JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	11 JUNE 2025
DELIVERED	**:**	24 JUNE 2025
FILE NO/S	**:**	CORC 3462 of 2023
DECEASED	**:**	WOOD, LEIGHTON MICHAEL

Legislation:

Coroners Act 1996 (WA)
Mental Health Act 2014 (WA)

Counsel Appearing:

Ms S. Markham appeared to assist the coroner.

Ms K. Ellson (State Solicitor's Office) appeared for the North Metropolitan Health Service.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Leighton Michael WOOD*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, PERTH, on 11 June 2025, find that the identity of the deceased person* ***Leighton Michael WOOD*** *and that death occurred on or about 18 November 2023 at D1, 25 Herdsman Parade, Wembley, from bronchopneumonia in the setting of combined drug effect in the following circumstances:*

Table of Contents

INTRODUCTION

1. Leighton Michael Wood (Leighton)[1] died in Wembley on or about 18 November 2023, from bronchopneumonia in the setting of combined drug effect.[2,3,4,5]

2. At the time of his death, Leighton was the subject of a community treatment order (CTO)[6] made under the *Mental Health Act 2014* (WA) (the MHA). Accordingly, immediately before his death Leighton was an "*involuntary patient*" and a "*person held in care*", and his death was therefore a "*reportable death*".[7,8]

3. In such circumstances, a coronial inquest is mandatory[9] and where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[10] On 11 June 2025, I held an inquest into Leighton's death that was attended by his father.

4. The Brief of evidence tendered at the inquest consisted of one volume and included a report on the police investigation into Leighton's death and a report from his supervising psychiatrist. The following witnesses gave evidence during the inquest:

a. Dr Himanshu Mistry (Consultant Psychiatrist);[11]
b. Mr Benjamin Davidson (Case Manager);[12] and
c. Mr Robert Smithson (Coronial Investigator).[13]

5. The inquest focused on the circumstances of Leighton's death and the supervision, treatment and care he received while he was the subject of an involuntary treatment order.

---

[1] At the request of his family, the deceased was referred to as "Leighton" at the inquest and in this finding.
[2] Exhibit 1, Vol. 1, Tabs 4 & 4.1, Life Extinct Form & Life Extinct Certification (19.11.23)
[3] Exhibit 1, Vol. 1, Tab 5, P92 Identification of Deceased Person - Visual Means (19.11.23)
[4] Exhibit 1, Vol. 1, Tab 6 P98 Mortuary Admission Form (19.11.23)
[5] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (10.10.24)
[6] A CTO is an order made under the MHA that a person receive treatment on an involuntary basis in the community.
[7] Exhibit 1, Vol. 1, Tab 9, Notice of Decision - Mental Health Tribunal (30.08.23)
[8] Section 3, *Coroners Act 1996* (WA)
[9] Section 22(1)(a), *Coroners Act 1996* (WA)
[10] Section 25(3) *Coroners Act 1996* (WA)
[11] ts 11.06.25 (Smithson), pp6-14
[12] ts 11.06.25 (Mistry), pp14-31
[13] ts 11.06.25 (Mistry), pp31-37

LEIGHTON

Background[14,15,16,17]

6. Leighton was born in New Zealand on 21 February 1979, and he was 44-years of age when he died on or about 18 November 2023.[18] Leighton had one brother, and although he reportedly struggled at school, he completed Year 10. Leighton had two children, one from a previous relationship, and one with his wife of 16 years, who he divorced about five years before his death.

7. Before he died, Leighton was living in an apartment in Wembley, which he rented from his father. Leighton was in receipt of the disability pension, and he also received support from care workers funded by the National Disability Insurance Scheme.

8. Leighton's criminal history included 38 convictions for offences including: driving offences, stealing, breaches of a family violence restraining order, breach of a suspended imprisonment order, disorderly conduct, and trespass.

Mental health diagnoses[19,20,21]

9. Leighton's medical history included: schizoaffective disorder, obesity, back pain, anti-social personality disorder, hearing impairment, chronic obstructive pulmonary disease, impaired blood glucose levels, and obstructive sleep apnoea, for which he used a CPAP machine at night,[22].

10. Leighton's mental health conditions were complicated by his non-compliance and/or misuse of prescription medication, and his history of polysubstance use including alcohol, methylamphetamine, and cannabis. Leighton was usually managed in the community, but on several occasions when he was floridly psychotic, he was admitted to hospital.

---

[14] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Smithson (22.10.24), p6
[15] Exhibit 1, Vol. 1, Tab 2.1, Memorandum - Const. D Trandos (undated), p3
[16] Exhibit 1, Vol. 1, Tab 8, Report - Dr H Mistry (27.12.23), pp1-2 and ts 11.06.25 (Mistry), pp15-17
[17] Exhibit 1, Vol. 1, Tab 16, History for Court: Criminal & Traffic
[18] Exhibit 1, Vol. 1, Tabs 4 & 4.1, Life Extinct Form & Life Extinct Certification (19.11.23)
[19] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Smithson (22.10.24), pp7-8
[20] Exhibit 1, Vol. 1, Tab 2.1, Memorandum - Const. D Trandos (undated), p3
[21] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23)
[22] A CPAP or Continuous positive airway pressure machine assists patients with obstructive sleep apnoea to breath while asleep

11. At the time of his death, Leighton was receiving the antipsychotic medication, zuclopenthixol decanoate, which works on the balance of chemical substances in the brain, and it can be administered in tablet form, or by means of long-acting intramuscular injections (depot injections). Leighton received his depot injections fortnightly, although there is no difference in efficacy between monthly, fortnightly or weekly depot injections.[23,24,25]

Community treatment order[26]

12. At the time of his death, Leighton was being managed in the community on a community treatment order (CTO), which was confirmed by the Mental Health Tribunal on 30 August 2023. The CTO required Leighton to attend regular appointments at the Clinic and consent to his depot injections.[27]

13. The *Mental Health Act 2014* (MHA) provides that a person is not to be placed on an CTO unless: "*[T]he person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order*".[28]

14. In Leighton's case, a CTO was required because he lacked insight into his mental illnesses and did not have the capacity to make treatment decisions about his mental health. Placing Leighton on a CTO meant that he could be regularly monitored and that if declined his depot medication, he could be required to attend an authorised place for an assessment by a psychiatrist. If necessary, his CTO could be also revoked and he could be admitted to hospital on an involuntary basis.[29]

15. Having carefully reviewed the available evidence, I am satisfied that the decision to place Leighton on an CTO was justified on the basis that this was the least restrictive way to ensure that he was provided with appropriate treatment for his mental health conditions.

---

[23] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23)
[24] ts 11.06.25 (Mistry), p18
[25] See also: https://patient.info/medicine/zuclopenthixol-clopixol
[26] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23) and ts 11.06.25 (Mistry), pp24-25
[27] Exhibit 1, Vol. 1, Tab 9, Notice of Decision - Mental Health Tribunal (30.08.23)
[28] s25(2)(e), *Mental Health Act 2014* (WA)
[29] See: Division 4, Part 8, *Mental Health Act 2014* (WA)

Management of mental health[30,31,32,33,34,35,36,37]

16. Leighton's mental health was difficult to manage and he presented a number of challenges to his treating team. Despite repeated encouragement, Leighton declined to cease his regular use of alcohol and illicit substances, including methylamphetamine.

17. Until the end of 2022, Leighton was managed by the Wanneroo Community Mental Health Service under a succession of CTO's. Leighton had multiple inpatient admissions to various hospitals. However, Leighton moved into his father's unit in Wembley, and in January 2023 his care was transferred to the Lower West Community Mental Health Service, now known as the Subiaco Mental Health Service (the Clinic).[38]

18. On 15 January 2023, Leighton was admitted Sir Charles Gairdner Hospital, (SCGH) after refusing his depot medication, stating it was "*poison*" and was "*fucking up*" his immune system. Leighton was diagnosed with acute methylamphetamine intoxication on a background of his known mental health conditions. There was "*limited ongoing evidence of psychosis*" and although he was offered a voluntary admission, Leighton discharged himself against medical advice.[39]

19. In late April 2023, Leighton was admitted to Graylands Hospital (GH) following numerous contacts with the police in relation to complaints about his behaviour. During his admission, Leighton repeatedly claimed he had "*been raped by police*" while he was at Hakea Prison, although he declined a referral to the Sexual Assault Resource Centre. After treatment, Leighton was discharged on a CTO on 12 May 2023. However, when seen at the Clinic on 18 May 2023, Leighton presented as hostile, aggressive and psychotic, and he was readmitted to GH.[40,41]

[30] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23) and ts 11.06.25 (Mistry), pp14-31
[31] Exhibit 1, Vol.1, Tab 17, Statement - Mr B Davidson (09.06.25) and ts 09.03.22 (Davidson), pp31-37
[32] Exhibit 1, Vol.1, Tab 10, Medical Records - Community Mental Health Service
[33] Exhibit 1, Vol.1, Tab 11, Medical Records - Royal Perth Hospital
[34] Exhibit 1, Vol.1, Tab 12, Medical Records - Graylands Hospital
[35] Exhibit 1, Vol.1, Tab 13, Medical Records - Joondalup Health Campus
[36] Exhibit 1, Vol.1, Tab 14, Medical Records - Sir Charles Gairdner Hospital
[37] Exhibit 1, Vol.1, Tab 15, Medical Records - Floreat Forum General Practice
[38] ts 11.06.25 (Davidson), p31
[39] Exhibit 1, Vol.1, Tab 14, Discharge Summary - Sir Charles Gairdner Hospital (17.01.23)
[40] Exhibit 1, Vol.1, Tab 12, Discharge Summary - Graylands Hospital (26.05.23)

20. Leighton said he believed he could spot paedophiles, and alluded to the fact that his case manager at the Clinic was one. During his admission at GH, Leighton presented as "*elevated, driven, sleeping poorly, playing loud music, and being generally disruptive on the ward*. Leighton was diagnosed with schizoaffective disorder, and after treatment he was discharged back to care of the Clinic on 26 May 2023.[42]

21. Leighton was often hostile and abusive towards Clinic staff, and he made various threats to, and allegations about them including that they were "*paedophiles*". There is no doubt that these behaviours added to the challenges in managing Leighton's mental health. Key aspects of Leighton's management in the period leading up to his death include:

a. *30 May 2023*: Leighton was taken to SGH with breathing difficulties. Although he had been diagnosed with sleep apnoea, it appears Leighton was not using his CPAP machine;[43,44]

b. *8 June 2023*: Leighton was seen at the Clinic and he was agitated, paranoid, and delusional. He was swearing at clinicians and accused his case manager of being a paedophile, and the dose of his depot injection of zucopenthixol was increased;[45]

c. *20 July 2023*: Leighton was seen at the Clinic and he appeared "*pressured in his speech and tangential*". Although Leighton denied methylamphetamine use, he disclosed using cannabis, but said he had recently ceased his heavy alcohol use. His manner was "*overfamiliar and grandiose*" and he was considered "*hypomanic*" in the context of "*schizoaffective disorder and polysubstance misuse*";[46]

d. *17 August 2023*: Leighton was seen at the Clinic and he was "*loud, accusatory, and abusive*" to his case manager. Leighton's ex-wife had contacted the Clinic to express concerns about his mental state, and she forwarded delusional late-night text messages he had sent her with themes including religion, aliens, and celebrities;[47]

---

[41] ts 11.06.25 (Mistry), pp23-24
[42] Exhibit 1, Vol.1, Tab 12, Discharge Summary - Graylands Hospital (26.05.23)
[43] Continuous Positive Airway Pressure machine used to treat sleep apnoea
[44] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 14 and ts 11.06.25 (Mistry), pp22-23
[45] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 15
[46] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 16
[47] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 17

e. *31 August 2023*: Leighton was seen at the Clinic and he was "*thought disordered, loud, irritable, disinhibited, responding to a TV in the waiting area, and voicing delusional ideas regarding being raped as a child*". Leighton was placed on forms under the MHA and admitted to SCGH as an involuntary patient;[48]

f. *31 August - 12 September 2023*: during his admission, Leighton was noted to be "*agitated, suspicious, disorganised and displayed disruptive behaviours on the ward*". Leighton was diagnosed with a psychotic episode likely related to polysubstance use, and he was discharged on an increased dose of his depot injection of zucopenthixol was increased;[49,50]

g. *17-20 September 2023 and 22-26 September 2023*: Leighton had two admissions to Royal Perth Hospital (RPH) in relation to episodes of shortness of breath. Leighton expressed concern that his CPAP machine was not working and after his condition settled, he was discharged home to be followed up by the sleep clinic;[51,52]

h. *21 September 2023*: Leighton was seen at the Clinic and his manner was "*challenging and hostile*", and he was repetitive, irritable and difficult to engage. He voiced paranoid and grandiose themes, and claimed he was sexually abused as a child. Leighton also demanded lorazepam (to help with "*anxiety and nightmares*";[53]

i. *early October 2023*: Leighton expressed suicidal ideation which appeared to be related to his forthcoming court appearance, and he complained of auditory hallucinations. Leighton's supervising psychiatrist (Dr Mistry) contacted his (Leighton's) GP and confirmed he had been prescribed olanzapine. At the inquest, Dr Mistry confirmed that his was the only occasion that Leighton had expressed any self-harm or suicidal ideation, and following his court appearance (when Leighton was not given the custodial term he had feared) there was no further such expressions;[54,55]

[48] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), paras 18-19
[49] Exhibit 1, Vol.1, Tab 12, Discharge Summary - Graylands Hospital (12.09.23)
[50] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 19
[51] Exhibit 1, Vol.1, Tab 12, Discharge Summary - Royal Perth Hospital (20.09.23)
[52] Exhibit 1, Vol.1, Tab 12, Discharge Summary - Royal Perth Hospital (26.09.23)
[53] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 20
[54] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 21 and ts 11.06.25 (Mistry), pp26-27
[55] See also: ts 11.06.25 (Davidson), pp34-35 who also confirmed this was the only occasion Leighton expressed suicidal ideation

j. *11 October 2023*: Leighton contacted his case manager and claimed to have taken 16 olanzapine tablets to help manage his anxiety regarding his court appearance. Although it was recommended that he attend an emergency department, Leighton declined to do so saying he had "*no ill effects*" and had slept well and felt more relaxed;[56]

k. *19 October 2023*: Leighton was seen at the Clinic and he discussed his anxiety relating to his court appearance on 24 October 2023. He also disclosed that his abstinence from alcohol had "*led him to feel suicidal*" and he had resumed drinking, but planned to stop after his court appearance. Leighton was given "*psychoeducation*" about the effects of alcohol on his physical and mental health and he was encouraged to "*implement better lifestyle choices*";[57] and

l. *16 November 2023*: Leighton was seen at the Clinic for the last time prior to his death. He was "*calm and appropriate*" and although he mentioned drinking less and focussing on weight loss, he declined to engage with a drug and alcohol rehabilitation service, saying he would manage his alcohol use himself. Leighton referred to having seen an alien "*a few months ago*" but he did not express any distress associated with this experience;

   Leighton's "*functioning and mood appeared settled*", and although he requested an increased dose of his depot injection of zucopenthixol, this was declined on the basis of the risk of unwelcome side effects. During this presentation, Leighton admitted to smoking in the early hours of the morning despite breathing issues, and he complained of issues with his CPAP machine mask. Leighton's case manager resolved this issue following day after liaison with the respiratory clinic at RPH.[58,59]

[56] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 22 and ts 11.06.25 (Mistry), pp26-27
[57] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 23
[58] Exhibit 1, Vol.1, Tab 8, Report - Dr H Mistry (27.12.23), para 23 and ts 11.06.25 (Mistry), pp20-23
[59] Exhibit 1, Vol.1, Tab 17, Statement - Mr B Davidson (09.06.25) para 65 and ts 09.03.22 (Davidson), pp35-36

EVENTS LEADING TO LEIGHTON'S DEATH[60,61,62]

22. At about 1.40 am on 19 November 20239, Leighton was discovered sitting in a chair in the lounge room by his ex-wife (Ms Sarah Wood) who had been staying with him for a few days. Leighton was unresponsive and not breathing, and Ms Wood called emergency services at 1.42 am.[63]

23. The first of two ambulances arrived at 1.53 am, and ambulance officers (including a clinical support paramedic) made extensive resuscitation efforts, including injections of adrenalin, and the use of a defibrillator. Despite these efforts, Leighton could not be revived and he was declared deceased at 2.22 am on 19 November 2023.[64,65,66,67,68]

24. Following Leighton's death, Leighton's father raised concerns about the circumstances of his son's death and the conduct of Leighton's ex-wife (Ms Wood). Leighton's father alleged that Ms Wood had "*moved in*" with Leighton shortly before he died, and that Ms Wood may have given Leighton some of her opioid medication, tapentadol.[69]

25. Ms Wood told police she had not given Leighton any of her medication, but she conceded he may have accessed some without her permission while she was asleep. Following an investigation, police concluded there was "*no evidence of criminality, third party involvement or suspicious circumstances*" in relation to Leighton's death.[70,71]

26. I acknowledge the concerns expressed by Leighton's father, however the evidence before me does not suggest any criminal conduct on Ms Wood's part. I also note that Leighton was found with therapeutic levels of tapentadol (which Ms Wood was prescribed) in his system.

---

[60] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Smithson (22.10.24), p6
[61] Exhibit 1, Vol. 1, Tab 2.1, Memorandum - Const. D Trandos (undated), p3
[62] Exhibit 1, Vol. 1, Tabs 2.3 & 2.4, WAPOL Incident Reports 191123 0300 18276 & LWP 23111900817310
[63] Exhibit 1, Vol. 1, Tabs 3.1-3.3, SJA Patient Care Records 23226439, 23226439 & 23226439 (19.11.23)
[64] Exhibit 1, Vol. 1, Tabs 3.1-3.3, SJA Patient Care Records 23226439, 23226439 & 23226439 (19.11.23)
[65] Exhibit 1, Vol. 1, Tabs 4 & 4.1, Life Extinct Form & Life Extinct Certification (19.11.23)
[66] Exhibit 1, Vol. 1, Tab 5, P92 Identification of Deceased Person - Visual Means (19.11.23)
[67] Exhibit 1, Vol. 1, Tab 6 P98 Mortuary Admission Form (19.11.23)
[68] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (10.10.24)
[69] Exhibit 1, Vol. 1, Tab 2.4, Letters & Email - Mr M Woods (20.11.23, 02.04.24 & 27.11.23
[70] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Smithson (22.10.24), p9 and ts 11.06.25 (Smithson) pp6-14
[71] Exhibit 1, Vol. 1, Tab 2.1, Memorandum - Const. D Trandos (undated), p4

CAUSE AND MANNER OF DEATH

27. Dr Joe Ong (a forensic pathologist) conducted a post mortem examination of Leighton's body at the State Mortuary on 28 November 2020. During his examination, Dr Ong noted Leighton had an increased body mass index in keeping with obesity, and that Leighton's heart was enlarged (cardiomegaly). Leighton's lungs were hyper-inflated and congested which is considered a non-specific finding, and a gallstone was also noted.[72,73]

28. Microscopic examination of tissues showed acute infective changes in both lungs in keeping with bronchopneumonia. Bronchopneumonia is a type of infection affecting the large tubes (bronchi) that carry air from the windpipe (trachea) to the lungs. A specific viral infection was not detected and microbiological testing "*showed mixed growth and did not isolate a specific bacterial organism*".[74]

29. Toxicological analysis found therapeutic levels of chlorpromazine, diazepam, orphenadrine, olanzapine, zuclopenthixol and the opioid, tapentadol, in Leighton's system, along with baclofen and paracetamol. Leighton had a urine alcohol level of 0.01%, but alcohol was not detected in his blood, and the analysis also detected pregabalin in his system at levels above the therapeutic range.[75]

30. Leighton was not prescribed the opioid pain medication, tapentadol, but it is possible he accessed Ms Wood's supply of this medication, as she was prescribed tapentadol and was staying with him at the relevant time. Leighton was not prescribed the muscle relaxant, orphenadrine, or the pain medication, pregabalin, and the source of these medications is unknown.

31. The chemist who conducted the toxicological analysis in this case noted that pregabalin has been known to lower the threshold at which some users may succumb to fatal opioid toxicity.[76]

---

[72] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (10.10.24)
[73] Exhibit 1, Vol. 1, Tab 7.1, Post Mortem Report (28.11.23)
[74] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (10.10.24)
[75] Exhibit 1, Vol. 1, Tab 7.3, Toxicology report (20.09.24)
[76] Exhibit 1, Vol. 1, Tab 7.3, Toxicology report (20.09.24)

32. Dr Ong also noted that some of the medications found in Leighton's system have sedative properties, and when taken together may have an enhanced effect "*potentially resulting in increased sedation with an increased risk of loss of consciousness, which is a risk factor for the development of bronchopneumonia*".[77,78]

33. At the conclusion of his post mortem examination, Dr Ong expressed the opinion that the cause of Leighton's death was "*bronchopneumonia in the setting of combined drug effect"*.[79]

34. I respectfully accept and adopt Dr Ong's conclusion as my finding as to the cause of Leighton's death.

35. Further, on the basis that there is no evidence that Leighton consumed the medications that were found in his system with the intention of taking his life, I find that his death occurred by way of accident.

[77] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (10.10.24), p2
[78] See also: ts 11.06.25 (Mistry), p18 where Dr Mistry discusses Leighton's cardiovascular risk factors related to his drug use
[79] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (10.10.24), p1

QUALITY OF SUPERVISION, TREATMENT AND CARE

36. The evidence establishes that Leighton had complex needs including chronic mental health conditions and regular polysubstance use. He was diagnosed with schizoaffective disorder and anti-social personality disorder, and he received regular depot injections of zucopenthixol.

37. The clinical staff interacting with Leighton did their best to manage his complex needs by a combination of community care, which consisted of regular meetings with his case manager, and periodic reviews by his supervising psychiatrist. Leighton also had several brief inpatient admissions to hospital, and this management approach enabled him to remain in the community in his own home.

38. As noted, Leighton's ongoing polysubstance use was a major impediment to the management of his mental health, and despite regular encouragement from his treating team, this issue was never successfully addressed.

39. I want to acknowledge the support provided by Leighton's father, who provided Leighton with stable accommodation, and maintained regular contact with Leighton's case manager. Not all mental health consumers have this level of family engagement, and Leighton's father is to commended for the support he provided to his son, in often difficult circumstances.[80]

40. Having carefully considered the available evidence, I am satisfied that it was appropriate for Leighton to be managed on a succession of CTOs on the basis that he lacked the capacity to make treatment decisions about his mental health.

41. I am also satisfied that the supervision, treatment, and care that Leighton received while he was the subject of a succession of CTOs was of a good standard. Despite Leighton's often aggressive and abusive manner, Clinic staff, and in particular his case manager continued to provide compassionate and appropriate care.[81]

[80] ts 11.06.25 (Mistry), pp27-30 and ts 11.06.25 (Davidson), pp32-33
[81] ts 11.06.25 (Mistry), p25

CONCLUSION

42. Leighton was clearly a much loved family member who was 44 years of age when he died on or about 18 November 2023, from "*bronchopneumonia in the setting of combined drug effect*". Touching photographs provided to the Court by Leighton's father show Leighton in happier times with his children.

43. Leighton had complex mental health issues, the management of which was complicated by his ongoing polysubstance use. Despite the challenging behaviour Leighton often displayed towards his treating team at the Clinic, the available evidence establishes that Leighton's treating team provided him with compassionate and appropriate care.

44. A police investigation into the circumstances of Leighton's death found "*no evidence of criminality, third party involvement or suspicious circumstances*" and I concluded that the manner of Leighton's death was accident.

45. Finally, as I did at the conclusion of the inquest, I wish to again convey to Leighton's family and loved ones, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner

24 June 2025