



ATTORNEY-GENERAL

Parliament House
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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and Recommendations regarding the death of
Martin Leach

Under section 46B of the *Coroners Act 1993* (the Act), I provide this Report on the findings and recommendations of Local Court Judge Elisabeth Armitage, Territory Coroner, regarding the death of Martin Leach (the Deceased) (Attachment A refers).

This Report includes the response to the recommendations of the Territory Coroner, by Mr Matthew Varley, Commissioner / Chief Executive Officer (CEO), Department of Corrections (DoC), and Ms Susan Bowden, CEO, Department of Health (DoH).

The Deceased was a 65 year old man, who passed away at 6.10 am on 3 August 2024 at the Royal Darwin Hospital Hospice facility. The cause of death was congestive cardiac failure. Prior to his death the Deceased was under an Advance Personal Plan in anticipation of health decline, due to his notably extensive medical history. This plan made under an Advance Consent Decision documented the Deceased's refusal of specific medical treatments. At the time of his death the deceased was in the custody of the Commissioner of DoC, while serving a life sentence in prison for rape and the murder of two women, therefore his death was reportable under section 27 of the Act.

Recommendations of the Territory Coroner

The Territory Coroner made the following formal recommendations regarding the death of the Deceased:

- '169. I recommend that the 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 the 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 full implemented within 12 months from the date of these findings.'

Response to Coroner's Recommendations

Department of Corrections

A copy of the Coronial Findings was provided to Commissioner Varley, on 2 June 2026, in accordance with section 46A(1) of the Act.

A written response was received from Commissioner Varley dated 17 August 2026, as required by section 46B(1) of the Act. The response includes the following:

'The Department ... is working collaboratively with NT Health to strengthen governance arrangements to progress their implementation.

Recommendation 169:

The Department has completed a review of the relevant Commissioner Directives, policies and standard operating procedures relating to prisoners who have an Advance Personal Plan (APP) or Advance Consent Decisions. The review identified opportunities to strengthen clarity regarding notification and management of prisoners subject to such arrangements.

In partnership with NT Health, the Department has commenced work through existing governance arrangements to strengthen communication, information sharing, and collaborative decision-making in relation to prisoners with complex care needs, including those with an APP. This information will guide amendments to relevant departmental procedure documents and support the development of relevant training and communication processes.

Recommendation 170:

The Department continues to progress a review of the current framework for managing prisoners who are at risk of suicide or self-harm. This work is being undertaken by a joint Department of Corrections and NT Health governance structure and includes review of the relevant procedures, clarification of responsibilities and roles, information sharing arrangements, and mapping escalation pathways.

Preliminary consultation has identified opportunities to further strengthen the At Risk framework and support a more coordinated approach to managing At Risk prisoners. The current scope of work will be implemented within the 12-month timeframe, with any broader reform actions considered as additional continuous improvement proposals.

Recommendation 171:

The Department continues to work collaboratively with NT Health to strengthen supporting arrangements for prisoners who are unsuitable for normal housing accommodation due to health needs, but who do not require emergency or hospital-based care.

A multi-disciplinary approach to complex care management is being established to support prisoners with complex health needs through defined stakeholder responsibilities and decision making, information sharing arrangements and coordinated prisoner health management. This work may inform the development of relevant operational procedures.

The Department of Corrections remains committed to improving coordinated and integrated service delivery for prisoners with complex health care needs.'

Department of Health

A copy of the Coronial Findings was provided to Ms Bowden, on 3 June 2026, in accordance with section 46A(1) of the Act.

A written response was received from Ms Bowden dated 8 September 2026, as required by section 46B(1) of the Act. The response includes the following:

Recommendation 169

'A joint NT Health-NT Department of Corrections governance approach has been established through the Prison Health Systems and Performance Committee to oversee implementation of the coronial recommendations.

The Complex Care Management Group has been re-established under an updated Terms of Reference to coordinate care planning for prisoners with complex health needs, including those with Advance Personal Plans (APPs), Advance Consent Decisions (ACDs), and palliative or end-of-life care needs.

The forum brings together operational and clinical decision-makers to support coordinated care planning, information sharing and agreed care pathways across correctional centres. Work has commenced to review operational procedures, governance arrangements, membership, referral criteria and escalation processes to support consistent implementation across all correctional centres.'

Recommendation 170

'A multidisciplinary review of the current 'At Risk' process has commenced under the governance of the Prison Health Systems and Performance Committee. The review includes representatives from NT Health, the NT Department of Corrections, Youth Justice and individual prison unit operational leadership to examine governance, roles and responsibilities, clinical and custodial interfaces, communication pathways, escalation processes and information sharing.'

Two multidisciplinary workshops have been completed. Initial discussions identified opportunities for broader system reform extending beyond procedural updates. As a result, feedback has been provided to the NT Department of Corrections Executive to clarify the intended scope of the review and determine whether broader policy and operational reform will be progressed. The group will continue development of revised governance arrangements, procedures, education and implementation plans to support a consistent, system-wide approach to managing prisoners identified as 'At Risk'.

Recommendation 171

'NT Health, in partnership with the NT Department of Corrections, will undertake the above review to define clinical criteria, roles and responsibilities, escalation pathways, multidisciplinary care planning, communication and information-sharing requirements, and decision-making processes across Health and Corrections.

The review will also consider the feasibility of a medical accommodation model and associated operational requirements to support prisoners requiring enhanced clinical oversight.'

I am satisfied that the Commissioner of DoC and the CEO of DOH have considered the recommendations of the Territory Coroner and that they have responded to the recommendations.

DATE: - 9 OCT 2026



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MARIE-CLARE BOOTHBY

Attachment A -
refer to findings