CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF MATTHEW BENJAMIN HOLDING

[2026] SACC 6

Inquest Findings of her Honour Deputy State Coroner Roper

13 March 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man serving a sentence of imprisonment in respect of the murder of his mother and grandmother. The inquest explored the cause of his sudden death and the adequacy of the initial first aid response.

Held:

1. Matthew Benjamin Holding, aged 44 years of Cadell, died at Cadell Training Centre on 2 January 2023 as a result of an unascertained cause.

2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MS R SCHELL
Hearing Date/s: 05/09/2025
Inquest No: 22/2025 **File No/s: 0024/2023**

INQUEST INTO THE DEATH OF MATTHEW BENJAMIN HOLDING [2026] SACC 6

1 Matthew Benjamin Holding was born on 1 March 1978. He died at the Cadell Training Centre on 2 January 2023 at the age of 44 years.

2 As Mr Holding died in custody, an inquest into the cause and circumstances of his death is mandatory. These are the findings of that inquest.

Background

3 Mr Holding spent his formative years in Fairview Park, before moving with his family to Oakbank when he was 11 years old. He had a troubled relationship with his mother but enjoyed a positive relationship with his father. He had one brother and three paternal half-siblings. Mr Holding left the family home at 15 years old following a dispute with his mother. He ceased attending high school at that time and became involved in juvenile offending and drug and alcohol use.

4 After leaving school Mr Holding worked as a labourer, vineyard worker and shelf-stacker at the local supermarket. Unfortunately, he developed an addiction to heroin, which led to a period of unemployment. With the assistance of his father, however, Mr Holding abstained from heroin use for a time and gained employment with his half-brothers at an earthmoving company in Alice Springs. He later returned to Adelaide where he resumed illicit drug use.

5 On 18 September 2000, Mr Holding had an argument with his grandmother as she had refused his request for a cigarette. He violently assaulted her, and then his mother when she entered the room. He killed them both, cleaned the house and buried their bodies in a quarry, where they remained undiscovered until 9 and 10 October 2000.

6 On 19 September 2000, Mr Holding was arrested. He was promptly transferred to James Nash House due to concerns regarding his mental state. He was assessed by a psychiatrist and diagnosed with schizophrenia.

7 Mr Holding pleaded guilty to two counts of Murder. On 10 November 2001 he was sentenced to life imprisonment, with a non-parole period of 18 years. Although his non-parole period expired on 17 September 2018, his application for parole was refused.

8 Mr Holding was therefore in the lawful custody of the Department for Correctional Services at the time of his death on 2 January 2023. As his death was sudden, and he was only 44 years old, the inquest examined the standard of medical care he received in custody, and whether the first aid response was adequate. Extensive investigations were also undertaken in an effort to determine the cause of his death.

Was Mr Holding's health adequately managed while he was in custody?

9 Throughout his time in custody Mr Holding was accommodated at various prisons and health facilities, with most of his time spent at the Cadell Training Centre. This facility is managed by the Department for Correctional Services, and his healthcare while at the Cadell Training Centre was provided by the South Australian Prison Health Service.

10 Mr Holding disclosed no known physical health conditions at the time he was remanded in custody. Following his schizophrenia diagnosis he was managed with various antipsychotic medications over the 22 years of his incarceration. The details of his early management for schizophrenia are not relevant to the issues requiring determination and will not be set out in these findings.

11 By August 2018, it had become evident that Mr Holding's illness met the criteria for treatment-resistant schizophrenia. His psychiatrist Dr Lim responded by increasing Mr Holding's dose of olanzapine, an antipsychotic medication. This was added to his ongoing regimen of intramuscular risperidone.

12 Dr Lim continued to monitor Mr Holding over the next four years. By December 2021 he considered Mr Holding's schizophrenia to be in remission. The increased dose of olanzapine appeared to have significantly improved Mr Holding's mental state and Dr Lim considered he was as stable as he could be.

13 However, while in custody, Mr Holding's weight increased significantly. His recorded weight following his incarceration was 60 kg. At the time of his death, Mr Holding weighed 129 kg with a body mass index of 41.6, putting him in the 'morbidly obese' category. This led to difficulties with his breathing which prompted a consultation with Dr Brunner on 16 August 2018 about possible sleep apnoea. However, Mr Holding declined to discuss the issue during the consult and refused Dr Brunner's recommendation to use a Continuous Positive Airway Pressure machine, commonly known as a CPAP.

14 Dr Brunner also monitored Mr Holding's cholesterol, which was high in October 2020. Dr Brunner prescribed simvastatin to manage this issue.

15 By 5 December 2022, Mr Holding's weight was 128 kg. An electrocardiogram was performed, which indicated normal electrical functioning of the heart. Mr Holding was advised to use a nasal spray to assist with his nasal breathing, but he declined to do so. It was hypothesised that Mr Holding's weight increase may have been related to the prohibition against smoking in prisons which occurred in 2019, as Mr Holding had been a heavy smoker of rolled cigarettes prior to that.

16 On 6 December 2022, Mr Holding was transferred back to the Cadell Training Centre from Mobilong Prison. He was assigned a single cell due to the severity of his snoring.

17 Mr Holding was employed in the kitchen as a pot washer. He had previously worked in the kitchen from 2016-2018, and was well-regarded by his supervisor, Mr Work. Mr Work provided an affidavit to the Court regarding his interactions with Mr Holding over the years.

18 Mr Work considered Mr Holding to be a fast learner with a good sense of humour. He engaged with Mr Holding about prison life as he was aware that Mr Holding had no contact with the world outside of the prison. Mr Work noticed that Mr Holding was overweight in 2016-2018 but had become obese by the time he returned to the Cadell Training Centre in 2022. He estimated that Mr Holding's weight had increased by 10-15 kg and noticed that he would sit down and fall asleep halfway through his shift, and would sometimes fall asleep while holding cake or a coffee in his hand. He became more difficult to communicate with due to his sleepiness, and seemed to be perspiring more than he had during his previous period of employment in the kitchen. Mr Work

advised the prison nurse on 31 December 2022 that Mr Holding was falling asleep during his breaks.

19 A fellow prisoner, TW, also provided the Court with an affidavit in which he outlined his observations of Mr Holding's physical condition over the 10 years he had known him. TW observed that Mr Holding had always been a bit sleepy, which he attributed to his medication. However, TW observed that Mr Holding's drowsiness became 'very bad' in the last weeks of his life. TW stated that Mr Holding would fall asleep during conversations and his speech was mumbled.

20 On 9 December 2022, registered nurse Ms Rice-Tilbrook attended upon Mr Holding at 9:21 pm to administer his risperidone. She conducted a comprehensive assessment and became concerned due to his low oxygen saturation. She telephoned the on-call doctor who recommended that Mr Holding be transported to hospital via ambulance. However, Mr Holding refused, despite being advised multiple times that he was at risk of death. Mr Holding signed an acknowledgement of medical advice form confirming his refusal to follow medical advice to attend hospital. The note appears as follows:

ACKNOWLEDGEMENT OF MEDICAL ADVICE

(MR82C)

Affix patient identification label in this box

Surname: HOLDING
Given: Matthew Benjamin
DCS Id: 111693
D.O.B: 01/03/1978
Admit: 20/09/2000

Hospital: CTC

D.O.B: __/__/____ Sex:

Patient or the parent of the patient to tick the boxes on the side of the form to affirm the following:

SECTION 3. REFUSAL OF TREATMENT

I Matthew Holding
(First or given names) *(Surname)*

refuse for myself/~~my child***~~
(First or given names) *(Surname)*

to undergo the following procedure(s)/treatment (specify): to be transfeured to Waikerie District Hospital, for review and monitoring of low oxygen Saturations. Pt's Saturation is between 89-91%.

for the following reasons (specify): cause I want get a good sleep and it is stressful "I have a broken nose" Dont want to go to Hospital

21 Due to ongoing concerns for his health, medical staff organised for correctional services officers to check on Mr Holding every 30 minutes, and for him to return for an in-person review in the morning.

22 By the morning of 10 December 2022, Mr Holding's oxygen saturation had risen to 97%. His saturation remained at a similar level throughout 12 December 2022.

23 On 13 December 2022, Mr Holding consulted with Dr Tom Turnbull, who at that time was the Medical Director of the South Australia Prison Health Service. Mr Holding spoke of trouble sleeping, a previous broken nose and a long period of smoking cigarettes. Dr Turnbull measured Mr Holding's oxygen saturation and found that it was low (90-91% on room air). Mr Holding repeated his refusal to use a CPAP machine, explaining that he had a phobia of wearing the apparatus. Dr Turnbull referred Mr Holding for spirometry, a test to measure lung function and potentially diagnose chronic obstructive pulmonary disease. Dr Turnbull also acknowledged Mr Holding's weight increase and suggested that he increase his physical activity.

24 A spirometry test was arranged to be performed at the Waikerie Medical Centre on 13 January 2023. However, on 1 January 2023, Mr Holding's health declined rapidly, and he passed away the following day.

25 Mr Holding's health was obviously deteriorating in December 2022. This was noted by Mr Work, a fellow prisoner, and by medical staff of the South Australia Prison Health Service. The concerns surrounding his drowsiness had been longstanding, with nasal congestion being observed as early as July 2018. However, Mr Holding had declined to follow medical advice to use a CPAP machine, which may have assisted in improving the quality of his sleep and reducing his daytime fatigue, which was increasingly problematic. The use of a CPAP was suggested and refused on 16 August 2018, 5 December 2022 and 13 December 2022.

26 Mr Holding's need for further investigations in hospital was recognised by the medical staff. Unfortunately, Mr Holding refused, as he was entitled to do. I am satisfied, based on the documentation before me, that Mr Holding was provided with sufficient information to enable him to make an informed decision as to his medical treatment. There is no suggestion that Mr Holding had impaired decision-making capacity such that an order compelling treatment ought to have been sought. I find that Mr Holding was entitled to make the informed decision he made to refuse medical treatment on 9 December 2022.

27 In conclusion, the general management of Mr Holding's physical and mental health by the South Australia Prison Health Service was adequate, insofar as it could be given his refusal of medical advice.

What occurred in the lead up to Mr Holding's death on 2 January 2023?

28 Sometime between 3 am and 4:30 am on 1 January 2023, Mr Holding's cell neighbour TW heard a loud bang from Mr Holding's cell. TW yelled out to ask if he was alright, to which he replied that he was.

29 The following morning, Mr Holding explained to TW that he had fallen asleep while standing on top of his TV cabinet and landed on his desk. He said had been standing on the cabinet to investigate whether a power point located high up in his cell was working. He had some swelling to one side of his face.

30 Mr Holding attended work in the kitchen as usual on 1 January 2023. Mr Work stated that there was nothing different about Mr Holding during his shift. TW observed that Mr Holding was falling asleep during his shift, as usual. TW reported to Mr Work that he was concerned about Mr Holding falling asleep all the time.

31 It appears that Mr Work notified the health centre, as just prior to 8 pm the registered nurse on duty was approached by two correctional officers asking her to see Mr Holding. At this time Mr Holding was refusing to attend the health centre. The officers reported that Mr Holding had fallen the previous evening in his cell.

32 Shortly thereafter Mr Holding was escorted to the Health Centre by the officers, and entered with complaints of a sore tooth. When assessed, Mr Holding was making snorting noises and fell asleep multiple times during the consultation, which was apparently not out of the ordinary for him. He denied any issues with his breathing, although his oxygen saturation was low. When asked about his fall, Mr Holding reported that he had sustained no injuries and had not hit his head.

33 His left check was observed to be extremely swollen. The nurse checked his airway and there was no apparent compromise. The on-call doctor was contacted, who prescribed antibiotics and a mouth wash.

34 Mr Holding was advised that emergency dental work the following day may be required. He agreed. Mr Holding was told to inform officers if he experienced any shortness of breath or his condition deteriorated. The nurse observed Mr Holding take his antibiotics and advised him that she would keep the medication in the clinic to allow her an opportunity to review him twice daily when he attended to take it. She also sent an email to corrections staff advising them that Mr Holding had been unwell and that an ambulance should be called if he was having trouble breathing, or if he felt his condition was deteriorating.

35 At 1:30 am on 2 January 2023, Mr Holding was seen by the correctional staff supervisor, Ms Armstrong, to be standing in his cell with a plastic bag full of clothes. He told Ms Armstrong that he was packing because he was going to be transferred the following day. Presumably, this related to his dental appointment.

36 A prison count was conducted at 3:30 am and Ms Armstrong saw that Mr Holding was awake and sitting on his bed. She asked if he was ‘okay’, and he responded that he was.

37 Just after 5 am, Mr Holding rang the intercom and asked to be allowed to go for a shower as he had been cleaning. He was told to wait until the usual time of 7 am. He sat down on his bed.

38 At 5:30 am, Ms Armstrong saw Mr Holding sitting on his bed. He appeared to be asleep sitting up. She tapped the glass of the door and asked Mr Holding if he was okay. He said ‘yes’. This was the last time Mr Holding was seen alive.

39 Just prior to 6:40 am, Ms Armstrong received a call on her radio to advise that there was liquid underneath Mr Holding’s cell door. She attended and looked through the glass viewing panel, where she saw Mr Holding sitting on the floor with his back against the door. She knocked on the glass of the door, but there was no response. This event was captured by Closed Circuit Television (CCTV) which enabled timing to be confirmed with precision. Ms Armstrong opened the door at 6:41 am in the company of two other correctional officers. She saw that Mr Holding was completely unresponsive.

40 Ms Armstrong entered the cell at 6:42 am. Mr Holding was physically removed from his cell at 6:43 am through the combined efforts of the three staff members. Cardiopulmonary

resuscitation was commenced at 6:44 am after it was ascertained that Mr Holding did not have a pulse. Ms Armstrong left the scene and returned with the automatic defibrillator at 6:45 am. The device did not detect a heart rhythm. Resuscitative efforts continued until the arrival of the ambulance officers at 7:06 am. Despite the collective efforts of everyone present, Mr Holding was pronounced life extinct at 7:25 am.

The coronial investigation

41 A coronial investigation commenced immediately, which included the attendance of a crime scene investigator, Brevet Sergeant McKay, who took photographs of the cell and of Mr Holding. Within the cell, there was a plastic kettle lying open on its side along with empty cordial bottles in the sink. There were also shampoo bottles on the floor. The liquid on the floor, which initially drew the attention of correctional officers to Mr Holding's cell, was sticky to touch in places. The substance was not identified.

42 Detective Brevet Sergeant Rivett was appointed as the investigating officer in relation to the coronial investigation of the death of Mr Holding. She produced a detailed report which included an account obtained from TW, in which TW expressed concern in relation to the first aid response of the correctional officers. He initially stated that he thought there was a delay of up to 12 minutes before CPR was commenced. In his affidavit, he estimated that there was a delay of 15-18 minutes.

43 I do not doubt that from TW's perspective, the delay felt considerable. However, having viewed the CCTV footage of the incident, the time in between locating Mr Holding and commencing resuscitation was approximately three minutes. I am not critical of the timeliness of the response, or more generally of the resuscitative efforts.

44 I note that a portion of the CCTV footage (from 3:56 am to 6:39 am) was not provided by the Department for Correctional Services to the coronial investigators at the time of Mr Holding's death and no longer exists for review. There is no evidence before the Court explaining why that footage was not provided in the first instance.

45 Accordingly, the interactions between Mr Holding and Ms Armstrong at 5 am and 5:30 am are incapable of independent verification. While this is unfortunate, these events are uncontroversial and the statement given by Ms Armstong and the statement of TW are aligned as to the occurrences within this timeframe. Fortunately, the footage resumes prior to Mr Holding being recovered from his cell.

What was the cause of Mr Holding's death?

46 A post mortem examination was conducted by forensic pathologist, Associate Professor Neil Langlois, of Forensic Science SA. Associate Professor Langlois performed an external examination and an internal examination. His notable findings included a bruise to the midline upper abdomen, with no evidence of significant internal injury, a fatty liver with congestion, and morbid obesity. He also found an impacted left molar tooth.

47 The only other sign of injury observed was a one centimetre bruise to the front of Mr Holding's scalp. However, there was no evidence of a significant head injury.

48 Associate Professor Langlois opined that these findings did not account for death. Accordingly, he submitted the heart for specialist cardiac examination.

49 An examination of Mr Holding's heart was performed by Professor Anthony Thomas. Professor Thomas found no evidence of any myocardial infarction, no scarring and no significant fibrosis. There was mild coronary atheroma with 20-25% restriction to blood flow, which Professor Thomas opined would not be expected to lead to cardiac arrhythmia. In short, Professor Thomas found no explanation for a sudden cardiac event causing death.

50 Both Professor Thomas and Associate Professor Langlois explained in their reports that there are electrical dysfunctions or abnormalities in the cellular channels in the heart which can lead to arrhythmia and sudden death. As these electrical cardiac conditions can only be detected during life, they cannot be excluded by post mortem examination.

51 Toxicological analysis revealed the presence of medications prescribed to Mr Holding, consistent with non-toxic concentrations allowing for post mortem redistribution.

52 Despite extensive investigations, Associate Professor Langlois found no pathological evidence of the cause of Mr Holding's death. While he considered obstructive sleep apnoea or obesity hypoventilation syndrome to be possibilities, these are functional abnormalities of breathing and therefore cannot be confirmed or excluded by post mortem examination. Associate Professor Langlois concluded that the cause of death remains unascertained, considering it mere conjecture that Mr Holding's sudden death was a result of acute respiratory failure.

53 Associate Professor Langlois raised the possibility of electrocution, noting the liquid on the floor of the cell and the presence of an electrical kettle. While there were no observations at autopsy consistent with electrocution, Associate Professor Langlois explained that electrocution can occur without evidence of electrical entry or exit injuries on the skin. Ultimately, he could not include or exclude electrocution as a cause of death based on his findings at autopsy. Accordingly, the possibility of electrocution was investigated by Detective Brevet Sergeant Rivett.

Was Mr Holding electrocuted?

54 Detective Brevet Sergeant Rivett arranged for officers from the Office of the Technical Regulator (OTR) to inspect Mr Holding's cell to identify whether an electrical fault may have caused or contributed to the death of Mr Holding.

55 George Nesic, a qualified electrician and authorised investigator with the OTR, and Alex Coulls, a senior electrical standards and safety officer, conducted two site visits to inspect Mr Holding's cell. Mr Nesic provided an affidavit to the Court setting out the results of their detailed inspection of Mr Holding's cell, which included testing of the plug-in electrical equipment which had been in Mr Holding's cell at the time of his death (except for the electrical kettle).

56 Mr Nesic explained in his affidavit that the parameters necessary to receive a fatal electric shock are:

a. A power source that delivers sufficient energy to cause a fatal electric shock, with a voltage of sufficient pressure that causes a fatal electric current to flow through the victim: and

b. A circuit with low enough impedance (to allow current flow) for the fatal electrical shock current to be carried from the power source, through the victim and return to the power source via the neutral or earthing system.

57 The electrical supply to Mr Holding's cell consisted of a single final subcircuit located in a hallway distribution switchboard. This subcircuit was protected by a Heinemann branded residual current breaker with overload (RCBO)[1] with a nominal trip rating of 15mA. Consistent with the operating characteristics of such devices, the RCBO would ordinarily operate to disconnect the electricity supply when the residual current approached that level. The RCBO was tested and found to operate correctly, tripping at 21mA[2].

58 Mr Nesic found that the electrical installation within the cell, and the plug-in electrical equipment available for testing, appeared to be in good working order. He was unable to identify a live mains electrical source that could have been readily or accidentally contacted by Mr Holding to cause a hazardous electrical shock current.

59 It is unfortunate that the kettle was no longer available for direct inspection and testing. However, photographs were made available to Mr Nesic, who observed that the kettle did not have any obvious signs of damage, exposed live parts or other apparent anomalies. Further, the cord attached to the base had a yellow-white tag attached, which he hypothesised may be an inspection and testing tag.

60 Given that a fault with the kettle could not be definitively excluded due to its unavailability for testing, Mr Nesic considered the possibility that the kettle could have been damaged such that there was an exposed live active part. He opined that even if Mr Holding was able to receive a sufficient shock current to a good earth path through a faulty appliance, the RCBO would have operated rapidly to disconnect the electricity supply.

61 Mr Nesic could not rule out the possibility that the protection afforded by the RCBO could be bypassed if independent conductive parts were inserted deliberately into the electrical socket, for example, if a paper clip were inserted in each aperture. However, there are clear photographs of each socket outlet which show no apparent interference.

62 Mr Nesic and Mr Coulls conducted measuring touch voltage testing to simulate whether it was possible to receive a hazardous shock current within the prison cell, for example if live parts were exposed on a damaged kettle which was plugged into a socket outlet[3]. Touch voltage testing results for all surfaces tested (wall, floor, wash basin, bed frame) were well under the safe limit for wet areas. The touch voltage testing also indicated that the floor material of the cell appeared to be acting like an insulator and did not provide a good path to earth for current to flow. In conclusion, testing was unable to simulate conditions in which it was possible to receive a hazardous shock current.

63 The testing conducted by the OTR was extensive. It did not reveal any likely source of electrocution. Considering the documented deterioration in Mr Holding's health in the

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[1] A safety device designed to disconnect the supply of electricity when residual current is detected, minimising the risk of electrocution.
[2] The RCBO was wired incorrectly. However, this did not affect the functionality of the device, which was tested and found to operate as intended despite the incorrect wiring.
[3] I note that the kettle stand in Mr Holding's cell was not plugged in to a socket-outlet.

month preceding his death, and the pathological evidence, I consider that it is more probable that his death was caused by a functional abnormality of his breathing or a cardiac conduction disorder. I am satisfied on the balance of probabilities that Mr Holding's death did not result from electrocution.

64 Regretfully, the evidence does not lead me to a comfortable level of satisfaction as to the most likely cause of Mr Holding's death. I find that the cause of Mr Holding's death is unascertained.

Concerns

65 Detective Brevet Sergeant Rivett raised the possibility that South Australian Prison Health Service staff could have utilised an Inpatient Treatment Order to compel Mr Holding to attend hospital for medical treatment when he declined. However, as acknowledged by Detective Brevet Sergeant Rivett, it does not appear that the necessary criteria for imposing such an order under the *Mental Health Act 2009* would have been met, as Mr Holding's mental state was stable at that time. Accordingly, I make no criticism of the South Australian Prison Health Service for accepting Mr Holding's refusal to attend hospital in December 2022.

66 Detective Brevet Sergeant Rivett also considered whether the Cadell Training Centre was a suitable facility for Mr Holding given the state of his health. She explained that the Cadell Training Centre does not have an onsite 24-hour health care centre. I consider there to be some merit in this concern. Notwithstanding, in this case, Mr Holding did have access to medical care at the Cadell Training Centre and was diligently monitored by the nursing and correctional staff. The advice of a qualified medical practitioner was sought and provided when required. I am not satisfied that accommodating Mr Holding within a facility with a 24-hour health care centre would have altered the outcome, particularly considering his previous refusals to accept medical care and the unascertained cause of his death. .

Conclusions

67 I find that the medical care provided to Mr Holding while lawfully incarcerated was comprehensive and appropriate. Management of his declining physical health was necessarily constrained by his refusal to accept medical advice and, in particular, his refusal to attend hospital to investigate his breathing difficulties.

68 I have no recommendations to make.

Keywords: *Death in Custody; Prison; Unascertained Cause*