QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Mario Emmy TYSSEN** |
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Brisbane |
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| FINDINGS OF: | Mr Michael Barnes, State Coroner |
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REPRESENTATION:

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| Counsel Assisting: | Detective Inspector Gil Aspinall |
| Department of Corrective Services: | Ms Kim Villis |

**Findings of the inquest into the death of Mario Emmy Tyssen**

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 Mario Emmy Tyssen. They will be distributed in accordance with the requirements of the Act.

## *Introduction*

Mario Emmy Tyssen was 45 years of age, when he died at 147 Staiers Road, Mungar via Maryborough whilst gardening on Friday, 3 December 2004. At the time, he was in the custody of the Department of Corrective Services, however he was on a 72 hour "leave of absence order" as part of his Re-integration Program to return to the general community.

These findings seek to explain how the death occurred and consider whether any changes to the practices or procedures of the Department of Corrective Services would reduce the likelihood of similar deaths occurring in future.

## *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 Tyssen 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.

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]

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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

[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

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 statements that a person is or maybe guilty of an offence or civilly liable for something.[5]

**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.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] 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.[8]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] 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*

Once it was established that Mr Tyssen had passed away, Plain Clothes Constable Melissa Collins of the Queensland Police Service's Corrective Services Investigation Unit was directed to conduct a "death in custody" coronial investigation.

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[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *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
[10] (1990) 65 ALJR 167 at 168

On 7 January 2004, an autopsy was conducted by Dr Paul Anderson at the Maryborough Hospital Mortuary.

I am satisfied that the investigation was competent and sufficiently thorough.

## *The inquest*

An inquest was held in Brisbane on Tuesday, 9 January 2007. Detective Inspector Aspinall was appointed to assist me. Leave to appear was granted to the Department of Corrective Services.

A copy of the police investigation report was provided to Mr Tyssen's wife, prior to the inquest. She advised Inspector Aspinall that the family did not wish to attend the inquest. The only issue raised by Ms Tyssen was her concern that the Department of Corrective Services had failed in their "duty of care" to her husband in failing to diagnose and treat her husband for his cardiac problems, coupled with her ongoing concern that the Department was also failing in their "duty of care" to other prisoners and their families in similar circumstances. I will address this issue later in these findings.

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

I determined that the evidence contained in these 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 family indicated that they did not wish to challenge or examine any of the witnesses' versions as contained in the documents, which have been tendered.

## *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 Tyssen was born in Antwerp, Belgium on 3 July 1959 and emigrated to Australia in 1972. His father is deceased. His mother still resides in Belgium.

Mr Tyssen's immediate family consisted of his wife, Debra Ann Tyssen and their four children aged 15 to 21 years of age. At the time of his incarceration, Mr Tyssen was separated from his wife, who was and still resides in Victoria. Three of their children live in Victoria, whilst the remaining child resides in Bundaberg.

### Custody

On 6 February 2004, Mr Tyssen was remanded in custody to the Maryborough Correctional Centre in connection with fraud charges then pending against him.

On 30 April 2004, Mr Tyssen was sentenced in the Maryborough District Court to a term of two (2) years imprisonment for dishonesty and fraud charges as well as for a breach of a suspended sentence imposed on him in 1999. He was due to be released on 4 February 2006, but died before this could occur.

## Medical issues

The medical issues are particularly important in this matter especially given the concerns held by Mr Tyssen's wife.

The Department of Corrective Services maintains one (1) medical record for each prisoner, which follows the prisoner in the event of movement from one facility to another. This medical record is reactivated when a prisoner re-enters the system.

Mr Tyssen's medical records held by the Department of Corrective Services were examined as part of the police investigation.

Mr Tyssen first came into Department of Corrective Services custody on 22 March 1996. He did not report any cardiac problems.

In 1999 when he was 40, Mr Tyssen was diagnosed with Type 2 Diabetes, which was noted as controlled by diet and Metformin medication.

On 6 February 2004, when Mr Tyssen was received at the Maryborough Correctional Centre his reported medical conditions included high blood sugar levels. He did not disclose any suspected cardiac disease or problems.

His medical records indicate, when received at Maryborough, Work Outreach Camp Program, [WORC Program], he was being administered Metformin and Brufen. Metformin being a medicine used to treat Type 2 diabetes mellitus, whilst Brufen is used for its analgesic and anti-inflammatory action for pain and inflammation.

On 8 October 2004, when received at the Darling Downs Correctional Centre, in response to a question, "*Do you have any current health problems?"* Mr Tyssen replied "*Type 2 Diabetes*". In doing so, he confirmed details of his medication. Again, he made no mention of his cardiac problems and advised that he was fit to perform manual work.

On 9 September 2004, at the Darling Downs Correctional Centre, Mr Tyssen replied in the negative to a question on the Reception Form "*Do you have any other comments about your physical, mental or emotional Health?"* He did however advise that his medical problems extended to be "*Diabetic, Headaches*" and nominated his current medication. Once again he confirmed that he was fit for manual work and made no mention of any cardiac problems.

Mr Tyssen's Medical Progress Notes make no mention of any cardiac disease or treatment. Whilst in custody, he received regular reviews by visiting medical officers. There is no record of Mr Tyssen reporting any symptoms of cardiac disease on any of the occasions he was examined by a visiting medical officer.

Additionally, there is no record of Mr Tyssen reporting cardiac disease symptoms to anyone else whilst he was in the custody of the Department of Correctional Services, although he had many opportunities to do so. It may well be that he suffered no detectable symptoms prior to the day of his death.

## Events leading up to the incident

On November 2004, when Mr Tyssen was in custody at the Wacol Correctional Centre, he applied for re-integration leave to attend his parents-in-law's residence at 147 Staiers Road, Mungar, via Maryborough. He was subsequently granted a 72 hour leave of absence order.

On 2 December 2004, Mr Tyssen travelled by bus from Brisbane to Maryborough to undertake the approved leave. He was required to return to the WORC Program at Wacol Correctional Centre by 9am on 5 December 2004.

When he arrived at Maryborough, he was collected by his mother-in-law, Mrs Hawken and transported to the family property at Mungar. Whilst with the Hawken family and prior to his death, Mr Tyssen showed no signs of ill-health and appeared to be "healthy and happy".

## The incident

On the afternoon of 3 December 2004, Mr Tyssen commenced working on his own instigation in the garden. After about 30 minutes work, at about 3.00pm he requested Mrs Hawken to provide him with an extension cord. She left him to retrieve the cord. At this time, Mr Tyssen was using a grass trimmer. She later returned and found him slumped on the ground unconscious, with the grass trimmer lying nearby.

Mrs Hawken immediately called for her husband and son to treat Mr Tyssen, whilst she called Queensland Ambulance Service for assistance at 4.15pm. The paramedics were dispatched at 4.15pm and arrived on scene at 4.29pm. Mr Tyssen did not regain consciousness and a decision was made at 4.35pm to cease resuscitation, as it was obvious that he had died.

Police were notified and attended the scene. Mr Tyssen was transported to the Maryborough Hospital Mortuary for the purpose of an autopsy.

## Autopsy results

An autopsy was conducted on Mr Tyssen's body at the Maryborough Hospital Mortuary by Doctor Paul Anderson, who advised that, in his opinion, Mr Tyssen died as a result of natural causes namely *Coronary Artery Disease* due to or as a consequence of *Severe Atherosclerosis*. In other words, Mr Tyssen died as a result of heart failure.

As previously noted Mr Tyssen suffered from Type 2 Diabetes Mellitus, but according to Dr Anderson there is no evidence that this contributed to his death.

There was no evidence of any suspicious circumstances or third party involvement in the death detected as autopsy.

## Independent expert medical advice

As a result of the concerns raised by Mr Tyssen's wife that the Department of Corrective Services had failed in its "duty of care" to her husband and was continuing to do so in relation to other prisoners, I engaged an independent medical expert, Doctor Kenneth Hossack, a cardiologist, to review the coronial file,

together with Mr Tyssen's medical records held by the Department of Corrective Services [DCS] and by the Maryborough Hospital, and to provide a report.

In his report, Doctor Hossack identifies a number of matters, which are relevant to this Inquest.

Mr Tyssen's first recorded heart related problem was on 22 May 1996, when he was admitted to the Redcliffe Hospital with chest pains. He discharged himself the following day. He subsequently lost weight, however continued smoking after being advised to cease. He was also advised to have blood sugar level checks and have a repeat exercise test in a year's time, which he does not seem to have done.

On 3 January 2002, Mr Tyssen presented at the Maryborough Hospital with chest pain. His blood sugar levels were "significantly elevated". Even though he had diet controlled diabetes, records indicate limited compliance with his diet to help control his diabetes. His cholesterol levels were also elevated, so much so, that arrangements were made for him to see the diabetic educator and dietician. He was again advised to stop smoking, but advised that he did not believe he could comply with this advice.

On 6 February 2004, Mr Tyssen was remanded in the custody of the Department of Corrective Services and transported to the Maryborough Correctional Centre.

On 12 March 2004, Mr Tyssen was examined by the Visiting Medical Officer at the Maryborough Correctional Centre. His blood sugar levels were elevated and he was provided with medication and advice on diet and physical exercise.

On 8 September 2004, Mr Tyssen denied any medical problems and his blood sugar was at an acceptable level.

On 9 September 2004, Mr Tyssen signed a Department of Corrective Services document wherein he advised that his only current medical problems were diabetes and headaches and that he was taking prescription medication for these conditions. In response to a specific question "Do you have any other comments about your physical, mental or emotional health?" Mr Tyssen wrote "No".

On 8 October 2004, Mr Tyssen was on prescription medication three times a day, however he had then recently missed doses.

Dr Hossack does not consider that the effort involved in performing the gardening at the time of his death contributed to Mr Tyssen's death. However, he does note that when Mr Tyssen was taken into custody in 2004, he had suboptimal control of risk factors for heart disease in that he was smoking and had poorly controlled diabetes. He had also failed to self-report his cardiac symptoms.

Significantly, Dr Hossack advised that, in his opinion, there were no features documented during his incarceration that would predict that Mr Tyssen was at risk of unexpected death.

Dr Hossack's report does not identify a failure by the Department of Corrective Services, insofar as their "duty of care" to Mr Tysson, is concerned. However, it does identify that Mr Tyssen died as a result of advanced coronary artery disease, which was contributed to by a number of risk factors including family history of ischaemic heart disease, poorly controlled diabetes, smoking and hyperlipidaemia (high level of cholesterol).

## *Conclusions*

The police investigation, coupled with the autopsy, revealed that Mr Tyssen passed away from natural causes, whilst gardening. Once he suffered the heart attack the medical prognosis was that his death was quick and not preventable.

I find that Corrective Services staff did all within their power, with the available information provided by Mr Tyssen, to provide appropriate medical assistance and treatment to him, whilst in custody.

In my view, as the Department of Corrective Services was not informed by Mr Tyssen of his cardiac problems, it is not reasonable to expect it to undertake further tests or investigations on the off chance that he could have any number of unknown medical conditions.

This situation also translates to the general community, where persons who are examined by general practitioners or at hospitals are only treated or tested for the conditions and/or symptoms that they report.
I am satisfied on the evidence provided that the Department of Corrective Services has fulfilled its "duty of care" obligations to Mr Tyssen given that they were not advised by him of his cardiac condition and could not reasonably have been expected to otherwise identify his cardiac condition. I am also satisfied that the Department of Corrective Services complied with their Offender Management Procedure as contained in Section 3.2, insofar as endeavouring to identify any medical problems.

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 Mario Emmy Tyssen

**Place of death** – He died in the custody of the Department of Corrective Services, whilst on approved "Leave of Absence Order" at 147 Staiers Road, Mungar, via Maryborough.

**Date of death** – Mr Tyssen died on 3 December 2004.

**Cause of death** – He died from natural causes namely coronary artery disease due to or as a consequence of severe atherosclerosis.

I also find that no one in the Department of Corrective Services or any of the Visiting Medical Officers contributed to the death and that, under the circumstances, nothing could have been done to save Mr Tyssen, who quickly and unexpectedly passed away from natural causes.

## *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.

Under the circumstances, I do not consider it necessary to make any comments or recommendations pursuant to Section 46(1) of the Coroners Act 2003.

Michael Barnes
State Coroner
Brisbane
19 January 2007.