obstructive pulmonary disease

88. Toxicology revealed no alcohol present and detected the following drugs in therapeutic levels indicating appropriate medical management without drug overdose: Morphine - 0.01mg/L; Paracetamol - 4mg/L; Duloxetine - 0.084mg/L; Metoclopramide; Ondansetron; Apixaban.

Correspondence between Mr Leach, the Office of the Coroner, the Commissioner of NT Correctional Services and others

89. As was reported in the medical records, on 9 February 2024, Mr Leach wrote a letter to the Office of the Coroner in which he disclosed his refusal of medical assistance while incarcerated. He was seeking assistance so that his decision to 'not resuscitate' would be upheld by DCC/NT Correctional Services. He indicated his intention to adopt a nil-by-mouth (no food or fluids) response “likely to see me dead within a week,” if Correctional staff attempted to force medication on him. In the interests of full transparency, the complete letter is reproduced:

Coroner's Office
GPO Box 1281
Darwin NT 0801

Dear Ms/Sir,

This may be an unusual letter, though I dare say your office has experience in the oddities of life. My apologies for my contributions in that area.

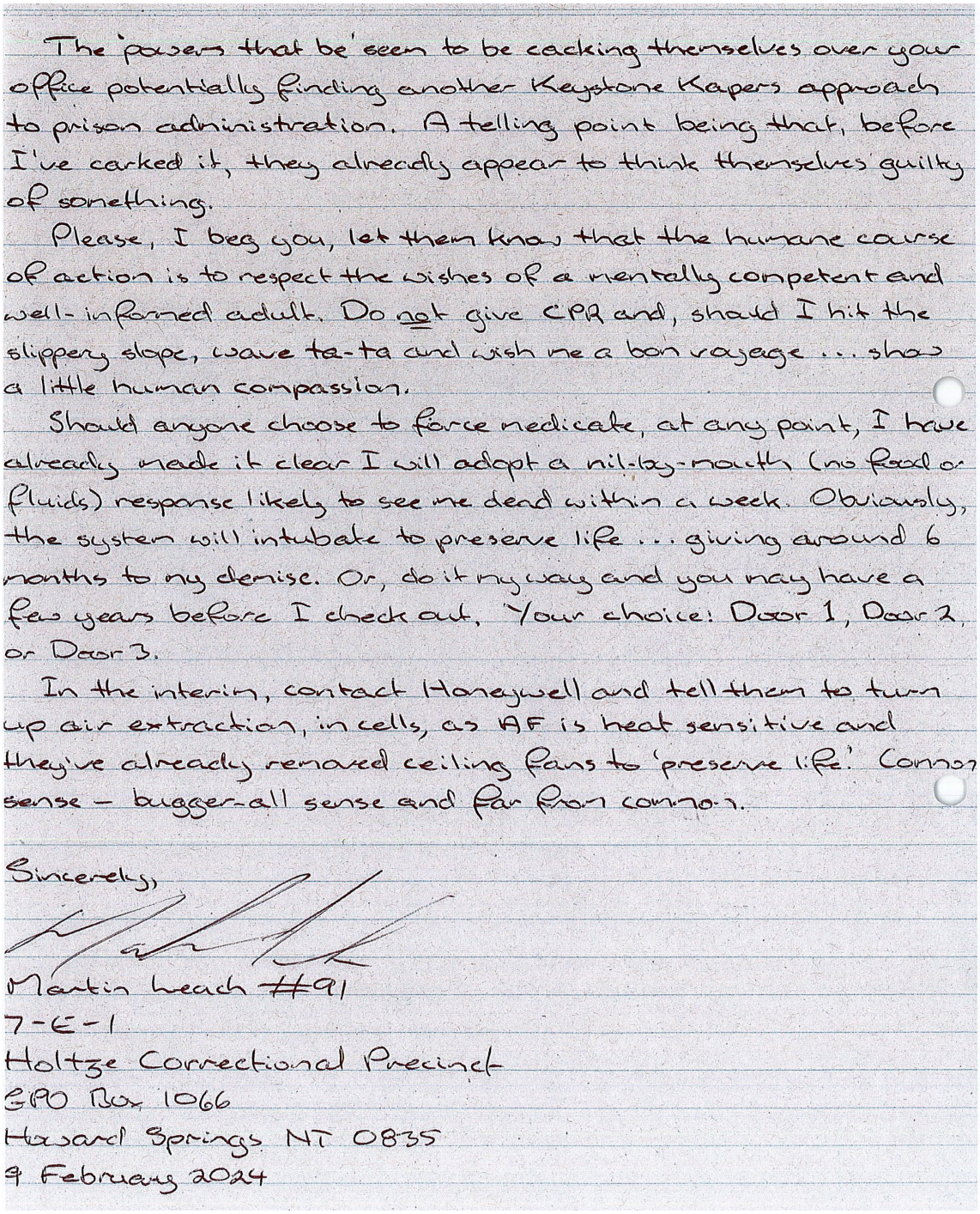
Originally incarcerated at Fannie Bay, with about a year at over 40 years ago, it isn't hard to imagine that I have too much experience and, unfortunately, a persistent memory. I've seen, experienced, and recall too bloody much.

At 65 I'm no spring chook and may already have had paroxysmal atrial fibrillation for about 15 years or so. My body is saying it is time to pop my clogs within the next few years. I am refusing medical assistance for my AF.

I filled out an advanced personal plan around 4 years ago. My wishes are clear and I still retain all my marbles (damaged, perhaps, but still otherwise complete). Recently, my AF took a nasty turn and I was taken to RDH category 1. Everybody out here now have a great interest in law books. My misfortune may have spawned a healthy respect for law; every cloud and silver linings.

The Correctional Services Act 2021 Ch. 3, 3.1, Div. 4, (92, 93) deals with forcibly treating prisoners. Section 92(1)(a)(ii) specifies "if appropriate." Ask three basic questions (i) what might I have experienced during my time to date, (ii) at what point does psychological duress (torment, torture) outweigh physical wellbeing, and (iii) is it appropriate for this torment to continue?

The Health Act forbids medical practitioners from actions that infringe the basic human right of self-determination, except under the Mental Health Act (doesn't apply here).



The 'powers that be' seem to be cacking themselves over your office potentially finding another Keystone Kapers approach to prison administration. A telling point being that, before I've carked it, they already appear to think themselves guilty of something.

Please, I beg you, let them know that the humane course of action is to respect the wishes of a mentally competent and well-informed adult. Do not give CPR and, should I hit the slippery slope, wave ta-ta and wish me a bon voyage ... show a little human compassion.

Should anyone choose to force medicate, at any point, I have already made it clear I will adopt a nil-by-mouth (no food or fluids) response likely to see me dead within a week. Obviously, the system will intubate to preserve life ... giving around 6 months to my demise. Or, do it my way and you may have a few years before I check out. Your choice: Door 1, Door 2, or Door 3.

In the interim, contact Honeywell and tell them to turn up air extraction, in cells, as AF is heat sensitive and they've already removed ceiling fans to 'preserve life.' Common sense – bugger-all sense and far from common.

Sincerely,

Martin Leach #91
7-E-1
Holtze Correctional Precinct
GPO Box 1066
Howard Springs NT 0835
9 February 2024

90. On 18 March 2024, the Office of the Coroner sent letters addressed to Matthew Varley, Commissioner NT Correctional Services, and Professor Marco Briceno, Chief Executive Officer Department of Health. Each letter annexed a copy of the correspondence received from Mr Leach dated 9 February 2024, and requested that Mr Leach's medical views and wishes, as apparently detailed in his APP, were known and documented by their respective departments. A response was sent to Mr Leach on 9 February 2024, acknowledging receipt of his correspondence and

informing him of the action taken by the Office of the Coroner.

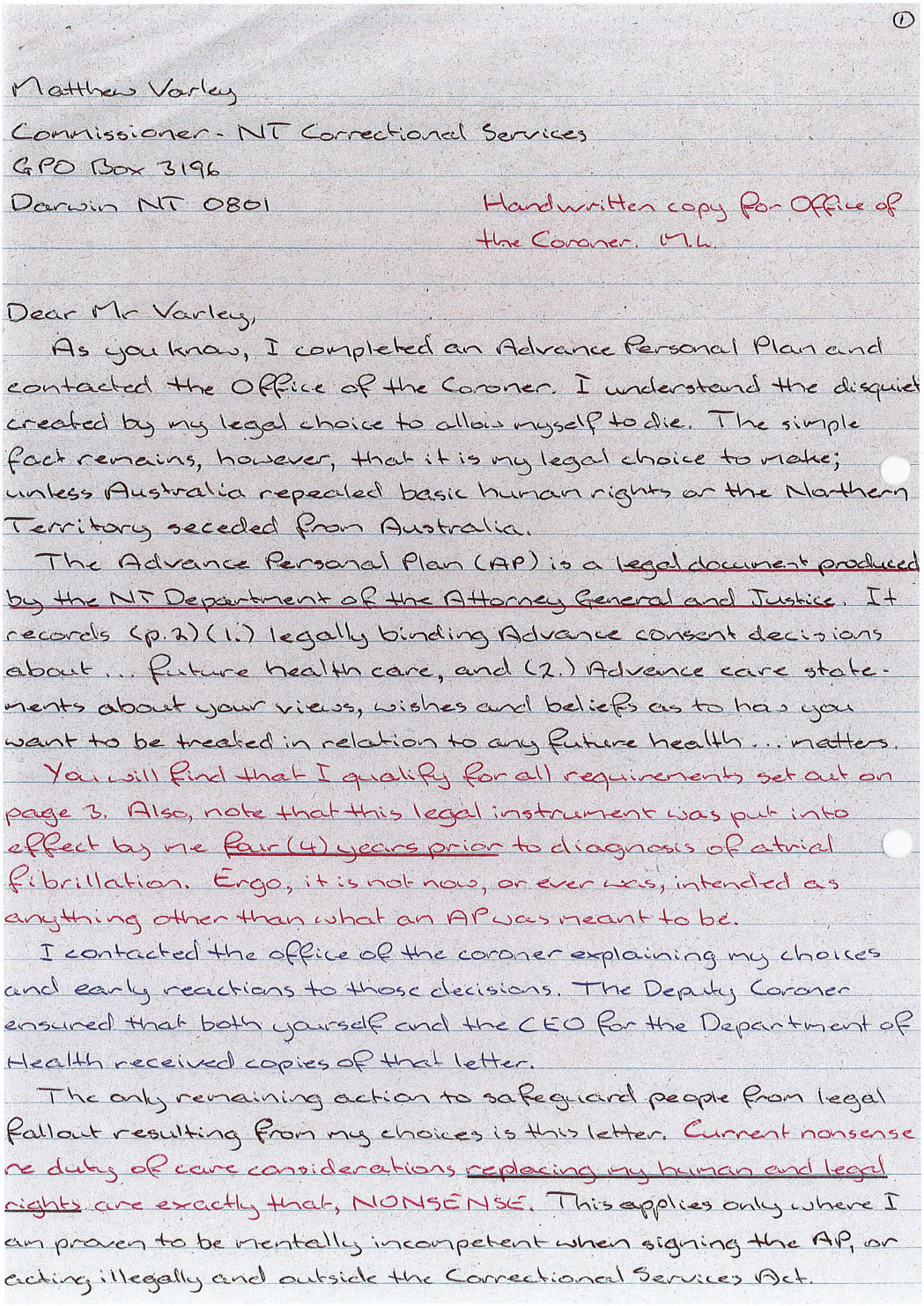
91. On 26 March 2024 Mr Leach again wrote a short letter to the Officer of the Coroner stating "should it be of any help. I have 82 pages of draught copies of letters I wrote trying to get somebody (anybody) to see sense. It may shed light on more than solely my own outcome."

92. On 4 June 2024, a letter was sent to Mr Leach from the Office of the Coroner, acknowledging receipt of the bundle of documents which appeared to contain copies of correspondence authored by Mr Leach addressed to various agencies and individuals, complaining of services provided by NT Correctional Services and other thoughts, suggestions and ruminations. Recipients of the letters sent by Mr Leach included (as addressed by Mr Leach):

    - Matthew Varley, Commissioner NT Correctional Services
    - Lia Finocchiaro, Leader of the Opposition
    - David Thompson, Deputy Commissioner -Correctional Services
    - Australian Human Rights Commission
    - Anthony Albanese, Prime Minister
    - Mark Dreyfus, Attorney-General
    - Ms Wilson, NT Law Society
    - Mark Payne, Commissioner NT Correctional services
    - Shelly Landmark, NT Legal Aid Commission
    - Scott McNairn, Commissioner NT Correctional Services
    - Health and Community Services Complaints Commission
    - Australian Competition and Consumer Commission
    - Robert Tickner, Justice Reform Initiative

93. Included in this bundle was a letter relevant to this inquest. On 31 March 2024, Mr Leach wrote to Mr Varley, Commissioner NT Correctional Services, advising he had been in correspondence with the Office of the Coroner. The letter outlined Mr Leach's position that his APP was a legally binding document and, in the event that he survived any interference (non-consensual medical intervention), "it is my intention to

commence legal action against both individual officers and NT Correctional Services (at all levels)." A full copy of that letter follows:



①

Matthew Varley
Commissioner - NT Correctional Services
GPO Box 3196
Darwin NT 0801

Handwritten copy for Office of the Coroner. MV.

Dear Mr Varley,

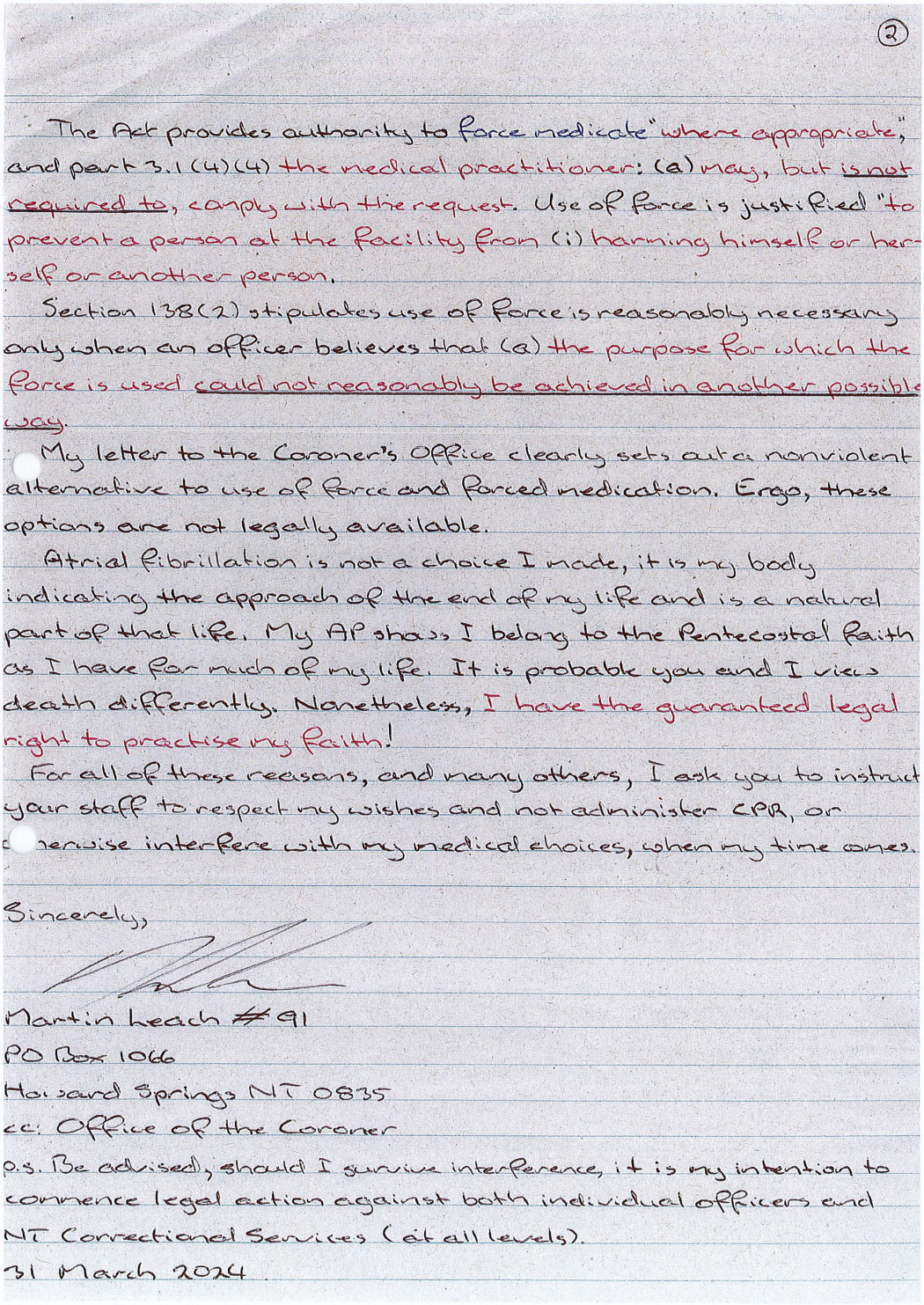
As you know, I completed an Advance Personal Plan and contacted the Office of the Coroner. I understand the disquiet created by my legal choice to allow myself to die. The simple fact remains, however, that it is my legal choice to make; unless Australia repealed basic human rights or the Northern Territory seceded from Australia.

The Advance Personal Plan (AP) is a legal document produced by the NT Department of the Attorney General and Justice. It records (p.2) (1.) legally binding Advance consent decisions about ... future health care, and (2.) Advance care statements about your views, wishes and beliefs as to how you want to be treated in relation to any future health ... matters.

You will find that I qualify for all requirements set out on page 3. Also, note that this legal instrument was put into effect by me four (4) years prior to diagnosis of atrial fibrillation. Ergo, it is not now, or ever was, intended as anything other than what an AP was meant to be.

I contacted the office of the coroner explaining my choices and early reactions to those decisions. The Deputy Coroner ensured that both yourself and the CEO for the Department of Health received copies of that letter.

The only remaining action to safeguard people from legal fallout resulting from my choices is this letter. Current nonsense re duty of care considerations replacing my human and legal rights are exactly that, NONSENSE. This applies only where I am proven to be mentally incompetent when signing the AP, or acting illegally and outside the Correctional Services Act.



② The Act provides authority to force medicate "where appropriate", and part 3.1 (4)(4) the medical practitioner: (a) may, but is not required to, comply with the request. Use of force is justified "to prevent a person at the facility from (i) harming himself or herself or another person.

Section 138(2) stipulates use of force is reasonably necessary only when an officer believes that (a) the purpose for which the force is used could not reasonably be achieved in another possible way.

My letter to the Coroner's Office clearly sets out a nonviolent alternative to use of force and forced medication. Ergo, these options are not legally available.

Atrial fibrillation is not a choice I made, it is my body indicating the approach of the end of my life and is a natural part of that life. My AP shows I belong to the Pentecostal faith as I have for much of my life. It is probable you and I view death differently. Nonetheless, I have the guaranteed legal right to practise my faith!

For all of these reasons, and many others, I ask you to instruct your staff to respect my wishes and not administer CPR, or otherwise interfere with my medical choices, when my time comes.

Sincerely,

Martin Leach #91
PO Box 1066
Harvard Springs NT 0835
cc: Office of the Coroner
p.s. Be advised, should I survive interference, it is my intention to commence legal action against both individual officers and NT Correctional Services (at all levels).
31 March 2024

Legislation and Procedures - NT Health and DCC clinic

94. While NT Health uses primary health care services available in the general community as a benchmark for designing the prison health service, the reality of a correctional setting is that the services will never fully align. In the wider community, individuals have autonomy when

they attend a medical practitioner or an ED and can typically elect to see a practitioner of their choosing. In the correctional setting, people can request to see a medical practitioner, but access is impacted by local procedures, guidelines, clinical judgement, and other operational factors.

95. Since 1 July 2021, NT Health has delivered primary health care at the DCC clinic through the Prison Health team as iterated in the Memorandum of Understanding (MOU) between the Department of Attorney-General and Justice and the NT Department of Health (as the relevant agencies were known at the time of execution) dated 1 November 2019.

The APP Governance Framework

96. NT Health and its staff, including those at DCC, are governed by a suite of legislation and policies with respect to treating patients with an APP (APP Governance Framework). The APP Governance Framework applies to NT Health's treatment of all patients by its staff, including those who are in the custodial care of NT Corrections, in other words, as submitted by NT Health, the APP framework "does not discriminate with respect to incarcerated persons."[12] The APP Governance Framework includes the following:

    - *Advance Personal Planning Act 2013* (NT) (APP Act), which relevantly provides that any adult who has planning capacity may make an APP (s8);
    - *Advance Personal Planning Regulations 2014* (NT);
    - *Health Care Decision Making Act 2023* (NT) (HDCM Act) which relevantly provides that a person is presumed to have capacity unless there is evidence to the contrary (s5) and an appointed substitute decision maker (under an APP) has the highest decision making priority in the event the APP maker's capacity is impaired;
    - NT Health Informed Consent Policy;

[12] Department of Health written submissions dated 9 February 2026

- NT Health Advance Personal Planning Procedure;
- NT Health Goals of Care Guideline;
- NT Health End of Life Care Policy;
- NT Health End of Life Care Guideline;
- NT Corrections Standard Operating Procedure (Primary Health Centre); and
- NT Corrections Notification of Prisoners' Critical Illness, Palliative Care or Serious Injury NT Corrections Directive.

97. Under s 39 of the HDCM Act a health care provider can administer urgent health care without consent (in certain circumstances) but not if health care provider is aware the individual has refused health care in (inter alia) an Advance Consent Decision. In Mr Leach's situation, urgent health care could not be provided by an 'aware health care provider' because he:

    - had an advance consent decision in his APPs refusing health care,
    - did not have impaired decision making capacity (nor was there any concern or indication of impairment); and
    - even if his decision making was impaired, Mr Leach had previously and repeatedly provided informed refusal against treatment for his AF.

98. NT Health holds the view that incarcerated persons are not excluded from being treated in accordance with the APP Governance Framework by NT Health staff, and NT Health staff cannot be directed by NT Corrections to act inconsistently with an APP.

Information sharing between NT Health and NT Corrections under the APP framework

99. The Primary Care Information System (PCIS) is the electronic medical record system used by NT Health to record a prisoner's health information and support ongoing care in NT Health's PPHC clinics and staff within the Prison Health team have access to PCIS. NT Health also uses the Community Care Information System (CCIS) to manage specific client information, and this is used by the Forensic Mental Health team

(FMHT). Acacia is a digital health system that integrates a range of other clinical systems (including PCIS and CCIS). Clinical data in each linked system is automatically uploaded to Acacia. The Prison Health team can access this information to view healthcare events that have occurred in other service areas. Acacia has recently added functionality to record and store APPs and Advance Consent Decisions.

100. Correctional Officers do not have access to PCIS. The electronic information system used by Corrections is IOMS. NT Corrections conducted an electronic trial which added alerts about APPs into IOMS. Although there was little detail provided about the trial or its outcomes, I was told it was decided that the risk outweighed the benefits for prisoner health care, and the trial was not adopted.

101. Despite the current lack of interoperability between NT Health clinical systems (including PCIS and CCIS) and NT Corrections information systems (including IOMS), NT Health and NT Corrections did communicate about Mr Leach and his First APP, but not his Second APP, albeit without the guidance of formal policies.

Joint NT Health and NT Corrections APP Management Policy Development

102. The contemporaneous email correspondence makes it clear that Mr Leach's APP created a dilemma for NT Corrections which impacted NT Health.

103. As discussed above, NT Health considers that any attempt to direct a health practitioner to deliver emergency treatment to a patient (including a prisoner) that is in clear violation of an Advance Consent Decision is morally, ethically and legally questionable and is not an action that is supported by NT Health. As far as NT Health is concerned, once a staff member is aware of an APP they must comply with its contents and NT Corrections management should not direct otherwise.

104. I accept NT Health's submission:[13]

> *It is clear that during the interaction between NT Health and NT Corrections following Mr Leach's admission on 6 February 2024, there was confusion as to whether NT Health had to follow NT Correction's purported authorization . Whilst this was the case, NT Health wish to emphasise that a situation never arose where Mr Leach required resuscitation and therefore no treatment was provide to Mr Leach that was contrary to the first APP.*

105. To address this dilemma, on 2 September 2025, representatives from NT Health and NT Corrections formed a Working Group to consider how to "align custodial obligations under the NT Correctional Services Act with NT Health responsibilities" to follow APPs. The Working Group determined that a) there was a need for a "tailored consent form to authorise sharing of APP details with [NT Corrections] ... [for] critically ill, palliative or seriously injured prisoners," and b) a Joint Care Coordination Working Group should commence to address operational, cultural and health requirements for end of life planning. A further meeting was planned for 9 September 2025 but did not proceed. On 22 September 2025, a 'Medical Directive Alerts and Coordinated End of Life Care' (the Draft Directive) was circulated for comment and/or approval. There was some back and forth correspondence but limited progress.

106. On 27 November 2025, an overarching Corrections and Health Strategic Governance Committee (Strategic Governance Committee) chaired by Kate Chambers, Assistant Commissioner NT Corrections, was established to provide governance oversight and alignment between NT Corrections and NT Health on key policies and directives. The membership is:

NT Health -

- Regional Executive Director Top End
- Regional Executive Director Central Australia
- Executive Director Population and Primary Health Top End
- Executive Director Aboriginal Workforce

[13] Department of Health submissions dated 9 February 2026 [25]

NT Corrections -

- Assistant Commissioner Rehabilitation and Integration
- Director Integrated Care
- Principal Health Advisor

107. A Clinical Governance Committee meets monthly and reports to the Strategic Governance Committee, and there are further sub-committees based in each detention centre, including the DCC Operational Committee which meets daily for operational discussions, or monthly in the case of senior leadership.

108. On 16 January 2026, the Strategic Governance Committee endorsed an Implementation Plan which provides key actions and timeframes for NT Health and NT Corrections to improve policy for prisoners with an APP.

(f)

Focus Area	Kev Actions	Res""nsibilitv	Timeframe	Status
Workforce and Culture	Promote shared understanding across NT Health and NT Corrections that APPs must be actively identified, respected and escalated appropriately in custodial settings; reinforce patient-centred decision-making.	NT Health (Custodial Health) in partnership with NT Corrections	Jan -Jun 26	In progress
Education and Training	Develop and deliver targeted education for clinical and senior custodial staff clarifying roles, responsibilities, escalation pathways and decision-making when an APP is in place.	NT Health (Education and Training)	Jan - Dec 26	Partially implemented
Policy and Procedures	Review and update NT Health custodial health policies and procedures to explicitly address APPs, including interaction with NT Corrections directives and operational protocols (g) Advance Personal Planning NT Health Procedure (h) End Of Life Care NT Health Guideline (i) End of Life Care NTH Policy (j) Goals of Care Guideline (k) **NTCS Directive 2.8.17: Notification of Critically** Ill, **Palliative Care or Serious Injury**	NT Health and NT Corrections NT Health NT Health NT Health NT Health NT Corrections	Jan -Jun 26 Mar-Sep 26 Mar-Sep 26 Jan -Jun 26 Jan -Jun 26	In progress Planned Planned In progress In progress
Interagency Processes	Jointly review, amend and implement agreed directions and guidelines with NT Corrections outlining processes, responsibilities and actions for staff when managing individuals in custody with an APP.	NT Health and NT Corrections	Jan - Dec 26	In progress
Communication	Include APP status as a standing agenda item in daily and/or weekly custodial health and prison operational huddles to ensure visibility and shared awareness.	Custodial Health Services	Feb 26	Ongoing
Governance	Establish or utilise existing clinical governance and interagency steering groups to oversee implementation, monitor compliance, and guide continuous improvement. Establish a new end of life/ complex care committee in the Too End.	NT Health (Clinical Governance) NT Health and NT Corrections	Nov 25 Mar 26	In progress / Ongoing Planned

Monitoring and Review	Ongoing review of incidents, feedback and compliance to ensure processes remain effective and are refined as needed.	NT Health and NT Corrections	Ongoing	Planned

NT Health – the bottom line

109. **As far as NT Health is concerned**, there is consensus between NT Health and NT Correctional Services on this - if NT Health staff are responding to a prisoner emergency/Code Blue the NT Health staff member:

- If aware that an APP exists, will act in accordance with the APP.
- If APP status is unknown, will provide medical interventions ongoing except if they become aware there is an APP, at which time they will act in accordance with the APP.
- NT Corrections are not to direct NT Health staff to provide medical assistance that would contravene an APP.

110. Further, though not apparently yet agreed, NT Health:

- Expect NT Corrections to have in place a system that will quickly alert Correctional Officers as to whether a prisoner has an APP and inform NT Health staff immediately if an APP exists.

111. However, according to NT Health there remains a lack of clarity concerning the initial response of NT Correctional staff (before Health staff arrive on the scene). It remains the position of Correctional Services that Corrections staff will administer first aid (CPR) until the Health Lead arrives, at which time Correctional staff are expected to follow the Health Lead's directions. This position is discussed further below. In those circumstances, NT Health supports legislative amendment to clarify the interoperability between sections 92 and 93 of the *Correctional Services Act 2014* and section 93 of the HCDM Act.

Legislation and Procedures - NT Correctional Services

Health Care

112. The Correctional Services Act 2014 makes provision for health care for prisoners including, relevantly to this inquest:

82 Commissioner to arrange health care

(1) The Commissioner must arrange for the provision of appropriate health care for prisoners.

(2) The Commissioner must ensure that prisoners are provided with access to health care that is comparable with that available to persons in the general community in the same part of the Territory.

85 Recommendations of health practitioner

(1) This section applies if a health practitioner makes a recommendation to the General Manager about health care for a prisoner (including a recommendation that the prisoner be taken to a health care facility).

(2) The General Manager must give reasonable consideration to implementing the recommendation.

92 Provision of health care without consent

(1) This section applies if:

(a) the General Manager of a custodial correctional facility:

(i) considers the provision of health care to a prisoner might be necessary to prevent serious harm to the prisoner; and

(ii) requests a medical practitioner to examine the prisoner and, if appropriate, provide health care; and

(b) the prisoner refuses to consent to the examination or provision of health care.

(2) The medical practitioner may, without the prisoner's consent:

(a) examine the prisoner to determine whether the provision of health care is necessary; and

(b) if the medical practitioner considers that it is necessary – provide the health care to the prisoner.

(3) If the prisoner does not submit to the examination or provision of the health care, a correctional officer may assist the medical practitioner in examining the prisoner or providing the health care.

(4) In providing the assistance, the correctional officer may use the force that is reasonably necessary.

Note for subsection (4)

Part 3.4 makes provision in relation to the use of force.

93 Administration of medication to prevent harm

(1) This section applies if the General Manager of a custodial correctional facility:

(a) considers the administration of medication to a prisoner might be necessary to prevent, or reduce the risk of, the prisoner causing serious harm to himself or herself or to another person; and

(b) requests a medical practitioner to provide advice on:

(i) whether administering medication would prevent or reduce the risk of harm; and

(ii) the health consequences for the prisoner of doing so.

(2) For the purpose of providing the advice, the medical practitioner may examine the prisoner (whether or not the prisoner consents).

(3) The General Manager may request a medical practitioner to administer the medication to the prisoner only if, after considering the medical practitioner's advice, the General Manager considers that doing so:

(a) is necessary to prevent or reduce the risk of harm; and

(b) is the least restrictive intervention available in the circumstance.

(4) The medical practitioner:

(a) may, but is not required to, comply with the request; and

(b) may administer the medication whether or not the prisoner consents.

(5) If the prisoner does not submit to the examination or administration of medication, a correctional officer may assist the medical practitioner in examining the prisoner or administering the medication.

(6) In providing the assistance, the correctional officer may use the force that is reasonably necessary.

Note for subsection (6)

Part 3.4 makes provision in relation to the use of force.

113. Concerning these provisions, I note that:

- the health care provided to prisoners **must** be comparable with that available to the general community,
- the General Manager **must** reasonably consider implementing the recommendation of a health practitioner,
- **if** the General Manager considers the health care is a) necessary to prevent serious harm and b) **requests** the health practitioner to examine a non-consenting prisoner; the medical practitioner **may** examine and provide health care to the prisoner, and a correctional officer **may** assist and use reasonable force.
- **if** the General Manager considers that a) medication might be necessary to prevent/reduce the risk of a prisoner causing serious harm to prisoner self/another and b) **requests** a medical practitioner to advise on the impact of medication and the health consequences for the prisoner; the General Manager **may request** the medical practitioner to administer the medication to a

non-consenting prisoner and a correctional officer **may** assist and use reasonable force. The medical practitioner **may**, but is not required to, comply with the **request**.

114. By using the words **must, may**, and **request** it appears that the legislature made a clear distinction in the *Correctional Services Act 2014* as to health care actions which are mandatory and actions which are discretionary. A General Manager's power to coerce a non-consenting prisoner to submit to medical examinations, health care or medication, arises in limited circumstances and, given the use of the words may and request, is seemingly discretionary. In addition, as identified by Professor Palmer, a medical practitioner is permitted to follow any such request but may also decline to follow any such request or, in Professor Palmer's words, any such request "does not trump the ethical duty of the doctor."

115. NT Correctional Services promulgate and maintain Directives which govern practical operations.

116. Directive 2.8.17 addresses actions required if a prisoner is critically ill, in palliative care or is seriously injured and includes these definitions:

> ***critical illness*** means a disease or state in which death is possible or imminent.
>
> ***palliative care means*** specialised medical care for people with serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.
>
> ***serious injury*** means bodily injury that involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ or mental faculty.

117. [7.6] of this Directive addresses terminally ill prisoners refusing medical treatment and provides:

> 7.6.1 In the event a terminally ill prisoner wishes to refuse medical treatment, he or she is to discuss their concerns with their treating health practitioner.
>
> 7.6.2 The prisoner will be provided with adequate medical, spiritual and psychological support to ensure his or future health choices are respected.
>
> 7.6.3 Upon request, prisoner will have access to the *Advance Personal Planning Act* and a copy of an Advance Personal Plan.

118. Directive 2.8.8 addresses Correctional Services responses to medical emergencies:

7.3 Medical emergencies include, but are not limited to:

a. acute onset of severe pain;
b. attempted suicides;
c. unconscious patient;
d. victims of serious violence;
e. epileptic seizure;
f. fitting;
g. severe blood loss; and
h. any other life threatening event.

119. Directive 2.8.8 provides that all Correctional Officers are to maintain certification in Senior First Aid and CPR [7.2], and, in the event of sudden illness or injury, first aid is to be rendered promptly by responding officers and continued until healthcare personnel take charge [7.4.4-7.4.7]. This Directive does not consider or directly address emergency responses for a prisoner with an APP.

120. It is admirable that NT Correctional Services is committed to upholding its duty of care for prisoners. In most circumstances, when confronted with a medical emergency, it is appropriate for Correctional Officers to provide first aid.

121. But Mr Leach's situation was different from that of most prisoners. He was regularly assessed as competent by medical professionals, he suffered from a number of serious chronic conditions about which he sought and was given medical advice, he repeatedly made it abundantly clear (orally and in writing) to anyone who would listen that he did not wish to receive life preserving measures (but would accept palliative measures and/or pain relief), he had completed two APPs to this effect and took great care to ensure Correctional Services knew of his health care decisions. Directive 2.8.8 fails to acknowledge or grapple with this difference.

122. To be fair, NT Correctional Services is not an outlier in this regard. Having made enquiries with correctional services in other jurisdictions, there do not appear to be clear directives that address this issue. The most comprehensive was provided by Victoria. The Victorian Corrections Commissioner promulgates and maintains Commissioner's Requirements

(CR) which contain directions for custodial staff.

123. CR 1.5.5's stated purpose is to establish clear guidelines, procedures, and reporting arrangements for managing situations where prisoners refuse medical treatment, where a hospital visit should be terminated due to refusal, and specifically where refusal may result in a serious or life threatening outcome. The CR [3.7] recognises that "the right to refuse treatment under the Medical Treatment Planning and Decisions Act 2016 Vic (MPTD Act) applies equally to people in our care as it does to any member of the community, and their wishes regarding medical treatment will be respected."

124. The CR provides for the sharing of health information by health practitioners with corrections staff if the disclosure is reasonably necessary for the performance of official duties. Similarly, corrections staff are to notify health staff if they hold concerns for the health of a prisoner. In instances where refusal of treatment or escalating health concerns may result in a medical emergency, serious harm or death of a prisoner; a multi-disciplinary case conference between health and corrections is to be convened at management level. The CR [5.9.3] recognises that an individual's choices may change, and both health and corrections staff are required, at regular intervals, to talk with the prisoner to reassess their willingness to receive treatment, "while respecting their choice to refuse medical treatment."

125. While on the one hand requiring corrections staff to respect a prisoner's right to refuse treatment, this CR also seemingly permits, in the event of an emergency, initial first aid by a Corrections Officer until a Field Commander arrives who will give directions [5.9.6], as I understand it, until health staff arrive who will then take over the health response. The CR recognises that: a health practitioner is not permitted to provide treatment if they are aware that a person has refused that treatment [3.8]; a person can refuse to be transported to hospital; and paramedics must follow their own clinical practice guidelines [5.9.8].

126. Although Mr Gordon gave a direction to DCC clinic staff on 6 February to provide medical treatment inconsistent with Mr Leach's APP, it is clear that NT Corrections now accepts that it cannot give such a direction (though it can make a request) and NT Health staff are not bound to follow any such request.

127. Consistent with this position, when Mr Gordon gave a direction on 25 July 2024 it was only directed to Correctional Officers. On this date, Mr Gordon authorised the administration of relevant healthcare without consent to preserve life by Correctional Officers under sections 92 and 93 of the *Corrective Services Act 2014*, "until handed over to medical who will abide by their own processes." This direction seems to be within the scope of NT legislation and seems consistent with the Victorian position.

128. Kate Chambers APM, Assistant Commissioner Department of Corrections, provided a detailed affidavit dated 28 January 2026[14] and was NT Corrections institutional respondent.

129. Ms Chambers and the Integrated Care Team considered this direction. Accepting that NT Corrections has a duty to exercise reasonable care for the safety of prisoners, Ms Chambers considered that the direction to Custodial Officers to render first aid was correct. Ms Chambers identified the challenges Correctional Officers would face interrogating IT systems for APPs when confronted with an emergency and (as they are not medical practitioners) questioned their capacity to interpret correctly what type of care is or is not consented to and in what circumstances. Ms Chambers also identified that there could be a risk to Correctional Officers from other prisoners (unaware of the APP) if they failed to provide first aid. She also noted that the statutory protections afforded to health care providers who act in accordance with an APP do not apply to Correctional Officers. I accept there is force in these considerations.

130. I also accept that there will likely only be short periods when

[14] Together with a short affidavit dated 5 February 2026

Correctional Officers may be required to apply first aid (or other measures) without consent of a prisoner with an APP because I am told that policy work is underway between NT Health and NT Corrections to ensure that in an emergency/Code Blue situation there is a designated 'Health Lead' and Correctional Officers will be required to take direction from the Health Lead concerning the delivery of health care. As I understand it, the Health Lead should be aware of any APP and will be obliged to follow (and direct Correctional Officers) in accordance with any APP. Implementation of this new policy will be supported by joint Health and Corrections training, including scenario based training. I commend these ongoing initiatives and those working hard to bring them to fruition. In the meantime, Kimberly McKay, Deputy Commissioner, has already issued a direction which includes that "When a prisoner experiences a medical episode: Corrections staff must seek and follow NT Health direction regarding medical care and management."

131. However, to be weighed against these considerations are the inherent rights of an individual to control their own body. In Hunter and New England Area Health Service v A [2009] NSWSC 761 McDougall J considered the rights of a capable adult to refuse medical treatment and the validity of an Advance Care Directive, albeit in a hospital setting. He said at [5] that:

> "The common law recognises two relevant but in some cases conflicting interests:
>
> (1) a competent adult's right to self-determination: the right to control his or her own body; and
>
> (2) the interests of the State in protecting and preserving the lives and health of its citizens."

132. In dealing with that conflict, McDougall J considered Re T [1993] Fam 95 in which he said: Lord Donaldson of Lymington MR recognised "that, at least when other factors did not tip the balance one way or the other, the individual patient's right was paramount;" and Staunton LJ said "an

adult whose mental capacity is unimpaired has the right to decide whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment. Thus far the law is clear." McDougall J concluded at [17]:

> "It is in general clear that, whenever there is a conflict between a capable adult's exercise of the right of self-determination and the State's interest in preserving life, the right of the individual must prevail."

133. McDougall also considered the "emergency principle" or "principal of necessity," that is for treatment to be administered when consent cannot be ascertained. But held at [34] that:

> ".. the principle of necessity cannot be relied upon to justify a particular form of medical treatment where the patient has given an advance care directive specifying that he or she does not wish to be so treated, and where there is no reasonable basis for doubting the validity and applicability of that directive."

134. In written submissions[15] Correctional Services have indicated that it does not propose to change the 'first aid response' of Correctional Officers even if it is (or they are) aware of an APP with documented decisions to the contrary. Ultimately, it is for the legislature to decide whether this approach gives appropriate weight to the **human right** to self-determination over medical treatment.

135. I do not for a moment wish to trivialise the complexity between balancing the duty of care owed to a prisoner against an individual's right to self-determination over their own body and the treatment and/or life preserving measures applied to their body. However, Mr Gordon's assertion that he had a "legal obligation" to authorise health care without consent is arguably incorrect. As already discussed, sections 92 and 93 of the *Correctional Services Act 2014* seemingly confer a discretion not an obligation.

[15] Written submissions on behalf of the Department of Corrections dated 9 February 2026 [15]

136. I do not imagine that NT Correctional Services will be inundated with prisoners with an APP. There is, therefore, the potential for a nuanced, even individualised, approach which could be achieved with clear guidance in policies and procedures as to how this is to be navigated. Similarly to the Victorian approach, at a minimum, where a prisoner has an APP this should be clearly documented in both NT Health and NT Corrections records and flagged as an alert, and there should be an avenue for regular meetings at the management level between NT Health and NT Corrections (including with the prisoner as considered appropriate) to ensure there is mutual understanding as to the APP. As already discussed, I understand that the Strategic Governance Committee and a proposed 'Information Sharing Committee' will progress work to formulate policy and procedures addressing prisoners with an APP.

137. If there is any doubt as to the validity, extent, or meaning of an APP, NT Correctional Services should obtain legal advice.

NT Corrections Directive 2.8.17 Notification of Critical Illness, Palliative Care or Serious Injury

138. This Directive establishes the process for notifying a prisoner's emergency contact, legal practitioner and any other person who has decision making authority for the prisoner, in circumstances where the prisoner is critically ill, receiving palliative care, or has sustained a serious injury. The Directive ensures that all legal, cultural, and spiritual requirements are met in such situations. The Directive is currently in its third iteration, which was approved on 16 October 2024.

139. Under the Directive, when a prisoner's 'known medical condition becomes life threatening, or is admitted for palliative care', the General Manager of the relevant correctional centre is responsible for notifying the prisoner's emergency contact person, legal representative or other person who has decision making authority for the prisoner. If a decision is made not to inform the emergency contact person for security reasons, and the prisoner's condition deteriorates until death is imminent, the

General Manager must be notified and the decision not to notify the relevant contacts must be reviewed immediately.

140. The General Manager of the DCC did not contact Mr Leach's appointed decision maker, to inform her of Mr Leach's palliation or to seek decisions from her as to his treatment. That is because the Second APP was not given to Correctional Services. This is another reason why policy and guidelines as to necessary and appropriate information sharing between NT Health and NT Correctional Services are required. It remains disturbing that death in custody inquests are not uncommonly uncovering failures to keep decision makers (in this instance) and next of kin (in other inquests) adequately informed when prisoners are approaching the end of their life.

'At Risk' episode 6 February 2024

141. NT Health and NT Corrections both have policies for 'At Risk.' As of 6 February 2024, the DCCs 'At Risk' procedures were "January 2015 version" (Correction's 2015 procedure), but there was also in existence an updated but draft version, "September 2021, Version 27" (Correction's 2021 draft procedure). NT Health's procedure was "Version 16.0, Approved date 21/06/17" (Health's 2017 procedure).

142. A prisoner can be identified as 'At Risk' prior to reception (for example at the Watchhouse or Court), at or after prison reception by a Correctional Officer, or by NT Health staff. Except if the 'At Risk' episode is initiated by NT Health staff; Correctional staff must inform NT Heath staff that a prisoner has been placed 'At Risk'.

143. On 6 February 2024, upon his return to DCC from RDH, Mr Leach was placed 'At Risk' as had been directed by Mr Gordon and he was placed in an 'At Risk' cell.

144. As required by the Correction's 2015 procedure, Chief Correctional Officer Leibhardt completed:

- the 'Notification of Concern Form' with the comment "Prisoner

Leach M#91 refused medical assistance."

- an Officer's report noting "upon his return was placed at risk due to him refusing any medical treatment from RDH and prison medical team. Prisoner Leach has made it very clear that he protests against myself CCO Leibhardt for placing him at risk. I informed him that it's a duty of care we have to ensure your health is ok. I informed him by not receiving medical treatment it's self harm."
- an 'At Risk Management Plan.' He was to be monitored by CCTV observations at 15-minute intervals and observed in person during meal issue, medication issue, and hygiene.

145. DCC clinic staff were told that Mr Leach was placed 'At Risk.'

146. According to the Correction's 2015 procedure flow chart (Appendix A) "a Health Practitioner is to conduct an initial assessment to confirm is risk present." According to the flow chart/Appendix A, that initial assessment seemingly permitted a Health Practitioner to determine the "At Risk episode does not continue." If so, the 'At Risk' episode would be closed on IOMS and presumably the prisoner would be released from 'At Risk'. I will refer to this procedure, outlined in the flow chart/Appendix A, as 'the early resolution mechanism'.[16] Although the flow chart/Appendix A also formed part of the Correction's 2021 draft procedure, it was seemingly well understood that, at least in practice, 'At Risk' status could only be removed at the recommendation of all members of the 'At Risk Assessment Team'(ARAT). The early resolution mechanism was not part of Health's 2017 procedure which provided that, when notified that a prisoner was 'At Risk', the health professional will, inter alia, "attend to the detainees acute medical needs and undertake a Mental State Examination." The case will then be discussed in the next ARAT meeting which may result in "removing the detainee from At Risk."

[16] According to the flow chart annexure A this early resolution mechanism is available for 'At Risk' prisoners which may be internally inconsistent with [3.4] which falls under the heading "Management of prisoners flagged "At Risk" prior to reception in a correctional facility" and [14.1].

147. Consistent with the normal practice, Dr Allen and a nurse saw Mr Leach at about 6pm and the medical progress notes included the following:

> *after return and in at risk*
> *very upset*
> *PR 103 to 128 PR about 105 BP 131/82 sats 98 %*
> *says will not take meds and will not eat or drink*
> *feels humanity being ignored*
> *long diatribe re terrible things seen and experienced*
> *feels will take it all the way*
> *disc write to the commissioner - writes to the deputy - they do not write back*
> *cut down 2 good friends who committed suicide - seen terrible things*
> *45 years here*
> *no quality of life - no happiness - no nice things*
> *Mx*
> *disc stopping meds presently on unlikely to harm him - Duloxetine 60 mg and osteo bd - he had thought it would adversely affect his condition and hasten his demise*
> *disc not our choice - not make the Act - trying to help -system unfair and complex etc..*
> *disc taking Digoxin to slow rate down - refuses*
> *disc if PR goes to slow AF may be able to be released from at risk to the block*
> *not to the block if hunger strike*
> *disc his choice if on the block and recurrence sxs - if no one knows will not have rx - felt it was reasonable that he came up*
> *obs prior to end of shift and again tomorrow*
> *offer meds tomorrow*
> *offer food and drink*
> *not formal hunger strike yet*

148. By email Dr Allen reported to Mr Gordon:

> *..He is in at risk and not happy.*
>
> *He now says he will not eat or drink or have any of his usual medications and refused the new one.*
>
> *His pulse rate has improved further and is only slightly elevated and the rest of his observations are normal. He looks well.*
>
> *I suggested if his pulse rate stays down and he eats and drinks he may be released back to the block but this is a Correctional decision which I would support..*

149. On 7 February 2024, Mr Leach's mental health was reviewed by the ARAT, and Jade Lomas, on behalf of FMHT, emailed NT Corrections that the FMHT have "no current concerns regarding the state of [Mr Leach's] mental health wellbeing ... [and] there is no current evidence to suggest that Mr Leach is mentally unstable nor does he require to be managed in at risk cells for reasons pertaining to the deterioration of his mental health."

150. Of relevance, the email continued: "this is an inappropriate referral for

FMHT"; it appears Mr Leach was placed 'At Risk' for "housing reasons only;" there is no evidence to suggest that Mr Leach is mentally unstable; and "FMHT will not be accepting this referral and will not be reviewing this man."

151. Mr Leach was later seen in 'At Risk' by Dr Sewell who recorded that "Corrections have advised ... no requirement to r/v pt, DCC GM happy for pt to go back to normal housing if presenting well at this am." Mr Leach was subsequently removed from 'At Risk' after a nurse recorded that his "vital signs were at a safe level so he can return back to his accommodation."

152. I am satisfied that NT Health staff complied with Health's 2017 procedure in the management of Mr Leach's 'At Risk' episode.

153. The Correction's 2015 procedure contains the following definitions and examples for identifying prisoners who are 'At Risk':

> *"At Risk" means any prisoner who is deemed likely to engage in suicidal or self-harm behaviour.*
>
> *"At Risk Incident" is the term used to refer to the actual occurrence of suicidal or self-harm behaviour.*
>
> *"self-harm" is a direct and deliberate act of harming one's body. Self-harm may result in death and is a risk factor for suicide.*
>
> *"suicide" is an act intended to end one's life which results in death.*
>
> *"suicidal behaviour" refers to a range of actions related to suicide including suicidal ideation, suicide attempt and suicide.*
>
> *An "At Risk" prisoner is a prisoner who is considered or assessed to be "At Risk" of suicide or self-harm, by one or more of the following indicators, for example:*
>
> *a) demonstrating self-harming/suicidal behaviour;*
> *b) expressing an intention to suicide or self-harm;*
> *c) demonstrating indicators of being "At Risk" of suicide or self-harm (see section 5);*
> *d) situational factors (e.g. hearing bad news) or receiving a substantial period of imprisonment (e.g. life sentence);*
> *e) historical factors (e.g. a prior episode of suicidal or self-harm behaviour recorded on IJIS or IOMS).*
>
> *EARLY WARNING SIGNS indicate that the prisoner is suffering some kind of emotional or mental disturbance. Some prisoners who display these signs may go on to harm themselves or others but most will not. The kinds of behaviour and circumstances may include:*
>
> - *undergoing withdrawal from alcohol or other substances;*
> - *persisting anxiety, nervousness, fear, tension, agitation or restlessness;*

- *persisting mood of sadness;*
- *a sense of hopelessness or helplessness (i.e. prisoner sees his/her situation as intolerable and sees no solution to it and no prospect of it ever getting better);*
- *loss of appetite;*
- *uncharacteristic lethargy without any obvious physical reason;*
- *difficulty sleeping;*
- *references to guilt, shame or depressed mood;*
- *uncharacteristic withdrawal from other people;*
- *loss of interest in usual activities;*
- *expresses beliefs that are clearly at odds with reality;*
- *has English as a first or second language and is usually a competent speaker but is now putting words together in such a disorganised way that he/she is difficult to understand;*
- *talking about being sung (Aboriginal term);*
- *talking about spirits in a negative way ("they are telling me to"...);*
- *talk of the bone being pointed;*
- *seeing devils.*

RED FLAGS are stronger indicators of imminent risk of harm to self or others. They may include:

- *credible disclosures by the prisoner (or others) that he/she has engaged in acts of self-harm or attempts at any time in the preceding week;*
- *overt threats to engage in self-harm;*
- *disclosures by the prisoner (or by others) that he/she has been contemplating self-harm; this is particularly serious if he/she has been considering specific methods of self-harm and the means to carry them out are accessible within the correctional facility;*
- *evidence that the prisoner has made preparations for an act of self-harm (e.g. concealment of weapons; stockpiling of dangerous medications; construction of noose; writing of suicide note);*
- *evidence that the prisoner has made preparations for his/her death in general (e.g. getting his/her affairs in order; giving away treasured possessions; etc.);*
- *reckless, chaotic, intrusive or irrational behaviours that are potentially hazardous to self or others;*
- *extreme agitation arising from (or suggestive of) irrational fears (e.g., spirits or demons entering cell through the walls).*

154. When Mr Leach was returned from RDH on 6 February 2024, although he was medically unwell and was refusing medical treatment, he was not suicidal, nor was he displaying any of the behaviours specified in the definitions or examples in the Correction's 2015 procedure; and, accepting that the decision to mark him 'At Risk' was made in good faith, I do not accept the factual assertion that "by not receiving medical treatment it's self-harm."

155. In X v The Sydney Children's Hospital Network [2013] NSWCA 320 at 59, Basten JA stated:

> "The legal concept of suicide, being the intentional taking of one's own life, is not engaged in a case where medical assistance is refused, even in the knowledge of certain death."

156. Equally, the legal concept of self-harm is not engaged where medical assistance is refused, even in the knowledge of certain death.

157. In her affidavit Ms Chambers described the style of accommodation in Sector 7 (where Mr Leach was normally housed) noting the limited use of cameras and reduced level of supervision particularly at night. Rather than relying on the assertion that Mr Leach was placed at risk because of "self-harm" she explained at [39] that "it was not safe for him to return to Sector 7 because of his health presentation and he required observation overnight." He was, in effect, placed 'At Risk' so his health could be monitored and he could be quickly returned to RDH if his health deteriorated, in circumstances where there were no medical staff overnight to keep an eye on him.

158. 'At Risk' procedures are designed to keep prisoners safe from intentional self-harm/suicide. They include: a 'strip search;' the removal of clothing and items that might be used by a prisoner to hurt themselves; isolation from others; regular observation (there is no privacy); and finger food only (cutlery is not permitted). If a prisoner is not genuinely believed to be 'At Risk' then the procedures could be deemed to be punitive, humiliating, even de-humanising, and that is how they were perceived by Mr Leach. The procedures also rely on and consume the resources of the FMHT.

159. The Correction's 2015 procedure was not designed to be used as a de facto form of increased observation for prisoners with health/medical conditions. While the decision may have been well intended, expedient and made in good faith, the decision to place Mr Leach 'At Risk' was an incorrect application of the 'At Risk' procedures. Mr Leach's complaints were justified as were the reprimands of the FMHT that "this is an inappropriate referral" and Mr Leach was placed 'At Risk' for "housing reasons only."

160. Given the willingness of very senior Correctional staff to use 'At Risk' in good faith but for an incorrect purpose, I am satisfied that there is a

systemic element to this decision. Considering the increasing size of the prisoner population, the serious chronic conditions of many prisoners and the presence of older prisoners, there should be appropriate procedures in place to monitor/care for prisoners who are unwell but who are not at the stage of requiring ED care or hospital admission. That might mean having Health staff available for overnight shifts when required or it might mean that prisoners are housed as 'health prisoners' in observation cells without additional and unnecessary restrictions being applied (such as the 'At Risk' measures), or some other solution or procedure might be developed. To be clear, it is not appropriate for the 'At Risk' procedures to be used for increased observation of unwell prisoners.

161. NT Correctional procedures for 'At Risk' are well overdue for review. The Correction's 2021 draft procedure has not been finalised and it seems to contain so many different pathways as to be unworkable in the reality of the prison environment. Although there may be several pathways for a prisoner to be marked 'At Risk' there really should be a single pathway for Correctional Officers and Health staff to follow thereafter. This will require harmonisation between Correction's and Health's policies and procedures. It is likely another area that requires the leadership, focus and priority of the Strategic Governance Committee.

His decision maker and executor

162. As noted earlier in these findings, Mr Leach appointed his lawyer to be his decision maker under his APP and the executor of his Will. She provided a memorandum dated 6 February 2026 and advised:

> *Throughout our interactions, Mr Leach spoke openly about his treatment in custody, particularly during the early stages of his incarceration. He described aspects of this treatment as inhumane. He informed me that he had documented his experiences extensively in his exercise books and indicated that I should receive the originals. He also advised that he had lodged a complaint with the Anti-Discrimination Commissioner. My understanding is that this material has since been provided to the Coroner's Office.*
>
> *We made formal requests for the exercise books; however, these were denied. Obtaining his personal belongings, including photographs and other items intended for his family, proved extremely*

difficult despite our role as the appointed executor. In casual conversation, Mr Leach also spoke about being placed in "At Risk" cells, and the impact it had on his mental state. He later described how he had come to accept his situation and was attempting to make the most of his life in custody.

We also received a letter from Mr Leach dated 28 June 2024, in which he raised concerns about discriminatory practices within the correctional system. Similar issues were evident in our dealings with Corrections, who were reluctant to release his belongings or notes, despite our legal authority under his Will. Mr Leach indicated that much of the information relevant to his concerns was contained in his exercise books, which we still hope to receive.

I also visited Mr Leach on the Friday evening following his admission to the hospice. During this visit, he expressed his gratitude and reiterated his instruction that I review his exercise books in full and take any actions I considered appropriate. I am currently awaiting the conclusion of the coronial inquiry so that I may access this material and fulfil the responsibilities he entrusted to me.

Finally, we respectfully request that any and all material relating to Mr Leach, including his written notes and personal effects, be released to us upon completion of the coronial investigation, in accordance with our duties as executor.

163. All of Mr Leach's belongings in possession of the Coroner's Office were returned to his decision maker and executor at Mr Leach's inquest.

Conclusion

164. Mr Leach endured a difficult and abusive childhood. As a still young adult he committed atrocious, vicious, crimes and on 16 May 1984 he was sentenced to life imprisonment. Having spent more than 40 years in prison he passed away in palliative care on 3 August 2024 from natural causes. His sentence was complete.

165. Although he declined preventative medical treatment, he received considerate and dignified care from NT Health staff at the prison and at RDH. Of note, no Health care was provided to Mr Leach that was contrary to either of his APPs or health care wishes. I commend those health professionals who cared for him, as he put it, "without judgement."

166. Equally, in general I do not criticise the care provided by NT Correctional Services, save for the two matters discussed in these findings. The two matters concern a) the management of Mr Leach in light of his Advance Personal Plans and Advance Consent Decisions; and b) his being marked 'At Risk', in my view inappropriately, on one occasion.

167. I acknowledge that since Mr Leach's passing NT Correctional Services

and NT Health have jointly progressed operational reform to develop and/or improve policy, procedure and training concerning these matters. This work is in varying stages of progress. I will make recommendations in an endeavour to ensure the work remains a priority and is completed and implemented in a timely way. Both Departments have submitted that they support these recommendations and that they are committed to working together to promote the safety and wellbeing of prisoners.

Formal Findings

168. Pursuant to section 34 of the *Coroners Act 1993* I make the following findings:

(i) the identity of the deceased person is Martin Leach;

(ii) he passed away at 6:10am on Saturday 3 August 2024 at Royal Darwin Hospital hospice facility;

(iii) the cause of death was congestive cardiac failure;

(iv) the particulars needed to register the death have been provided to Births, Deaths and Marriages.

Recommendations

169. I recommend that NT Department of Corrections and the NT Department of Health together review, amend and/or develop directives, procedures, training, guidelines, standard operating procedures or similar, and/or progress legislative reform if necessary, that clearly addresses the processes, responsibilities, sharing of information and actions of respective Correctional Services and Health staff when dealing with prisoners who have an Advance Personal Plan or who have made Advance Consent Decisions and that this work should be completed and fully implemented within 12 months from the date of these findings.

170. I recommend that NT Department of Corrections and the NT Department of Health together review, amend and/or develop directives, procedures, training, guidelines, standard operating procedures or similar,

that clearly address the processes, responsibilities, sharing of information and actions of respective Correctional Services and Health staff when dealing with prisoners who are marked ‘At Risk’ and that this work should be completed and fully implemented within 12 months from the date of these findings.

171. I recommend that NT Department of Corrections and the NT Department of Health together review, amend and/or develop directives, procedures, training, guidelines, standard operating procedures or similar that clearly address the processes, responsibilities, sharing of information and actions of respective Correctional Services and Health staff when dealing with prisoners who are too unwell for ‘normal housing’ but do not require emergency department care or hospitalisation and that this work should be completed and fully implemented within 12 months from the date of these findings.