CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Craig Leishman
Hearing dates:	7 June 2017
Date of findings:	7 June 2017
Place of findings:	The State Coroner's Court, Glebe
Findings of:	**Deputy State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death Chronic alcoholism Alcoholic ketoacidosis (AKA)
File number:	2016/00327854
Representation:	**Ms Bronwyn Lorenc, Coronial Advocate** **Mr Peter Walsh for Susan Leishman and John Leishman**
Findings:	**Identity of deceased**: The deceased person was Craig Leishman **Date of death**: Mr Leishman died on 2 November 2016 **Place of death**: He died at 22 William Street, North Parramatta, NSW **Cause of death:** His death was caused by complications of chronic alcoholism and hypertension **Manner of death:** Natural causes

Table of Contents

The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the reasons and findings of an inquest into the death of Craig Leishman.

Reasons

Introduction:

This is an inquest into the death of Craig Leishman. Mr Leishman was born on 17 May 1970 and was 46 years old at the time of his sudden death. Mr Leishman had been married to Susan Leishman for 21 years and they have two children, a son and a daughter. Mr Leishman had a long-term history of alcoholism, the extent of which is described differently by those who were closest to him. At the time of his death he was living with his father, John Leishman. It was John Leishman who made the sad discovery of his son deceased in the shower at his home on 2 November 2016

The Inquest:

An Inquest concerning the death of a person is required to be held if it appears to the coroner that the manner and the cause of the persons death has not been sufficiently disclosed.[1]

Section 81 of the Coroners Act 2009 requires a coroner presiding over an inquest to confirm that the death occurred and make findings as to:-

- the identity of the deceased;
- the date and place of the death; and
- the manner and cause of the death.

There is no controversy in this case as to identity, date or place of death. I am able to find that Craig Leishman died on 2 November 2016 at 22 William Street, North Parramatta. The only issues in this inquest related to the manner and cause Craig Leishman's death.

In assisting me with the task of establishing the manner and cause of Mr Leishman's death, I was grateful for the oral evidence given by Dr Jennifer Pokorny, the Forensic Pathologist who performed the autopsy on Craig Leishman.

[1] s27(1)(d) Coroners Act NSW

The evidence

Social history:

For around 2 years prior to his death, Mr Leishman had lived periodically with his father, John Leishman, at North Parramatta and also at times with his wife Susan Leishman and their children at the family home in Castle Hill.

Mr Leishman's alcoholism impacted upon his family and work life. Mr Leishman was unemployed at the time of his death, however had previously held long-term employment as a lift technician but lost his job in March 2016.

Medical history:

The evidence establishes that Mr Leishman had long term difficulties with alcohol consumption.

In February 2016, Mr Leishman was admitted to Westmead Hospital Intensive Care Unit after a '10 day binge' of alcohol where he told doctors he had consumed around a ¾ bottle of scotch per day along with paracetamol.[2] During this admission it was identified that Mr Leishman had liver failure and that his situation was grave. He was advised to abstain from drinking alcohol due to his compromised liver.

Mr Leishman had a further relapse and on 24 March 2016, his general practitioner wrote to Cumberland Hospital requesting that he be urgently reviewed.

Following this, it appears that Mr Leishman was able to remain abstinence from alcohol and entered a drug and alcohol rehabilitation centre in Lilyfield for a period of 30 days and then attended Glebe House for a further 3 month residential placement.

He had a further relapse on 22 September 2016 at the family home in Castle Hill and was transported to hospital by ambulance officers. This incident resulted in him moving in with his father, John Leishman, where he remained until his death.

Mr Leishman also had hypertension (high blood pressure) and had been prescribed medication (Olmesartan medoxomil) to assist with treating this condition.

The days leading up to Craig's death:

The evidence indicates that in at least the fortnight prior to his death, Mr Leishman had been drinking alcohol heavily and would consume at least a half a bottle of spirits daily.

On Sunday 30th October 2016, 3 days before Mr Leishman's death, his father John Leishman contacted an ambulance as he was concerned about his son's drinking.

[2] Westmead Mental Health Referral Consultation records – Craig Leishman – dated 11th February 2016.

Ambulance officers attended William Street however Craig refused to be transported to hospital.

On the 1 November 2016, the day prior to his death, Mr Leishman stopped drinking alcohol.

Discovery of Craig's body:

On the morning of 2 November 2016, Mr Leishman was at home with his father John Leishman. John saw his son that morning and he appeared to be sober and unaffected by alcohol. Mr Leishman heard his son in the bathroom and then heard a series of 'thud' noises. He went to the bathroom and found Craig lying on the floor and he went to assist him. Mr Leishman told his father that he was okay. John left the bathroom and then several minutes later heard the shower running.

John saw Mr Leishman exit the bathroom and he said that he was experiencing indigestion and returned to the bedroom. John later went out to the garden to pass some time before a scheduled flight later that day.

Around 9.30am John Leishman went back into the house and was surprised to hear the shower running. He spoke with Craig through the bathroom door and asked him to finish using the bathroom. John then returned to the garden, and then around 15 minutes later, he went back into the house.

John Leishman called out to Craig through the bathroom door and after he didn't receive a response he became concerned and forced the door open. He found Craig in the shower with the water turned off and he was not breathing. An ambulance was contacted and attended 22 William Street, however sadly Craig was unable to be resuscitated and was pronounced deceased.

Mr Leishman's death was reported to the Coroner.

The autopsy:

In this case, a coronial post mortem was conducted by Forensic Pathologist, Doctor Jennifer Pokorny.

Following her post mortem examination of Mr Leishman, Doctor Pokorny provided a detailed report. In this report, she indicated that the cause of Mr Leishman's death was 'unascertained' however several possibilities were suggested by her findings. In summary, these possibilities are:[3]

- 'Alcoholic ketoacidosis' ('AKA') which is a metabolic condition that can occur in an 'alcoholic person who abruptly abstains' from alcohol.[4] Mr Leishman's blood level of betahydroxybutrate (an indicator of ketoacidosis) was elevated leading Doctor Pokorny to state that AKA was a 'very real possibility for the cause of death';

[3] Exhibit 1, Tab 2, page 3.
[4] Exhibit 1, Tab 14, page 1365.

- Mr Leishman's liver was found to be 'enlarged and markedly steatotic' (a 'fatty liver') leading Doctor Porkorny to consider the possibility of 'significant electrolyte disturbances' due to the apparent 'chronic liver disease'; and

- Mr Leishman's heart was found to be enlarged which suggested an 'increased risk of sudden death' possibly as a result of a 'sudden onset abnormal heart rhythm (arrhythmia)'.

Doctor Pokorny's Evidence:

In addition to the post mortem report, I was greatly assisted by further oral evidence from Doctor Pokorny which was adduced during the inquest.

Doctor Pokorny's evidence was that Mr Leishman's 'true cause of death [was] amongst this set' referring to the possibilities listed in her report.[5]

Doctor Pokorny gave evidence about AKA and stated that it was a potentially lethal metabolic condition in and of itself and the circumstances of Mr Leishman's heavy consumption of alcohol followed by abrupt cessation was a 'textbook classical history' for AKA. Doctor Porkorny indicated that AKA does not necessarily only occur in alcoholics but can also result from a 'binge' of drinking alcohol which stops suddenly. Biochemical analysis of Mr Leishman's blood revealed a betahydroxybutrate level of 1,299 µmol/L which Doctor Pokorny agreed would be approximately 135mg/L. A low level of alcohol was also detected.

Doctor Pokorny gave evidence that Mr Leishman's betahydroxybutrate level was in the 'grey' area; meaning that although it was not sufficiently high enough to indicate that death was due to AKA (diagnosable ketoacidosis), it was not a normal level and indicated a 'metabolic derangement'.[6]

Doctor Pokorny stated that Mr Leishman's liver showed 'very extensive fatty change'. This is consistent with Mr Leishman's history of alcoholism and also placed him at risk of further metabolic effects.

Whilst I accept that an enlarged heart can result from hypertension, Doctor Pokorny's evidence was that she was 'almost certain' that Mr Leishman's raised ketoacids and the risk posed by his chronic liver disease would have impacted upon any arrhythmia that may have occurred on the day of his death.[7] Hypertension may or may have not been caused by Mr Leishman's alcoholism.

Doctor Pokorny considered that Mr Leishman's death was a probable combination of the three factors outlined in her report, and if his death had resulted from a fatal arrhythmia, it would have 'almost certainly' been a result of his raised ketoacids and

[5] Oral evidence of Doctor Pokorny at Inquest
[6] Ibid
[7] Ibid

his enlarged and steatotic ('fatty') liver both of which are considered to be complications of his alcoholism.

Doctor Pokorny agreed in evidence that it would be reasonable for me to find that Mr Leishman died of 'complications of chronic alcoholism and hypertension' based upon her post mortem findings and I accept this evidence.

Manner and Cause of death:

Section 81 of the Coroners Act 2009 requires me to make a finding as to the cause and manner of Mr Leishman's death.

In making such a determination, I have considered the evidence contained within the Coronial brief which was supplemented by the oral evidence of Constable Andrew Aird and Doctor Jennifer Pokorny given at inquest. I have also considered the submissions of Mr Walsh, counsel for Mrs Susan Leishman and Mr John Leishman.

Mr Leishman's medical history indicates that he had struggled with his alcoholism for some time. Prior to his death on 2 November 2016 he had suffered from health complications resulting from his alcoholism including liver failure. Due to his alcoholism, Mr Leishman was at risk of other health complications and sudden death.

In the days leading up to his death, Mr Leishman had been drinking a significant amount of alcohol, to the extent that his father, John Leishman, who had seen firsthand Craig's drinking habits, was sufficiently concerned to contact an ambulance. Around 1 November 2016, the day prior to his death, Craig stopped drinking alcohol.

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am satisfied, on the balance of probabilities, that the cause of Mr Leishman's death on the morning of 2 November 2016 was due to complications arising from his chronic alcoholism. Although I am satisfied that a fatal arrhythmia that day would have likely resulted from a metabolic derangement caused by AKA and chronic liver damage, hypertension is included due to the possibility that it may be a condition that was independent from his alcoholism.

As such, I find that that cause of Mr Leishman's death was due to the complications of Mr Leishman's chronic alcoholism and hypertension.

The manner of death is due to natural causes.

I would like to thank the Officer in Charge, Constable Andrew Aird and the Coronial advocate, Ms Bronwyn Lorenc.

In closing I would like to offer my sincere condolences to Craig's family.

The subject matter of an inquest is often quite technical and medical terms and conditions are described in their cold detail. It is important to remember that the person spoken about was more than a diagnosis or an illness. He was a man who loved and was loved. Craig Leishman was a father, a son and a partner. He is someone who will be thought of and missed every day.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Craig Leishman

Date of death

Mr Leishman died on 2 November 2016

Place of death

He died at 22 William Street, North Parramatta, NSW

Cause of death

His death was caused by complications of chronic alcoholism and hypertension

Manner of death

His death was due to natural causes

Magistrate Teresa O'Sullivan
Deputy State Coroner

Date: 9 June 2017