CORONER'S COURT
OF NEW SOUTH WALES

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| **Inquest:** | Inquest into the death of George McLeod |
| **Hearing dates:** | 27 May 2021 |
| **Date of findings:** | 27 May 2021 |
| **Place of findings:** | Coroner's Court of New South Wales, Lidcombe |
| **Findings of:** | Magistrate Derek Lee, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – death in custody, cause and manner of death |
| **File number:** | 2019/362566 |
| **Representation:** | Ms K Mackay, Coronial Advocate Assisting the Coroner<br><br>Ms K McKinlay for the Commissioner of Corrective Services New South Wales<br><br>Ms N Szulgit for Justice Health & Forensic Mental Health Network |
| **Findings:** | I find that George McLeod died on 18 November 2019 at Long Bay Hospital, Long Bay Correctional Complex, Malabar NSW 2036. The cause of Mr McLeod's death was atherosclerotic cardiovascular disease, with dementia, diabetes mellitus and hypertension being significant conditions contributing to the death, but not relating to the disease or condition causing it. Mr McLeod died from natural causes, whilst in lawful custody serving a sentence of imprisonment. |
| **Non-publication orders:** | See Annexure A |

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## 1. Introduction

1.1 At the time of his death, George McLeod was 80 years old and was being held in lawful custody as a forensic patient within Long Bay Hospital at Long Bay Correctional Complex. Mr McLeod had a lengthy history of physical and mental health conditions. After having been charged with a serious offence of violence, Mr McLeod was subsequently found unfit to stand trial, and a limiting term was later imposed that was to expire on 25 September 2021.

1.2 In the early hours of the morning on 18 November 2019, Mr McLeod was found in his bed inside his cell to be unresponsive, and showing no signs of life. In accordance with an advanced care directive that had been instituted some months earlier due to Mr McLeod's deteriorating condition, no resuscitation measures were initiated. Mr McLeod was subsequently pronounced life extinct.

## 2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr McLeod was not appropriately cared for and treated whilst in custody.

## 3. Mr McLeod's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Regrettably, only limited information is available regarding Mr McLeod's personal circumstances.

3.2 Mr McLeod was born in 1939. At the age of two Mr McLeod and his five siblings were removed from their mother's care. Mr McLeod was subsequently placed in foster care, and he reported that his stepfather subsequently visited him whilst he was living in a care placement.

3.3 In November 1970 Mr McLeod married, and later had two children. Sometime later the marriage ended and Mr McLeod lost contact with his children, who were later adopted by their stepfather.

3.4 In his later years of life, Mr McLeod resided at an aged care facility.

## 4. Mr McLeod's custodial history

4.1 Between 1954 and 1974 Mr McLeod had a number of interactions with the criminal justice system in relation to relatively minor property and assault offences. However, between 1974 and 2016 Mr McLeod had a number of further interactions with the criminal justice system in relation to more serious personal assault offences. During this period, Mr McLeod was convicted in relation to a number of offences of violence and was sentenced to lengthy terms of imprisonment.

4.2 On 26 September 2016 Mr McLeod was arrested and charged with an offence of wounding with intent to cause grievous bodily harm. Following his arrest, Mr McLeod was remanded in custody and initially housed at the Metropolitan Remand & Reception Centre at Silverwater. On 6 October 2016 Mr McLeod was transferred to the Metropolitan Special Programs Centre at Long Bay Correctional Complex due to his medical conditions.

4.3 On 25 July 2017 a Fitness Hearing was held in the District Court to determine Mr McLeod's fitness to stand trial. Medical evidence adduced at the hearing indicated that due to Mr McLeod's history of vascular dementia with impairment of cognition he:

4.4 (a) was incapable of fairly participating in a trial; and

(b) lacked the ability to make out a defence and answer the charges presented against him by giving necessary instructions to his legal representatives.

4.5 Ultimately, a determination was made by the District Court that Mr McLeod was unfit to stand trial. Accordingly, an order was made for Mr McLeod to be detained at Long Bay Correctional Complex to receive care and treatment, pursuant to section 14 of the *Mental Health (Forensic Provisions) Act 1990* (**the Mental Health Act**).

4.6 On 7 September 2017 the Mental Health Review Tribunal (**the Tribunal**) determined that Mr McLeod was unfit to stand trial and would not become fit to be tried within 12 months of the date of his Fitness Hearing. Therefore, pursuant to sections 46 and 47 of the Mental Health Act, the Tribunal determined that Mr McLeod should continue to be detained at Long Bay Correctional Complex for care and treatment.

4.7 On 22 March 2018 a Special Hearing was held in the District Court. A qualified finding of guilt was made against Mr McLeod for the offence that he had been charged with. The District Court imposed a five year limiting term pursuant to section 23 of the Mental Health Act, with the limiting term to commence on 26 September 2016 and expire on 25 September 2021. Mr McLeod was referred to the Tribunal for review pursuant to section 24 (1) of the Mental Health Act and was to be kept in custody pending the determination of the Tribunal.

4.8 On 10 May 2018 the Tribunal determined that Mr McLeod was suffering from a mental illness and a mental condition. Further, the Tribunal formed the opinion that Mr McLeod had not become fit to be tried for the offences in relation to which he had been found unfit, and that he should continue to be detained for care and treatment as a forensic patient at Long Bay Correctional Complex. An order for detention was subsequently made pursuant to section 47(1) of the Mental Health Act.

4.9 A further determination was made by the Tribunal on 10 December 2018 that Mr McLeod remained appropriately detained, and that due to the permanent nature of his condition there was no evidence that there had been any change to his fitness to be tried.

4.10 On 3 May 2019 the Tribunal noted that Mr McLeod was still unfit to stand trial, with more than 12 months having elapsed since being found unfit by the District Court. The Tribunal noted that the medical evidence provided to it indicated that Mr McLeod continued to be unfit to stand trial and that the conditions which made him unfit were permanent and getting worse. The Tribunal therefore determined that Mr McLeod remained properly detained and that there should be no change to his current circumstances. The Tribunal also determined that a subsequent review would be held within six months.

## 5. Mr McLeod's medical history

5.1 Mr McLeod had a history of chronic obstructive airways disease, ischaemic heart disease with two coronary bypass grafts, bradycardia, type II diabetes, hypertension, hypercholesterolaemia and right leg amputation.

5.2 During his time in custody, Mr McLeod was primarily housed in the Kevin Waller Unit at Long Bay Correctional Complex, which provides additional supports for older inmates with physical frailties. In January 2018 Mr McLeod was transferred to the Aged Care and Rehabilitation Unit at Long Bay Hospital due to his deteriorating mental state.

5.3 On 6 June 2019 an advanced care directive was put in place noting that Mr McLeod was not for resuscitation due to his existing medical conditions and poor prognosis. On 10 November 2019 the advanced care directive was reviewed and continued, noting that even if resuscitation were to be successful it would likely be followed by a significantly reduced quality of life which would not be in Mr McLeod's best interests.

5.4 On 13 July 2019 a marked deterioration in Mr McLeod's condition was noted. He was found to have little reactivity, no spontaneous behaviours and increased thought disorders. Accordingly, on 8 August 2019 Mr McLeod was transferred to the Garrawarra Centre, an aged care facility for treatment of inmates with dementia.

5.5 In October 2019, due to Mr McLeod's deteriorating condition, consideration was given to the institution of palliative care.

5.6 On 10 November 2019 Mr McLeod was noted to have poor appetite and to be displaying signs of tiredness and lethargy. At this time Mr McLeod was frail, non-verbal and unable to independently

mobilise, spending most of his time bed-bound. Mr McLeod was monitored for increased confusion, agitation and disorientation.

## 6. What happened on 18 November 2019?

6.1 On the evening of 17 November 2019 Mr McLeod was noted by Justice Health & Forensic Mental Health Network (**Justice Health**) staff to be asleep in his bed. Between 12:00am and 2:30am on 18 November 2019 Justice Health staff performed routine observations of Mr McLeod and attended to repositioning.

6.2 During a routine medication round at 4:30am Justice Health staff attend Mr McLeod's cell and found him to be unresponsive, with no signs of life. In accordance with the advanced care directive in place, resuscitation was not initiated. Mr McLeod was subsequently pronounced life extinct.

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

7.1 Mr McLeod was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 22 November 2019. The examination identified severe advanced atherosclerosis involving the larger arteries, with coronary artery disease and a slightly enlarged heart noted. No acute bony pathology and no acute event within the cranium were identified.

7.2 Ultimately, in the autopsy reported dated 15 April 2020, Dr Szentmariay opined that the cause of Mr McLeod's death was atherosclerotic cardiovascular disease, with dementia, diabetes mellitus and hypertension noted to be significant conditions contributing to the death, but not relating to the disease or condition causing it.

## 8. Conclusions

8.1 Having regard to the relevant records from Corrective Services NSW (**CSNSW**) and Justice Health regarding Mr McLeod's period in custody, and the findings from the postmortem examination, it is evident that Mr McLeod died as a result of significant pre-existing natural disease. Mr McLeod had a complex medical history which made him entirely dependent on the care and treatment provided by Justice Health staff during his time in custody. Following a significant decline in Mr McLeod's condition, and given his poor prognosis, an appropriate advanced care directive was instituted in June 2019.

8.2 Overall, the available evidence establishes that Mr McLeod was provided with an adequate and appropriate level of medical care during his period in custody. There is no evidence to suggest that any aspect of Mr McLeod's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

## 9. Findings

9.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Karissa Mackay, Coronial Advocate, for her excellent assistance both before, and during, the inquest. I also thank Plain Clothes Senior Constable Marcus Witts for his role in the police investigation and for compiling the initial brief of evidence.

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

***Identity***

The person who died was George McLeod.

***Date of death***

Mr McLeod died on 18 November 2019.

***Place of death***

Mr McLeod died at Long Bay Hospital, Long Bay Correctional Complex, Malabar NSW 2036.

***Cause of death***

The cause of Mr McLeod's death was atherosclerotic cardiovascular disease, with dementia, diabetes mellitus and hypertension being significant conditions contributing to the death, but not relating to the disease or condition causing it.

***Manner of death***

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

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

9.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
27 May 2021
Coroners Court of New South Wales

**Inquest into the death of George McLeod**
File Number: 2019/362566

**Annexure A**

Pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act), I direct that the following material contained within Exhibit 1 is not to be published:

1. The names, visitor index numbers, contact numbers, and addresses of the following persons:

   (a) any member of George McLeod's family, friends and/or visitors, other than legal or professional visitors; and

   (b) The direct contact details of Corrective Services New South Wales (CSNSW) and staff from external service providers.

2. CCTV footage from Long Bay Correctional Complex and any stills of that footage.

Pursuant to section 65(4) of the *Coroners Act 2009:*

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

Magistrate Derek Lee
Deputy State Coroner
27 May 2021
Coroners Court of New South Wales