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

# Andrew David Leader

# Contents

# Record of Investigation into Death (With Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Andrew David Leader with an inquest held at Hobart in Tasmania, make the following findings.

**Hearing Dates**

31 March 2023

**Representation**

Counsel Assisting the Coroner: M Turner

**Introduction and background**

1. Andrew David Leader was born on 14 October 1961 and was 60 years of age at the time of his death. He was born in England but later moved to Australia with his parents, residing in Tasmania until his death. Mr Leader married Maria Maloney in 1985 but separated in about 1993. They had one son together, Jonathon Leader. In his working life, Mr Leader was a builder and bricklayer, before ceasing work in about 2010. At the time of his death, Mr Leader was homeless but generally resided in the Launceston area.

2. Mr Leader's significant health issues began in about 1992 when he was diagnosed with chronic, treatment-resistant paranoid schizophrenia. He experienced paranoia and delusions which persisted until his passing. He is recorded as having numerous hospital admissions subsequent to his diagnosis of schizophrenia. In 2014, he was placed on a Mental Health Treatment Order under the *Mental Health Act* 2013. This order commenced in 2014 and remained in effect at Mr Leader's time of death. Whilst under the order, he was subject to treatment conditions but lived in the community.

3. Mr Leader suffered from other serious physical health conditions. These included emphysema, alcohol misuse syndrome, chronic obstructive pulmonary disease, chronic hyponatraemia, and heart failure.

4. In the 12 months prior to Mr Leader's death, he was admitted to hospital on 12 occasions. Significant visits in this period involved admissions for bilateral lower limb oedema and breathlessness, atrial fibrillation and CT pulmonary angiogram. Mr Leader often self-discharged from hospital and he absconded on at least one occasion. Mr Leader was recorded as exhibiting numerous behavioral issues during these visits, including abusive behavior, refusing medication and being a nuisance in the ward and in public.

5. I have, for this investigation, categorised Mr Leader as a person "held in care" under the *Coroners Act* 1995 on the basis that he was "liable to be detained" under a Mental Health Order pursuant to the *Mental Health Act* 2013. This is because the Mental Health Order, by its terms, authorised him to be admitted and, if necessary, detained in an approved mental health facility for the purpose of receiving treatment.

6. On the basis that he was "liable to be detained", I was required by section 24(1)(b) of the *Coroners Act* to hold a public inquest into Mr Leader's death and, in addition to my usual functions, to report on his care, supervision and treatment whilst he was a person held in care as required by section 28(5) of the *Coroners Act*.

7. I also note that Mr Leader was subject to an emergency 28-day Guardianship Order under the *Guardianship and Administration Act* 1995. This order commenced on 19 November 2021 and was due to expire on 17 December 2021 and appointed the Public Guardian to make decisions regarding treatment for his physical conditions. Whilst this order gave the guardian coercive powers over him, it did not, alone, render him a person held in care under the *Coroners Act.*

**Evidence at inquest**

The documentary evidence tendered at inquest comprised the following exhibits;

- Police Report of Death for the Coroner;
- Hospital Report of Death;
- Affidavits confirming life extinct and identification;
- Affidavit of the forensic pathologist, Dr Donald Ritchey, regarding cause of death;

- Affidavit of Jonathan Leader, son of Mr Leader;
- Mental Health Treatment Order;
- Guardianship Order;
- Tasmanian Health Service records for Mr Leader;
- Report by the medical consultant to the Coroner, Dr Anthony Bell.

I did not require oral evidence at inquest, but I was helpfully taken through the exhibits by counsel assisting in her submissions.

**Circumstances surrounding death**

8. Mr Leader presented to the Launceston General Hospital on 17 November 2021 after having already been discharged from the hospital that same day.

9. In hospital, he was assessed as having pleural effusions, bilateral lower limb oedema and atrial flutter. His mental state examination revealed that he was relatively stable in mood, thought disordered and had poor insight and judgement. He was admitted as an inpatient to the general medical unit where he was treated for his conditions.

10. On 19 November 2021, Mr Leader was noted by hospital staff to be confused at times and talking to himself.

11. On 22 November 2021, Mr Leader had stabilised, but was refusing nursing care and hygiene, and was smoking in the bathroom with the door closed. The following day, he expressed to staff that he believed carbon monoxide would fix his heart.

12. On 24 November 2021, a psychiatric review found that he was still psychotic. He continued to behave inappropriately and refused important medication and fluid restriction.

13. On 26 November 2021, Mr Leader was febrile, with cellulitis present in the lower limbs. Antibiotic treatment was changed, but Mr Leader refused the necessary intravenous antibiotics.

14. On 28 November 2021, Mr Leader became hypotensive and his heart rate slowed.

15. Mr Leader's condition subsequently deteriorated and he died on 6 December 2021.

**Care, supervision and treatment of Mr Leader**

16. Coronial medical consultant, Dr Tony Bell, undertook a review of Mr Leader's medical records subsequent to his hospital admission.

17. I accept Dr Bell's opinion that in light of Mr Leader's persistent schizophrenia and severe medical issues, the hospital staff performed to a high standard tolerating unacceptable behaviours and increased workload.

18. Unfortunately, Mr Leader's refusal of treatments meant that the prescribed treatments were not taken and the medical issues finally led to his death from sepsis. Although there was power under the Mental Health Treatment Order and the Guardianship Order to restrain him and forcibly treat him, I do not consider that such a course was warranted in light of his poor prognosis and his own wishes. Mr Leader's death from natural causes could not have reasonably been prevented.

**Formal Findings**

19. I find, pursuant to section 28(1) of the *Coroners Act*, that:

    a) The identity of the deceased is Andrew David Leader;

    b) Mr Leader died in the circumstances set out in this finding;

    c) Mr Leader's cause of death was sepsis/leg cellulitis with peripheral oedema and congestive cardiac failure in the setting of treatment-resistant schizophrenia and emphysema; and

    d) Mr Leader died on 6 December 2021 at the Launceston General Hospital in Tasmania.

20. I further find, pursuant to section 28 (5) of the *Coroners Act,* that the care, supervision and treatment of Mr Leader whilst subject to the Mental Health Treatment Order in the period leading up to his death, was of a good standard.

**Acknowledgements**

21. I acknowledge the valuable assistance provided to me by counsel assisting, Ms Mollie Turner, in the preparation and hearing of this inquest.

22. I convey my sincere condolences to the family and loved ones of Mr Andrew David Leader.

**Dated:** 13 April 2023 at Hobart, Tasmania

**Olivia McTaggart**
**Coroner**