OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Wayne Barry MATSCHOSS**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Brisbane
FILE NO(s):	COR 2654/04(1)
DELIVERED ON:	**13 March 2006**
DELIVERED AT:	Brisbane
HEARING DATE(s):	6 March 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: Inquest, Death in Custody, Natural Causes
REPRESENTATION:	

Counsel Assisting:	Detective Inspector Gil Aspinall
Department of Corrective Services:	Ms Annie Little

Findings of the inquest into the death of Wayne Barry Matschoss

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The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system. These are my findings in relation to the death of Wayne Barry Matschoss. They will be distributed in accordance with the requirements of the Act.

Introduction

Wayne Barry Matschoss was 60 years of age, when he was died in the custody of the Department of Corrective Services, whilst he was an inpatient at the Rockhampton Base Hospital on Wednesday, 27 October 2004.

These findings seek to explain how that occurred.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because when he died, Mr Matschoss was in the custody of the Department of Corrective Services under the *Corrective Services Act 2000*, his death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, the coroner is required to find:-

- whether the death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as there is no contention around that issue in this case I need not seek to examine those authorities here with a view to settling that question. I will, however, say something about the general nature of inquests.

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[1] See s10

[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state corners or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future[4]. However, a coroner must not include in the findings or any comments or recommendations or [5]statements that a person is or maybe guilty of an offence or civilly liable for something.[6]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate".* That doesn't mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[7]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Brigenshaw* sliding scale is applicable.[8] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[9]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[10] This means that no findings adverse to the interest of any party

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[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5]
[6] s45(5) and 46(3)
[7] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[8] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[9] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[10] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[11] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

Immediately after Mr Matschoss passed away, Sergeant Hayden Lenz of the Queensland Police Service's Corrective Services Investigation Unit was directed to conduct a "*death in custody*" coronial investigation.

All relevant witnesses were interviewed and statements obtained and exhibits collected. On 29 October 2004, an autopsy was conducted by Dr Nigel Buxton, a forensic pathologist at the Rockhampton Base Hospital.

I am satisfied that the investigation was competently undertaken and sufficiently thorough.

The Inquest

An inquest was held in Brisbane on Monday, 6 March 2006, Detective Inspector Aspinall was appointed to assist me. Leave to appear was granted to the Department of Corrective Services.

Prior to the inquest, a copy of the police investigation report was provided to Mr Matshoss' sister, Christine Matschoss. She advised that neither she nor any other family member wished to attend the inquest and that there were no issues they wanted raised during the hearing.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

I determined that the evidence contained in those materials was sufficient to enable me to make the findings required by the Act and that there was no other purpose which would warrant any witnesses being called to give oral evidence.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Background

Mr Matschoss never married and he has no known children. His nearest family member is his sister, Christine Diane Matschoss of Yeppoon.

[11] (1990) 65 ALJR 167 at 168

Custody

On 20 April 2004, Mr Matschoss was sentenced to three years imprisonment to be suspended after he had served twelve months. He was due for release on 19 April 2005. Unfortunately, he passed away before his release.

Medical issues

Throughout his period of incarceration Mr Matschoss was frequently in need of medical attention. Indeed, on the date of his initial reception, he was located on the floor next to his bed by nursing staff and had sustained a small laceration to the back of his head. He was transferred to the Rockhampton Base Hospital and returned to the Correctional Centre on 22 April 2004 after being diagnosed by Doctor Whitchurch a suffering an epileptic fit.

Further, he had a history of cardiac disease - he had three heart attacks in 1980, and suffered from frequent chest pains and shortness of breath. He had been a heavy smoker for fifty years. He had suffered from epilepsy, which was controlled by medication. He also suffered from neurological problems resulting from a self-inflicted gunshot wound to the head in 1994. He had a history of being a heavy drinker of alcohol. It can be readily accepted that when Mr Matschoss went into prison, he was not a well man.

Events leading up to the incident

On 12 October 2004, Mr Matschoss was admitted to the Medical Centre at the prison because he was having trouble breathing and was regurgitating phlegm. His pulse and respiratory rates were elevated. His oxygen saturations levels were below normal. He appeared to have a chest infection and was dehydrated.

He was reviewed later that date by Doctor Moore and diagnosed to be suffering from right mid and lower lobe pneumonia.

The Queensland Ambulance Service was called and Mr Matschoss was transported to the Rockhampton Base Hospital

The decline and death of Mr Matschoss

On 12 October 2004, Mr Matschoss was admitted to the Medical Ward, Rockhampton Base Hospital, and treated with intravenous antibiotics.

During the evening of 13 October 2004 his condition deteriorated and he was given breathing assistance and transferred to the Intensive Care Unit.

On 14 October 2004 he continued to deteriorate. He was intubated and ventilated by medical staff.

On 15 October 2004 Doctor CHAPMAN reviewed him and as a result his next of kin were advised that his survival chances were slim.

On 17 October 2004, he underwent a bronchoscopy.

On 19 October 2004, a tracheostomy was performed on him to assist with his breathing.

On 20 October 2004, he had a new central venous catheter replaced and a noradrenalin infusion was commenced.

On 24 October 2004 he underwent a surgical examination of his tracheostomy due to persistent bleeding.

On 25 October 2004, he was treated for a heart condition.

On 26 October 2004, his condition deteriorated considerably.

On 27 October 2004, Doctor Chapman spoke to Mr Matschoss's next of kin and advised that the medical consensus was not to prolong his life and to withdraw medical attention. His sister agreed. He was pronounced deceased at 1.05pm. His sister and a Minister were in attendance when Mr Matschoss passed away.

Autopsy results

Forensic Pathologist, Doctor Nigel Buxton conducted an autopsy examination at the Rockhampton Mortuary on 29 October 2004. He advised that, in his opinion, Mr Matschoss died from natural causes namely "*bronchopneumonia as a result of or secondary to cerebral haemorrhage*". Contributing to death was severe chronic bronchitis and bronchiectasis. These conditions were found to be longstanding as evidenced by the development of low grade pulmonary hypertension and chronic venous congestion affecting the liver.

Conclusions

A thorough investigation has been conducted into the circumstances of this death. It, coupled with the autopsy, revealed that Mr Matschoss passed away peacefully from natural causes namely heart failure, whilst resting on his bed, in this presence of his sister and minister of religion.

The investigation has revealed no suspicious circumstances concerning this death.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. I have already dealt with this last aspect of the matter, the manner of the death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Wayne Barry Matschoss

Place of death – He died whilst in the custody of the Department of Corrective Services at the Rockhampton Base Hospital at Rockhampton, Queensland.

Date of death – Mr Matschoss died on 27 October 2004

Cause of death – He died from natural causes namely "*bronchopneumonia as a result of or secondary to cerebral haemorrhage*". Contributing to death was severe chronic bronchitis and bronchiectasis.

Comments and recommendations

Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

I find that none of the correctional services personnel, medical staff, inmates or medical personnel at the Rockhampton Base Hospital caused or contributed to the death. I find that the Corrective Services authorities and the staff at the Rockhampton Base Hospital provided Mr Matschoss with an appropriate level of care and treatment whilst he was in their custody and that, under the circumstances, nothing could have been done to save Mr Matschoss, who died from natural causes.

In those circumstances there are no preventive recommendations that can be made. I close the inquest.

Michael Barnes
State Coroner
Brisbane
13 March 2006