CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Leonard John Warwick
Hearing dates:	14 May 2026
Date of findings:	14 May 2026
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Judge Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in Corrective Services NSW custody - - natural causes - whether care and treatment concerns
File number:	2025/00062594
Representation:	Durand Welsh, Advocate Assisting the Coroner G Amal on behalf of the Justice Health and Forensic Mental Health Network H Short of the Department of Communities and Justice, Legal on behalf of the Commissioner of Corrective Services NSW
Non-publication order	A non-publication order has been made pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW) in relation to material contained within the brief of evidence. A copy of this order is on the Registry file.
Findings:	Leonard John Warwick died on 14 February 2025 at the Long Bay Hospital Aged Care and Rehabilitation Unit, Long Bay Correctional Complex, Malabar NSW 2036 The cause of Mr Warwick's death was aspiration pneumonia on a background of advanced vascular dementia. Mr Warwick died of natural causes while in the lawful custody of Corrective Services New South Wales

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1 Introduction

1.1 At the time of his death, Mr Warwick was serving a sentence of life imprisonment without the possibility of parole. He had been in the custody of Corrective Services NSW (**CSNSW**) since 31 July 2015.

1.2 Mr Warwick was diagnosed with advanced vascular dementia, hydrocephalus, type 2 diabetes and hypertension. As his conditions progressed, he required 24-hour nursing care and assistance with all activities of daily living.

1.3 By 6 February 2025 Mr Warwick had deteriorated to the extent that medical staff from Prince of Wales Hospital (**POWH**) put in place a resuscitation plan which specified that no cardiopulmonary resuscitation was to be initiated in the event of cardiopulmonary arrest and further, that he receive no medication except morphine.

1.4 Mr Warwick was returned to Long Bay Hospital for palliative care. He was managed with an open cell door with custodial officers and Justice health staff conducting regular checks for signs of life.

1.5 Between 9 February and 13 February Mr Warwick received daily visits from his family. He died on the morning of 14 February 2025. He was 78 years old.

1.6 Although Mr Warwick's family chose not to participate in the inquest, his records evidence the considerable support his family provided to him during his time in custody. On behalf of the Coroners Court of NSW, I extend my condolences to them for their loss.

2 Why was an inquest held?

2.1 Under the Coroners Act 2009 (**the Act**) a Coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 When a person is sentenced to a term of imprisonment, they are lawfully detained in the custody of CSNSW until their sentence has been served. By depriving that person of their

liberty, CSNSW assumes responsibility for the care of that person as the person is unable to independently take steps to seek medical assistance or other care. The combined effect of sections 23(1)(d) and 27(1)(b) of the Act is that it is mandatory for a Senior Coroner to hold an inquest where a person dies while in, or temporarily absent from, a correctional centre. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that CSNSW has cared for a person in its custody in a reasonable and appropriate way.

2.3 In this case, there is no suggestion that CSNSW cared for Mr Warwick in anything other than a reasonable and appropriate way.

3 Mr Warwick's life

3.1 Leonard John Warwick was born on 24 January 1947 in Helensburgh, New South Wales.

3.2 Mr Warwick had previously worked as a fireman before his retirement.

3.3 He was first married in 1974. He and his first wife had a daughter before they separated in 1979. Mr Warwick later remarried. He had two daughters and a son from his second marriage.

4 Mr Warwick's time in CSNSW custody

4.1 On 29 July 2015 Mr Warwick was arrested and charged with 32 offences relating to alleged offending in the early 1980s. He was refused bail and entered the custody of CSNSW at Amber Laurel Correctional Centre on 31 July 2015.

4.2 On 23 July 2020 Mr Warwick was found guilty of offences arising from the June 1980 shooting murder of Judge David Opas, the April 1984 bombing of the Family Court of Australia at Parramatta, the July 1984 bomb attack on the home of Judge Ray Watson that resulted in the death of his wife, Pearl Watson, and the July 1985 bombing of the Jehovah's Witness Hall in Casula resulting in the death of minister, Graham Wykes, and injury to 13 members of the congregation. Mr Warwick was found not guilty of the February 1980 shooting murder of his former brother-in-law, Stephen Blanchard.

4.3 On 3 September 2020 Mr Warwick was sentenced to life in prison without the possibility of parole.

4.4 Mr Warwick spent his time in custody in several locations including the Metropolitan Remand and Reception Centre, the Metropolitan Special Programs Centre, Cessnock Correctional Centre, Parklea Correctional Centre, Amber Laurel Correctional Centre, Long Bay Correctional Centre and Long Bay Hospital.

4.5 Although he initially found the adjustment to custody stressful, he later reported during interviews that this was no longer an issue for him. Throughout his imprisonment, Mr Warwick required placement in protective custody due to safety concerns and the high-profile nature of his case.

4.6 On 9 December 2020, Mr Warwick was transferred to Long Bay Hospital (**LBH**) Aged Care and Rehabilitation Unit (**ACRU**) due to age and mobility-related issues that required ongoing medical treatment. He remained at ACRU until his death.

5 Mr Warwick's medical history

5.1 Mr Warwick had a medical history that included several degenerative conditions, including advanced vascular dementia, hydrocephalus, type 2 diabetes, and hypertension.

5.2 In December 2020 Mr Warwick was transferred to the ACRU primarily due to mobility issues. This placement was initially temporary, however as time progressed, the placement became permanent. Testing conducted in January 2021 recorded a notable decline in Mr Warwick's cognitive functioning since 2015.

5.3 During 2022 Mr Warwick became increasingly less mobile and by 2023 he had become mostly bedridden and was unable to use both hands. His general health deteriorated significantly. His cognition reduced and he spoke only minimally. Between May and June 2023, it was determined that due to this significant deterioration, palliative care was appropriate. Mr Warwick's children agreed with this determination. He required full-time care, including a hoist and two nursing staff for showering, staff assistance with all meals, and 24-hour nursing care for all activities of daily living.

5.4 Throughout 2024 Mr Warwick's health deteriorated significantly. In April 2024 it was determined that Mr Warwick had advanced dementia and he was managed by the Palliative Care Team and the Allied Health Team. He was receiving occupational therapy and physiotherapy treatment for movement. Mr Warwick had limited communication skills and used gestures as a form of non-verbal communication to answer questions.

5.5 By July 2024 Mr Warwick had become increasingly drowsy and non-responsive to verbal interaction. Although it was often possible to rouse him by verbal commands, he would close his eyes shortly after. It became challenging to provide food and fluids to him. Occasions were noted where Mr Warwick would not open his mouth. During outings in the yard Mr Warwick was moved to a wheelchair. He often slept during his time outside.

5.6 Between 9 December 2020 and 14 February 2025, Mr Warwick was transported to POWH for treatment on six occasions, the last being on 5 February 2025.

6 Events preceding Mr Warwick's death

6.1 On 5 February 2025, Mr Warwick was transported to POWH with respiratory distress and presumed aspiration. Hospital staff contacted LBH advising that Mr Warwick had a terminal illness and could pass away at any time.

6.2 On 6 February 2025, Dr Natasha Hyde established a resuscitation plan specifying comfort care only, with no CPR to be initiated in the event of cardiopulmonary arrest. That afternoon, Mr Warwick was discharged back to LBH for end-of-life care, with an open cell door for continuous monitoring. He received daily family visits from 9 to 13 February 2025, with the last family visit occurring on 13 February 2025, the day before his death.

6.3 By 14 February 2025, Mr Warwick was completely immobile. He engaged in only minimal communication, usually by hand gestures or noises to indicate if he was in pain. In accordance with his comfort care plan, he received no medication except for morphine, which he was given every four hours.

6.4 Nursing staff conducting routine checks found Mr Warwick unresponsive in his cell at approximately 10:40 am. He was declared deceased by Justice Health staff. Detective Valentin Roukchan from Maroubra Police Station attended and reported no suspicious circumstances.

7 The post-mortem examination

7.1 On 24 February 2025, Forensic Pathologist, Dr Lena Quinto, conducted a post-mortem examination. She recommended that Mr Warwick's cause of death be recorded as aspiration pneumonia, with advanced vascular dementia listed as an antecedent cause.

7.2 Dr Quinto listed other conditions contributing to Mr Warwick's death as hypertension, type 2 diabetes mellitus, cerebrovascular accident, normal pressure hydrocephalus, and hypercholesterolaemia.

8 Investigations after Mr Warwick's death

8.1 CSNSW Senior Investigator, Anne Barudi, investigated Mr Warwick's death. This involved a review of Mr Warwick's Case Management File, Case Notes, Warrant File, CCTV and Body Worn Camera footage. She concluded that the overall management of Mr Warwick by CSNSW during his incarceration up to and including his death on 14 February 2025 complied with Departmental policies and procedures, and that existing departmental policies and procedures are considered appropriate.

9 Conclusions

9.1 An inquest is mandatory because Mr Warwick died whilst in the custody of CSNSW. However, unlike most other inquests, no issues apart from the statutory requirements pursuant to section 81 of the Act were identified from the coronial investigation which required discrete examination during the inquest.

10 Consideration

10.1 Having regard to the above, the available evidence establishes the following:

- Mr Warwick was diagnosed with several progressive medical conditions;
- Mr Warwick deteriorated over time and was appropriately transferred to the ACRU at Long Bay Hospital to manage his ongoing medical conditions.
- Mr Warwick was appropriately transferred to POWH when external medical attention was required

- Mr Warwick's family was allowed increased visiting time with him from the point when he was transitioned to end of life care;
- All the care and treatment Warwick received while in custody is recorded in notes kept by Justice Health staff and staff at POWH.

10.2 The evidence establishes that there was no issue or concern regarding the management of Mr Warwick while at POWH or at the ACRU prior to his death.

11 Findings pursuant to s 81(1) of the Act

11.1 I would like to express my thanks to the Officer in Charge, Detective Senior Constable Valentin Roukchan, and Advocate, Durand Welsh, for all the work they have done in investigating this matter and preparing it for inquest.

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

Identity

The person who died was Leonard John Warwick.

Date of death

Mr Warwick died on 14 February 2025.

Place of death

Mr Warwick died at the Long Bay Hospital Aged Care and Rehabilitation Unit, Long Bay Correctional Complex, Malabar NSW 2036.

Cause of death

The cause of Mr Warwick's death was aspiration pneumonia on a background of advanced vascular dementia.

Manner of death

Mr Warwick died of natural causes while in the lawful custody of Corrective Services New South Wales.

11.3 On behalf of the Coroner's Court of New South Wales, I offer my sincere and respectful condolences to Mr Warwick's family.

11.4 I close this inquest.

Judge Kasey Pearce

Deputy State Coroner

14 May 2026