STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Garry Weigand
Hearing dates:	16 November 2017
Date of findings:	16 November 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural cause, bronchopneumonia, arrhythmogenic right ventricular dysplasia, cardiac arrhythmia
File numbers:	2014/307093
Representation:	Mr B Hart, Coronial Advocate assisting the Coroner Ms S Binning for Corrective Services New South Wales Mr M Sterry for Justice Health and Forensic Mental Health Network
Non-publication order:	I direct that, pursuant to section 74(1)(b) of the *Coroners Act 2009*, the following material is not to be published: 1. Tab 11 of the brief of evidence tendered as Exhibit 1 in the inquest on 16 November 2017.
Findings:	I find that Garry Weigand died on 18 October 2014 whilst in lawful custody at the Metropolitan Remand and Reception Centre in Silverwater NSW. Mr Weigand died from a fatal cardiac arrhythmia due to complications from acute bronchopneumonia and arrhythmogenic right ventricular dysplasia. Mr Weigand died from natural causes.

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Introduction

1. Garry Weigand died on 18 October 2014 whilst in lawful custody. He had been placed in custody only 17 days prior to his death after being arrested and charged with an extremely serious offence.

Why was an inquest held?

2. When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

3. Section 23 of the *Coroners Act 2009* (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. This is because when a person is imprisoned or held in lawful custody as a result of allegedly breaching a law, the State, by depriving that person of their liberty, assumes responsibility for the care of that person. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

Garry's life

4. Before going on to set out the findings from the inquest it is appropriate at this point to recognise, and say a few brief words about, Garry's life.[1] Much of the evidence that is gathered in a coronial investigation relates to the final period of a person's life. That final period is often measured in hours, minutes and, sometimes, seconds. That final period is often intensely scrutinised during an inquest. These circumstances rarely allow for much consideration to be given to the (usually) years of life that preceded a person's death, who that person was, and how their death has impacted their family and loved ones. Therefore it is important to recognise the life of that person in some small, but hopefully meaningful, way.

5. Garry was born in Sydney in 1958 to Jill and William Weigand. He and his older sister, Maria Doolan, lived with their parents in the Granville area before later moving to Pearl Beach on the Central Coast.

6. When Garry was 5 or 6 years old he was involved in an incident where he was struck by a motor vehicle whilst crossing the road. Garry suffered a number of injuries and it was later discovered that he had sustained damage to his brain leading to impairment of his intellectual functioning.

7. Garry initially went to Umina Primary School but his family later returned to Sydney due to a change in his father's work. Upon the family's return to the Granville area Garry attended a

[1] I will refer to Mr Weigand by his first name in these findings. No disrespect is, of course, intended to Mr Weigand or his family members.

school which was able to provide specialist assistance with the learning difficulties that Garry had developed due to his brain injury.

8. Some years later, Garry and his parents returned to the Central Coast after his parents bought at house in Budgewoi. According to Ms Doolan, Garry enjoyed life on the Central Coast; he became an enthusiastic member of the local surf club and spent much of his time fishing. Garry also attended a local TAFE in order to improve his literacy skills.

9. Sadly both of Garry's parents passed away some years later. However Ms Doolan and her family had moved to the Budgewoi area by this time and they continued to see Garry regularly and support him. Ms Doolan asked Garry if he wanted to live with her family, but Garry was insistent that he was capable of living independently. Over the following years Ms Doolan continued to visit Garry regularly and proudly discovered that Garry was capably looking after himself and his parents' former house.

10. Sometime in 2002 Ms Doolan noticed a change in Garry's behaviour as he became more forgetful and would repeatedly talk about the same topic. Ms Doolan arranged for Garry to be seen by a specialist physician who informed them that due to Garry's brain injury as a child it was likely that his neurological functioning would deteriorate as Garry grew older.

11. In the years following this, Ms Doolan noticed that Garry began to drink alcohol more frequently and that he began to gamble. Despite having some concerns about Garry's ability to manage his own finances, Ms Doolan saw that Garry was still able to live independently.

Events in 2013 and 2014

12. Sometime in early 2013 Garry met Sandra Deacon at a social event organised by a not-for-profit organisation that engaged with people in the community with intellectual impairment. Garry and Ms Deacon formed a relationship shortly afterwards. Sadly, it appears that the relationship between Garry and Ms Deacon was a volatile one and was an on-and-off type relationship.

13. Sometime in March 2014 Garry began behaving erratically. He made a number of public accusations against Sandra, including that she was using illicit drugs. This erratic behaviour continued into the following month. In late April 2014 Greg Boulton, one of Garry's friends, told Ms Doolan that Mr Weigand was not well. Ms Doolan went to see Mr Weigand and discovered that he appeared to be terrified and repeatedly said that some unnamed people were going to harm him. Mr Weigand also said that he believed that listening devices had been placed in his home and that his phone calls were being monitored.

14. Ms Doolan thought that her brother was suffering from some mental health issues and so she took Garry to Wyong Hospital on 27 April 2014 for treatment. Garry was diagnosed as suffering from paranoid ideations and it was noted that he had been abusing alcohol. He was prescribed anti-psychotic medication.

15. After being discharged from hospital, Ms Doolan and her husband stayed with Garry for several days to make sure that he was well. During this period of time they noticed that Garry's mental well-being appeared to improve. It was also during this time that Garry told Ms Doolan that he had been seeing Ms Deacon regularly and described her as a "bad influence".[2] Garry also said

[2] Exhibit 1, page 335.

that he did not want to see Sandra anymore. According to Ms Doolan, Garry seemed to be somewhat scared of Sandra. Exactly why Garry made these comments, and the reason for this attitude towards Ms Deacon, is unclear on the available evidence. However, it appears that Garry's deteriorating mental condition was likely a contributory factor.

What happened on 30 September 2014 and 1 October 2014?

16. Several of Garry's neighbours noticed that he was behaving erratically during the day on 30 September 2014. They also noticed that the lights at the back of Garry's house remained on late into the night, which was unusual.

17. At about 11:20pm on 30 September 2014, the residents of 152 Scenic Drive, Budgewoi saw Garry in the front yard of their neighbouring house. This house is approximately 500 metres from Garry's address. The residents saw that Garry was dressed only in his underpants and was behaving erratically. The residents contacted the police.

18. Two police officers arrived on the scene at about 11:34pm. They saw that Garry was still in the front yard of the house. They also saw that Garry had what appeared to be blood on his hands and feet. Arrangements were made for an ambulance to take Garry to Wyong Hospital for an assessment, accompanied by one of the police officers.

19. At about 12:10am on 1 October 2014 police officers went to Garry's address. They found the front door open and most of the lights on inside the house. The rear door was also open. At the back of the house the police officers found Ms Deacon, unresponsive, lying at the bottom of a set of steps, with her head resting on the bottom step. It was immediately obvious to the police officers that Sandra was deceased and that she had suffered a number of serious injuries to her head. Paramedics were called. They arrived at the scene at 12:20am and confirmed that Sandra was deceased.

20. After Sandra's body was discovered the police officer who was in the ambulance accompanying Garry to hospital was alerted. The police officer placed Garry under arrest, whilst in the ambulance, and made arrangements for him to be transferred to a police vehicle. Garry was taken to Wyong police station, charged with Ms Deacon's murder, and placed into custody.

Custodial history

21. Due to the serious nature of the offence that Garry had been charged with, the fact that Garry had been placed in custody for the first time, and because he was identified as someone with mental health issues, a Risk Intervention Team (RIT) protocol was initiated. This required Garry to be placed under observation whilst in custody and eventually assessed by a psychiatrist.

22. Garry was initially kept at the Sydney Police Centre in Surry Hills but on 4 October 2014 he was transferred to the Metropolitan Remand and Reception Centre (**MRRC**) in Silverwater. The RIT protocol remained in place until 7 October 2014 when Garry was assessed by a psychiatrist. Following that assessment Garry was placed in a cell on his own and kept under observation whilst waiting to be transferred to the MRRC Mental Health Screening Unit (**MHSU**).

23. On 16 October 2015 Garry was transferred to the MHSU where he was assessed and placed in a cell on his own in the acute area of the unit.

What happened on 18 October 2014?

24. At 3:30pm on 18 October 2014 Garry and the other inmates in the MHSU were locked in their cells for the night. Sometime later Garry was given his evening meal by Corrective Services NSW (**CSNSW**) officers. He told the officers that he felt unwell and, as a result, only ate 2 pieces of fruit and not the rest of his meal.

25. Sometime during the afternoon, before 6:00pm, a Justice Health and Forensic Mental Health Network (**Justice Health**) nurse, Edwin Coronel, and 2 CSNSW officers went to Garry's cell in order to give him his prescribed medication. When they arrived at the cell Garry was standing up and appeared alert, however he told the nurse that he was feeling nauseous. Mr Coronel told Garry that he would come back to see him after he finished his medication rounds.

26. After finishing distributing medication to the other inmates, Mr Coronel went to the dispensary and obtained a bottle of metoclopramide, medication used to treat vomiting and nausea. Mr Coronel and some CSNSW officers returned to Garry's cell sometime between 6:15pm and 6:30pmm and asked him if he was still feeling nauseous. Garry confirmed that he was and Mr Coronel gave him a 10mg tablet of metoclopramide. This was the last occasion that Garry was seen alive.

27. At about 10:50pm a CSNSW officer was carrying out a routine head check in the cell area where Garry was housed. The officer opened a flap on the door to Garry's cell and saw that Garry was lying motionless across his bed, with his feet on the floor and his head resting against the wall. Believing Garry to be asleep, the officer called out Garry's name and knocked on the cell door in an attempt to wake him.

28. When Garry did not respond the officer became concerned and alerted a fellow officer who in turn called Justice Health staff for assistance. An ambulance was called for and arrived on the scene a short time later. However, Garry could not be revived and was later pronounced deceased.

What was the cause of Garry's death?

29. Garry was later taken to the Department of Forensic Medicine at Glebe. Dr Kendall Bailey performed the post-mortem examination on 20 October 2014 and later prepared an autopsy report dated 23 March 2015.[3] In her report Dr Bailey noted that microscopic examination of the lungs revealed widespread acute bronchopneumonia. Dr Bailey ultimately concluded that this was the cause of Garry's death.

30. However, Dr Bailey also noted two other clinical findings from the autopsy. Firstly Dr Bailey found that microscopic changes in the heart (fatty change, fibrosis and focal inflammation) suggested that Garry may have had a condition known as arrhythmogenic right ventricular dysplasia (**ARVD**). This is an inherited heart disease caused by genetic defects of parts of the heart muscle. Dr Bailey explained that ARVD is linked to cardiac arrhythmia (which may cause sudden death) and it could not be excluded as a contributory factor to Garry's death.

[3] Exhibit 1, tab 2.

31. Secondly, Dr Bailey noted that Garry had a reported history of seizures on a background of brain injury as a child, and that he had not been prescribed any anti-epileptic medication. Given these factors Dr Bailey also noted that seizure activity could not be excluded as a contributory factor to death.

32. Given Dr Bailey's findings, an independent expert was briefed to consider the autopsy results and the circumstances of Garry's death. This second issue will be discussed in more detail below. Professor David Bryant, a specialist respiratory physician, was asked to consider these issues and to provide an expert report. Professor Bryant's report dated 19 April 2017[4] was tendered into evidence at the inquest.

33. Professor Bryant noted that Garry was last seen alive around 6:15pm on 18 October 2014 and was discovered to be deceased at 10:50pm, almost 5 hours later. Professor Bryant explained that, in his opinion, it is highly unusual for pneumonia to progress from minimal symptoms (such as the nausea that Garry was complaining of before 6:15pm) to death within a period of about 5 hours.

34. Professor Bryant concluded that the pneumonia which Garry had acquired was progressively fatal, but would not have proved fatal in itself. Given the autopsy findings in relation to possible ARVD, Professor Bryant concluded that it was likely that Garry was suffering from this condition at the time of his death. Professor Bryant explained that if this was the case, the ARVD made the pneumonia severe enough to provoke a sudden and fatal cardiac arrhythmia.[5] As cardiac arrhythmia is a physiological phenomenon it is not possible to demonstrate it at autopsy and there will be no clinical findings to confirm it.

35. **CONCLUSION:** I accept the evidence from Professor Bryant that it would be unusual for the cause of death to be pneumonia alone given the relatively short period of time between the onset of minimal symptoms and eventual death. The autopsy findings support a conclusion, on the balance of probabilities, that Garry was suffering from undiagnosed and untreated ARVD. The combined effects of this condition and the pneumonia that Garry had acquired resulted in Garry suffering a fatal cardiac arrhythmia which caused his death.

Was Garry's care appropriately and adequately managed whilst in custody?

36. As Garry had complained of nausea and general malaise in the hours before his death, the response by Justice Health and CSNSW staff to these complaints needs to be considered and examined. This is done to answer the question of whether appropriate and adequate care was provided to Garry.

37. Professor Bryant was asked to consider this issue. Professor Bryant firstly noted that Garry had had a very high alcohol intake (up to 24 beers a day) prior to entering custody. Professor Bryant explained that heavy alcohol intake is known to suppress the immune system and make persons more susceptible to the risk of respiratory infection.

38. In his report Professor Bryant also noted that in his interactions with Justice Health and CSNSW Garry had none of the symptoms that are usually associated with pneumonia such as cough, fever, breathless and pleuritic chest pain. On this basis Professor Bryant concluded that when

[4] Exhibit 1, tab 25.
[5] Exhibit 1, tab 25, page 5.

Garry was last seen at about 6:15pm by Mr Coronel and the CSNSW officers, Garry had no symptoms to suggest a diagnosis of pneumonia.

39. In Professor Bryant's opinion there was no clinical reason to suspect that Garry was suffering from a serious medical condition. This is because his only symptoms were nausea and lack of appetite, both of which were non-specific. Professor Bryant also noted that when Garry was seen on 9 October 2014 he denied any respiratory symptoms and any past history of asthma, and that a chest examination disclosed no abnormality. In these circumstances, Professor Bryant explained that diagnosing Garry's pneumonia would have been problematic and could only have been done after very detailed examination and a chest x-ray.

40. It appears that Garry's immune system was suppressed by his heavy alcohol use prior to entering custody. This made him more susceptible to respiratory infection which led to acute pneumonia. However, Garry displayed none of the usual symptoms associated with pneumonia during any of his interactions with Justice Health and CSNSW staff and instead was showing only non-specific symptoms.

41. **CONCLUSION:** Based on Garry's presentation on 18 October 2014, and his earlier known medical history, there was no clinical reason for Justice Health or CSNSW staff to suspect that Garry was suffering from a serious medical condition. There was also no clinical reason for Justice Health or CSNSW staff to believe that any further medical investigation on 18 October 2014 was warranted. Therefore, I conclude that the care provided to Garry whilst in custody, particularly on 18 October 2014, was adequate and appropriate. There is no evidence to suggest that any inaction by Justice Health or CSNSW staff contributed to Garry's death.

Findings

42. Before turning to the findings that I am required to make, I would like to thank Mr Peter Bain and Mr Ben Hart, Coronial Advocates, for their assistance with the preparation and conduct of this inquest. I would also like to thank Detective Inspector Garry James, the officer-in-charge of the police investigation.

43. The findings that I make under section 81(1) of the Act are as follows:

Identity
The person who died was Garry Weigand

Date of death
Garry died on 18 October 2014.

Place of death
Garry died whilst in lawful custody at the Metropolitan Remand and Reception Centre in Silverwater NSW.

Cause of death
Garry died from a fatal cardiac arrhythmia due to complications from acute bronchopneumonia and arrhythmogenic right ventricular dysplasia.

Manner of death

Garry died from natural causes.

Epilogue

44. Tragic events led to Garry being placed in custody and his death, 17 days later, was itself a tragic event. On behalf of the Coroner's Court I extend my condolences to Garry's family and loved ones for their loss.

45. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
16 November 2017
NSW State Coroner's Court, Glebe