OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Wayne Matthew PETTIGREW**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Brisbane
FILE NO(s):	COR 300/04(7)
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 Wayne Matthew Pettigrew

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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 Matthew Pettigrew. They will be distributed in accordance with the requirements of the Act.

Introduction

Wayne Matthew Pettigrew was 54 years of age, when he passed away on his bed at the Princess Alexandra Hospital Secure Unit on Saturday 17 January 2004. At the time, he was in the custody of the Department of Corrective Services.

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 Pettigrew 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

[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

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.

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 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 *Brigenshaw* 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]

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

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 Pettigrew had passed away, Plain Clothes Senior Constable Robert Priddey of the Queensland Police Service's Corrective Services Investigation Unit was directed to conduct a "death in custody" coronial investigation.

On 20 January 2004, an autopsy was conducted by Dr Alex Olumbe, a forensic pathologist from the John Tonge Centre.

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. Mr Pettigrew's family advised that they did not wish to attend the inquest and had no matters they wished to raise during the inquest. A copy of the police investigation report was provided to Mr Pettigrew's brother Lloyd Pettigrew, prior to the inquest.

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 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 family indicated that they did not wish to challenge or examine any of the witnesses' versions as contained in the documents that were 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.

[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

Background

Mr Pettigrew's family consisted of himself and his brothers Allen, Neville, Barry and Lloyd. At the time of his incarceration in 2000, he had a de-facto wife. They were the biological parents of two children. His brothers do not know the whereabouts of the former de-facto wife or their children.

Custody

On 28 May 2001, Mr Pettigrew was sentenced in the Brisbane Supreme Court to life imprisonment for murder. He was serving this sentence at the time of his death.

Medical issues

In 1991, Mr Pettigrew was diagnosed with Hepatitis C at the Toowoomba Hospital.

On 30 October 2000, whilst in the custody of the Department of Corrective Services, he was diagnosed by Dr. Hall of the Princes Alexandra Hospital with long-standing chronic liver disease and cirrhosis of the liver.

On 11 November 2003, he was diagnosed by Dr. McDonald of the Princess Alexandra Hospital with cancer of the liver. Dr. McDonald advised that there were no treatment options other than palliative care and that Mr Pettigrew should not expect to survive more than a few months.

The decline and death of Mr Pettigrew

On 9 January 2004, Mr Pettigrew was admitted to the Princess Alexandra Hospital Secure Unit for assessment by the Palliative Care Team to discuss his pain relief for his medical conditions. His condition continued to deteriorate.

On 16 January 2004, Dr. McDonald, after discussion with Mr Pettigrew's family, provided instructions to medical staff at the Secure Unit that he had deteriorated to a terminal phase and was not suitable for cardiopulmonary resuscitation.

At 9.05pm on Saturday, 17 January 2004, Mr Pettigrew passed away peacefully in his bed at the Princess Alexandra Hospital Secure Unit surrounded by his family.

Autopsy results

An autopsy examination was conducted at the John Tonge Centre by forensic pathologist, Doctor Alex Olumbe, who advised that, in his opinion, Mr Pettigrew died as a result of natural causes namely "*chronic lever failure due to or as a consequence of hepatocellular carcinoma due to chronic hepatitis C and liver cirrhosis and diabetes mellitus".* There were no suspicious circumstances detected at autopsy.

Conclusions

The police investigation, coupled with the autopsy, revealed that Mr Pettigrew passed away peacefully from natural causes, whilst resting on his bed surrounded by his family. The medical prognosis was that his death was entirely expected.

I find that Corrective Services staff did all within their power to provide appropriate medical assistance and treatment to Mr Pettigrew, whilst in custody.

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 Matthew Pettigrew

Place of death – He died whilst in the custody of the Department of Corrective Services at the Princess Alexandra Hospital, Secure Unit at Brisbane

Date of death – Mr Pettigrew died on 17 January 2004

Cause of death – He died from natural causes namely "chronic lever failure due to or as a consequence of hepatocellular carcinoma due to chronic hepatitis C and liver cirrhosis and diabetes mellitus".

I also find that none of the correctional officers, inmates or medical personnel at the Princess Alexandra Hospital caused or contributed to the death and that, under the circumstances, nothing could have been done to save Mr Pettigrew, who has expectedly 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. As already mentioned, I have found that no

one caused or contributed to Mr Pettigrew's death and that there was nothing that the Department of Corrective Services could have done to prevent it.

Accordingly there is no need for me to make any comments or recommendations pursuant to Section 46(1) of the Coroners Act 2003. However, I do wish to acknowledge those responsible in the Department of Corrective Services for their compassion in allowing Mr Pettigrew's family to be at his bedside in the Princess Alexandra Hospital Secure Unit in the hours leading up to his death.

I close the inquest.

Michael Barnes
State Coroner
Brisbane
13 March 2006