# **Transcript of Proceedings**

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Date: 24 November, 2006

CORONER'S COURT

HALLIDAY, Coroner

No 615 of 2000

IN THE MATTER OF AN INQUEST INTO THE CAUSE AND CIRCUMSTANCES SURROUNDING THE DEATH OF ANDREW NICHOLAS PETRELIS (ALSO KNOWN AS ANDREW NICHOLAS PARKER)

BRISBANE

..DATE 26/05/2006

..DAY 24

FINDINGS

<u>WARNING</u>: The publication of information or details likely to lead to the identification of persons in some proceedings is a criminal offence. This is so particularly in relation to the identification of children who are involved in criminal proceedings or proceedings for their protection under the *Child Protection Act* 1999, and complainants in criminal sexual offences, but is not limited to those categories. You may wish to seek legal advice before giving others access to the details of any person named in these proceedings.

26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) CORONER: This is the further hearing of the Inquiry and Inquest into the death and circumstances of Andrew Nicholas PETRELIS (also known as Andrew Nicholas PARKER). I note the appearances of the interested parties, as previously. The purpose of the proceedings this date is for me to deliver my findings pursuant to the provisions of the Coroner's Act 1958, and I so do.

#### The Scope and Purpose of Inquest

Pursuant to section 24 of the Act, the purpose of this Inquest is to establish, as far as is practicable, the fact that a person has died; the identity of the deceased person, when, where and how death occurred, and whether any person should be charged with any of the offences referred to in section 24(1)(d) thereof.

Throughout this Inquiry I have been mindful, amongst other things, of the observations made by His Honour Justice Toohey in Annetts v. McCann 170 CLR 596, and in particular the following words of His Lordship, Lord Lane, referred to therein:

"Once again it should not be forgotten that an Inquest is a fact finding exercise, and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an Inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, **50** there is no defence, there is no trial. It is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation, unlike a trial, where the Prosecutor accuses and the accused defends."

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26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) It may thus be noted that a Coroner's inquest is an investigation by Inquisition in which no one has the right per se to be heard, there are no sides in the sense of adversary proceedings. Although a coronial inquiry is not a judicial proceeding, in the traditional sense, the rules of natural justice and procedural fairness are applicable, and must be applied. The contents of such rules, to be applied, depending upon the particular facts of the case in question.

In making my findings I am not permitted by the legislation to express any opinion on any matter which is outside the scope of this Inquest, except in the form of a rider or recommendation, and I should also make it quite clear, and abundantly clear, that any findings that I do make in these proceedings are not to be framed in any way which may determine or influence any question or issue of liability which may fall to be determined in any other place, or which might suggest that any person should be found guilty, or otherwise, in any such other proceedings.

I have referred in the broadest of terms to the function and role of the Coroner, and of this Court, as there is perceived by some within the community a belief that a Coronial Inquiry and Inquest is an ongoing Royal Commission with unlimited terms of reference and unlimited resources and finances. I so comment as there have been certain observations made within inquiries and media commentary in Western Australia and by others as to what is perceived to be the function of this Inquiry and the supposed or expected outcome.

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All proceedings before this Court, unfortunately, are sad proceedings because they involve the death of a human person, and of a loved one. And before I go any further I express the condolences of my Court to the family of the deceased in their sad loss, in the sudden and tragic death of their son Andrew Nicholas PETRELIS.

I want to set out in a little more detail the statutory functions of this Coronial Inquest so that they may be better and fully understood.

The jurisdiction and the function of the Coroner's Court are to be found within section 43 of the Act which provides:-

"After considering <u>all</u> the evidence before the Coroner at the Inquest the Coroner shall give the Coroner's findings in open Court." (Emphasis added)

That is what we are here for today.

"Where the Inquest concerns the death of any person, the 40 finding shall set forth"

- and it then sets out the matters that I have to turn my mind to,

(a) so far has been proved, firstly, 50(i) who the deceased was. (Emphasis added)

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26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) [And I will later spend a little time on that, because the initial investigation, in my view, one might well term incompetent as regards the identification of the deceased. If it was not for some evidence recently forthcoming from Mr PETRELIS, the father of the Deceased, this Inquest may well 10 have been in a position where it was not able to make any finding as to the identity of the deceased.]

- (ii) when, where and how the deceased came by his or her death; and
- (iii) the persons, if any, who should be committed for trial.

The word "how" the deceased came by his death, has been judicially defined, in this State of Queensland, in the recent 30 decision of the Court of Appeal in Atkinson v. Morrow (2005) 13 Court of Appeal, where it was determined that the word, "how", means, "by what means and in what circumstances the relevant death occurred."

The Justice at nisi prius, Justice Mullins, whose decision, as I appreciate it, was upheld, said this:

"How the death occurred should not be given the unduly restricted meaning of 'by what means the death occurred', but should be given the broad construction of, 'by what means and in what circumstances the death occurred.'"

[2005 QSC 92 at 11]

That is the type and the extent, the breadth and the depth of what this Inquiry is all about. It is not an ongoing, far-

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26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) reaching Royal Commission with unlimited terms of reference as some, especially in Western Australia, perceive.

The Inquest arrives at its decision by having regard to evidence which has been adduced before it. Section 34 of the Act provides:

"In any inquest the Coroner may admit any evidence that the Coroner thinks fit, whether or not the same is admissible in any other Court, provided that no evidence shall be admitted by the Coroner for the purposes of the inquest unless in the Coroner's opinion the evidence is necessary for the purpose of establishing or assisting to establish any of the matters within the scope of such inquest."

It can therefore be seen that the Inquest is not bound by the Rules of Evidence, and it may therefore admit into evidence what has been referred to as hearsay evidence.

In R v. War Pensions Entitlement Appeal Tribunal, ex parte Bott, in the dissenting judgment of Mr Justice Evatt, the following was said,

"Some stress has been laid by the present respondents **40** upon the provision that the Tribunal is not 'bound by any rules of evidence'. Neither it is. But this does not mean that all rules of evidence may be ignored as of no account. After all, they represent the attempt made, through many generations, to evolve a method of inquiry best calculated to prevent error and elicit truth. No Tribunal can, without grave danger or injustice, set them on one side and resort to methods of enquiry which necessarily advantage one party and necessarily disadvantage the opposing party. In other words, 50 although rules of evidence, as such, do not bind, every attempt must be made to administer 'substantial justice'."

[(1933) 50 C.L.R. 228 at 256]

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26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) Such dicta was referred to by Brennan J, as His Honour then was, when speaking as President of the Administrative Appeals Tribunal in Pochi v. Minister for Immigration and Ethnic Affairs (1979) 36 FLR 482 and his Honour said further:

"To depart from the rules of evidence is to put aside a system which is calculated to produce a body of proof which has rational probative force, as Evatt J pointed That does not mean, of course, that the rules of out. evidence which have been excluded expressly by the statute creep back through a domestic procedural rule. Facts can be fairly found without demanding adherence to the rules of evidence."

His Honour then referred to the statement of Lord Denning that Tribunals are entitled to act on any material which is logically probative, even though it is not evidence in a court of law (Millar Pty Ltd v. Minister of Housing and Local Government (1968) 1WLR at 995).

The foregoing does not mean that this Inquiry is required or is permitted to rampage on a fact finding frolic of its own.

The Inquiry, in assessing the evidence that has been placed 40 before it, and in arriving at any determination of a fact, must not speculate, toss a coin or consult an astrologer - as may have been suggested if one gives proper consideration to some of the suggested arguments and hypotheses that have been put forward prior to and in the course of this Inquiry, and which have been raised, suggested and alleged by various newspaper articles and media pundits especially in Western Australia and which may be viewed as irresponsible and completely unfounded in fact.

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It must be remembered that evidence of fact is that which tends to prove that fact; something which satisfies the Inquiry of the existence of the fact. Such is to be found in cogent, reliable evidence or reasonable inferences to be drawn from proven facts or facts which are not in dispute or in issue.

In arriving at a determination of a fact the Inquest is required to be satisfied to the requisite standard and that standard in this proceeding, as in all coronial matters, is the civil standard of proof, that is, on the balance of probabilities. So that a fact is proved if the Inquiry is reasonably satisfied of it. The degree of persuasion necessary to establish a fact, on the balance of probability, varies according to the seriousness of the issues involved, and in such regard I refer to Brigginshaw v. Brigginshaw 60 CLR 336 per Dixon J at 362; and to the succinct statement of Lord Denning in Hornal v. Neuberger Products Ltd (1957) 1 QB 247 at 258:-

"The more serious the allegation the higher the degree of probability that is required."

I also refer to the following judicial dicta which clearly illustrate the way in which the aforesaid principles are to be applied.

In Luxton v. Vines 85 CLR 352 it was said by the High Court at 358:

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"The difference between the criminal standard of proof in its application to circumstantial evidence and the civil is that in the former the facts must be such as to exclude reasonable hypotheses consistent with innocence whilst in the latter you need only circumstances raising a more probable inference in favour of what is alleged. In questions of this sort while direct proof is not available, it is enough if the circumstances appearing in the evidence give rise to a reasonable and definite inference; they must do more than give rise to conflicting inferences of equal degrees of probability so that the choice between them is a mere matter of conjecture. But if the circumstances are proved in which is it reasonable to find a balance of probabilities in favour of the conclusions sought, then, though the conclusion may fall short of certainty, it is not to be regarded as mere conjecture or surmise."

Further, it has been said what the cause is of a particular fact must be determined by applying common sense to the facts of each particular case and in such regard I refer to the High Court decision of March v. Stramare 171 CLR at 515; that is, the proven facts to the requisite standard and in such regard it is relevant to consider the function and role of a medical or expert witnesses, such as Drs NAYLOR and HOSKINS, who were called to give evidence in these proceedings.

#### The Role of the Expert Witness

In R v. Laurie (1987) 2 QR 762 at 765 it was said by the Court **40** of Appeal per Connolly J:-

"The fundamental rule is that an expert's opinion is admissible to furnish the court with scientific information which is likely to be outside the experience and knowledge of a judge or jury. If on the proven facts a judge or jury can form their own conclusions without help then the opinion of an expert is unnecessary. Thus in R v Turner [1975] Q.B. 834 the Court of Appeal held that the evidence of a psychiatrist as to the likelihood of the accused being provoked, he being a normal human being, was inadmissible being well within ordinary human experience." 10

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26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) Further, the duty of an expert witness is to furnish to the 1 Inquest necessary medical or scientific criteria for testing the accuracy of their conclusions so that the Inquest is in a position to form its own independent judgment by the application of those criteria to the <u>facts proven in evidence.</u> (Vide Davie v. Edinburgh Magistrates (1953) SC 34 at 40.

And I emphasise the words 'facts proven in evidence.'

It has been further said that whatever may be proved by expert evidence of medical practitioners, or the like, the Inquest is left to sieve such expert evidence through the filter of its common sense; and that in cases where science or medicine might demand a more exacting standard of reasoning the Inquest however may reason on the balance of probabilities. And in that regard I refer to the interesting article entitled "Medical Causation" by Travers 76 A.L.J at 258.

Furthermore, it is generally **inadmissible** by an expert to give evidence in a form that takes up the very ultimate issue that it is the duty and function of the Inquest to determine.

In relation to the 'causation' of an event in medical matters it was said in R v. Poplar Coroner; ex parte THOMAS (1993) QB 610 at 610, where Lord Justice Dillon applied the following observation of Lord Salmon in Alphacell Ltd v. Woodward (1972) AC 824:

"I consider that **what** or **who** caused a certain event to occur is essentially a practical question of fact which

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can best be answered by ordinary common sense rather than by abstract metaphysical theory."

I refer to the foregoing dicta in order for it to be better understood and fully appreciated as to the role and function 10 of this Inquiry and the basis of decision making having regard to the various arguments and speculation that have been raised prior and during the course of the Inquiry.

The circumstances leading up to and surrounding this most unfortunate death, are not only grossly unfortunate but may well be described as bizarre and highly suspicious. However, much of the suspicion surrounding the circumstances of this particular death have been engineered by certain media frenzy involving misrepresentation of relevant facts, sheer and bold speculation and irresponsible assertions of 'murder' and the Reference in such regard need only be made to various like. media articles published particularly in Western Australia which have been placed before this Court by way of exhibit.

#### Circumstances Giving Rise to this Inquest

Andrew Nicholas PETRELIS was born on the 27th of January 1970. Until his taking residence in Queensland on the 28th of May 2005 he was a resident of Perth, Western Australia. He had. unfortunately, a reputation for being involved in the drug 50 scene from at least in about October 1992 and was an associate of "criminal identities," John KIZON, Michael RIPPINGALE and Craig CHRISTIAN.

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26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) In the course of this Inquiry, the Inquest has been provided with a great number of files relevant to Investigations and Inquiries made by Australian Law enforcement Agencies and others of the persons to whom I have just referred, and to others, and the Inquest, in arriving at its Decision has had regard to such material in so far as it is relevant. It is not intended to refer specifically to the contents or conclusions of such reports.

In May 1993 it is said that some 13 tons of cannabis was imported into Western Australia on the ship "Diana Avril". In March 1994 PETRELIS was asked by RIPPINGALE to arrange a selfstorage unit for him and PETRELIS obtained such a unit at Osborne Park, Perth, and secured such a unit with a padlock apparently supplied by RIPPINGALE. In September 1994, PETRELIS was requested by RIPPINGALE to attend a 'certain' location and dig up two canvas bags and store them in premises then leased by PETRELIS at Osborne Park. Such bags, it appears, contained some 20 kilograms of compressed cannabis blocks and were believed to be part of the "Diana Avril" consignment. It was thought that such cannabis was owned by CHRISTIAN who at such time was in custody on remand for the murder of one MORRISON outside the Hotel Leederville on the 4th of August 1994.

There was a joint Western Australia and Federal Police Task Force investigation which located such aforesaid cannabis consignment said to be owned by CHRISTIAN and which substituted for it grass clippings for the cannabis. In

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26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) November 1994 RIPPINGALE was photographed by police removing the bags of supposed cannabis from the storage unit. In November 1994 RIPPINGALE threatened the life of PETRELIS and that of his parents if the police were spoken to by him. Law enforcement agency telephone interceptions or intercepts were made of conversations between KIZON and RIPPINGALE which included personal violence or threats of personal violence intended against PETRELIS should he speak to the police .

Police officers of the Western Australia Drug Squad (VOYEZ and CLAY) convinced PETRELIS to give evidence against both KIZON and RIPPINGALE in exchange for indemnity from his own prosecution. In January 1995 PETRELIS gave a statement implicating RIPPINGALE with the aforesaid drugs. PETRELIS was given an indemnity against prosecution by the Director of Public Prosecutions (WA) on the 10th of February 1995 in respect of certain drug offences on condition that he, "cooperate" in the prosecution of KIZON and RIPPINGALE.

In March of 1995 PETRELIS was approached by KIZON and one **40** RICCIARDELLO who enquired about his involvement in "informing the police". On 31 March 1995 KIZON and RIPPINGALE were charged conjointly with conspiring to possess a trafficable quantity of cannabis with intent to sell or supply. On the 25th of May 1995 PETRELIS formally entered into what has been referred to as a Witness Protection Program and after being given a false identity of the surname PARKER he was relocated to Queensland where he arrived in the company of Western Australian Police Officer THOMPSON on the 28th of May 1995.

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Subsequent to his arrival in Queensland PARKER, as he was then known, enrolled as a trainee pilot with an organisation referred to as Chopperline Flying School and he took up residence at unit 6, Windsurfer Units, 9 Leichhardt Street, Caloundra.

In early September 1995, the deceased contacted Western Australian police officer CLAY by telephone and indicated to him that he was prepared to give a further statement and new evidence implicating KIZON.

On the 11th of September 1995 police attended the aforesaid unit and after gaining forceful entry, found the naked body of a male adult. The body was conveyed to the John Tonge Centre, Brisbane where, at 2.20 p.m. on the 11th of September, after examination by Professor Ansford, a life extinct certificate was issued. Subsequently, on the 12th of September 1995 a post-mortem examination upon that body was undertaken by Dr Charles NAYLOR, and following receipt of toxicology reports, a medical cause of death of "opiate toxicity" was opined.

It will be observed that I have mentioned that the body that was found was that of a male and I have not, at this stage in my reasons, ascribed an identity to that body as the evidence as it then stood, in my view, and subsequently, was such that there was an issue as to the identification of that body.

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26052006 D.24 T2/WJS M/T BRIS 38 (Halliday, Coroner) In November 1995 the parents of PARKER, after they had been contacted by police and informed of the death of their son, visited Caloundra and attended upon Mr Crabtree, the then Clerk of the Court and Statutory Coroner for Caloundra, and requested that an Inquest be held. And subsequently, on the 27th of November 1995 a written request for same was made with specific mention of a number of reasons for the conduct of an Inquest.

On the 22nd of November 1995 Mr Vagg, who held the position of Acting Clerk of the Court at Maroochydore, and hence Statutory Acting Coroner during the absence of Mr Crabtree, recommended to the then Director General, Department of Justice for the State of Queensland that no Inquest be held. On the 27th of November 1996 the then Director General accepted the aforesaid recommendation and determined that an Inquest not be conducted.

Subsequent to such determination there was, inter alia, personal agitation on the part of Mr and Mrs PETRELIS, intense media, community and political interest in Western Australia which culminated in November 1995 when the then Honourable Minister for Police (WA) announced the proposal to appoint a Queens Counsel to conduct a review of the death and of the Protected Witness Program then in place in Western Australia.

As a consequence, Mr Len W Roberts-Smith RFD, QC was appointed to conduct such a Review and following such an undertaking, a Report dated the 30th of June 2000 was presented to the then 10

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26052006 D.24 T3/RC M/T BRIS38 (Halliday, Coroner) Commissioner of Police (WA). Subsequently, a Royal Commission 1 was held between 2002 and 2003, and conducted by Mr G A Kennedy QC and chapter 13 of such Royal Commission Report relates to Andrew Nicholas PETRELIS.

This inquiry and Inquest has been furnished with a copy of that Report and I incorporate such Report herein by reference. The only parts from such Report that ought to be read in open Court in these proceedings at this stage for purposes of brevity and having regard to the tyranny of time, are the following paragraphs:-

"Four months prior to PETRELIS' death, it was known by the Western Australian Police Service that two officers had unlawfully accessed his covert, personal and vehicle details on the police computer system. Those officers were former members, Murray John Shadgett and Kevin Davey. It was further suspected that shortly after the accesses, the information was communicated by these officers directly or indirectly to persons of interest to law enforcement authorities.

Because PETRELIS was registered in the witness protection 40 program at the time of his death, public speculation has arisen that he may have been murdered and that police may have been implicated. Some of the issues were investigated by the Anti-Corruption Commission, but of course, not in a public hearing. Media conjecture has continued up to the time of the Royal Commission and it was decided the Royal Commission would examine the matter in a segment of its public hearings.

Determination of the cause of PETRELIS' death however was not the subject of Royal Commission hearings, there being a coronial inquiry in Queensland in that regard, which remained incomplete as at the date of this report." 30

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26052006 D.24 T3/RC M/T BRIS38 (Halliday, Coroner) I pause there to make reference to the fact of the mention by the Royal Commission not undertaking any examination of the death of PETRELIS, and I only mention that in the context of the expectation, if that is the right word, that this Inquiry 10 would conduct a similar type of inquiry to that of a Royal Commission.

Further it is said within the report:

"It is clear that Davey and Shadgett unlawfully accessed the police computer system and disclosed information from There is no evidence that those accesses were it. motivated by desire to locate PETRELIS, rather they occurred because a person referred to as P3 wished to determine whether the person to whom he had been selling drugs was an undercover police officer. Some information was received through P2 and P3 then made other telephone calls and inquiries in an attempt to confirm whether either PARKER or Clay was a police officer."

And the final part of the report to which I wish to specifically refer is this:

"Whilst ultimately no connection can be made between the release of confidential information and PETRELIS' death, the potential for those releases to compromise his safety was very real and deserved to be treated with speedy and decisive response from the Western Australian Police Service."

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Subsequent to the publication of the Roberts-Smith QC report, the Western Australian then Minister for Police made certain representations to his equivalent in Queensland and as a

26052006 D.24 T3/RC M/T BRIS38 (Halliday, Coroner) consequence thereof, the then Queensland Attorney-General, pursuant to the provisions of the Queensland Coroners Act, directed that this Inquest be held and such has occurred.

10 In the course of this Inquest, there has been much inquiry made, and such has incurred within Queensland, Western Australia and of the relevant Commonwealth and State Law Enforcement Agencies. As a consequence, a large number of witnesses have been interviewed and called to give evidence 20 over a period of time.

The Inquest has, in the main, received the full cooperation of all relevant law enforcement agencies and for this the Inquiry is indeed greatly appreciative. However, in matters of "criminal intelligence" and the like one is always left with a certain degree of suspicion as to whether one has been fully informed of all relevant matters and in this regard there will be one matter referred to later in the course of these **40** reasons.

In the course of the Inquiry, there has been produced to the Inquest a number of files, reports and documents relating to quite relevant personnel and such have been appropriately investigated and those found to be relevant have been placed into evidence. For reasons of security, those reports have been edited, but I am sure that the parties before this

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26052006 D.24 T3/RC M/T BRIS38 (Halliday, Coroner) proceeding are well aware of the identity of those various persons referred to therein.

There have been made, by members of the coronial investigative team, visits to Western Australia for the purpose of carrying 10 out relevant inquiries and of interviewing prospective witnesses and the like.

It is my view that this matter has been thoroughly 20 investigated and that no further line of inquiry is necessary, save for the reservation, which will be apparent later in these reasons.

At the conclusion of the hearing, all represented parties, including the parents of the deceased, were expressly asked whether any further witnesses were required to be called. There was no such application. Counsel Assisting the Inquiry, Mr MacSporran SC, Senior Counsel, and with him Mr Grealy, informed the Inquiry and the Inquest that it was their submission that there was no further avenue of investigation that ought reasonably to be undertaken. However, Mr MacSporran SC submitted that there may well be warranted a further Royal Commission with appropriate terms of reference.

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#### REVIEW OF THE EVIDENCE

It will be readily appreciated that it is not possible, having regard to the tyranny of time, to refer to all of the evidence, which has been given or all of the material which 10 has been placed before the Inquest.

Much of the evidence surrounded the activities of PETRELIS prior to his departure from Perth for Queensland, and that concerning the activities of certain Western Australia Police, are to be found in the Western Australian Inquiries and need not be referred to specifically herein.

It is therefore the intention only to refer to the more <sup>30</sup> salient aspects of the evidence insofar as it relates to the circumstances surrounding the death of the deceased, such as indicated earlier, being given a special meaning, having regard to the decision of the Queensland Court of Appeal. 40

In arriving at its decision herein, the Inquiry has had regard to all evidence, which has been placed before the Court, both written and oral, and of the various reports from the various inquiries, which have been undertaken touching upon this matter.

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26052006 D.24 T3/RC M/T BRIS38 (Halliday, Coroner) It is apparent from the evidence that various individuals, who 1 will be mentioned shortly, had a motive and purpose for the disposal, if that is the right word, of PETRELIS as he was an important, vital and crucial prosecution witness with potential evidence against both KIZON and RIPPINGALE. 10

I intend to deal firstly with the movements of PARKER immediately prior to the 11th of September 1995, that is the date upon which a body was found in the unit.

A Victor GORDON gave evidence and he was the chief ground school instructor with Chopperline Air Training School. He said, in the course of his evidence, that on the weekend 30 immediately prior to his death, the deceased attended an air show with both himself and his daughter Kia. He says that on that weekend, PARKER revealed to GORDON that he was on the witness protection program. The next time that GORDON saw PARKER was on the Tuesday at the unit and on that day, it was **40** mentioned to GORDON the names John KIZON and another male person, who was about to be released from prison in Western Australia. Apparently that mention was made in the context of PARKER expressing concern for his own personal safety and an 50 expression by him that he could not stay in the one flat for any length of time.

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26052006 D.24 T3/RC M/T BRIS38 (Halliday, Coroner) On the Thursday 7 September 1995 PARKER failed to attend his flying instructing course and GORDON telephoned him. On the Thursday, immediately prior to the 11th, GORDON received a phone call from PARKER, in the course of which he advised that the front door of his unit had been repaired or was being repaired as he had forcibly been required to gain entry because he had locked his keys inside. PARKER expressed concern about his own safety and said words to the effect, "If they find out where I am, I could be in trouble". Later on, apparently, on the Thursday evening, there was further advice that the damaged door was to be repaired or had been repaired and that he had bought them a few beers for their efforts. An arrangement was made for him to attend the flying centre on the Friday and for him to take GORDON's daughter KIA to the Gold Coast on the following Saturday.

There was no further contact made by PARKER with GORDON. GORDON and one Allan MARTIN, who was the flying instructor, **40** were concerned about the welfare of their pupil and so they attended the unit on the Monday morning. They noticed that the front door had been damaged, that there had been an attempt to repair the door, that it looked pretty flimsy. They knocked on the door, there was very loud music coming from the interior, but there was no response to their knocking. They contacted the police, the police attended and after some initial inquiry, entry was gained with the use of a

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26052006 D.24 T3/RC M/T BRIS38 (Halliday, Coroner) wheel brace and the application of bodily force to the door. It was then found upon entry to the unit, the naked body of the adult male previously referred to.

10 Allan MARTIN also gave evidence, he being the flying instructor. He said that he knew PARKER after his first commencing the flying course in June of 1995. He said that PARKER was a very good pilot for his level and went solo flying after a certain number of hours, which was quite an achievement. He said that the deceased was required to attend a training flight on Thursday the 7th of September 1995 at 9 a.m. He did not arrive, the witness telephoned him and he advised of the problem of his locking himself out of his unit and of kicking in the door. Arrangements were made for PARKER to attend the next day at 8 a.m. PARKER did not attend for his training and the witness then gave evidence corroborating that of GORDON that on the Monday the 11th, they went to the premises and found the body, as previously referred to.

A witness, Michael HARWOOD, who was a ground floor neighbour in the same block of units as PARKER saw him around about midday on the Thursday the 7th of September 1995 and at that time he was building what appeared to HARWOOD to be a wooden structure in the garage.

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Later on, at about 7 p.m. PARKER walked past HARWOOD'S unit in order to leave the premises and HARWOOD did not see him return and he did not see him again. HARWOOD'S unit was so situate that either the deceased or any visitor to his premises were required to walk past HARWOOD'S unit. HARWOOD did not observe 10 anything untoward from that time on.

Simon WINGETT, a fellow student at the flying school, was accustomed to cycle past the block of units, on occasions making a phone call to his girlfriend from a phone box opposite the units and was prone from time to time to drop in to see PARKER. WINGETT says that he last visited PARKER in his unit during the week prior to his death. On the Thursday at about 8 p.m. he made a phone call from the public box; he looked across the road; the deceased's car was not there. On the following Sunday - that is the 10th - at about 7.45 p.m. he observed that there were lights on in the unit but the car was not there.

WINGETT referred to what one might feel to be the rather **40** strange practice of PARKER placing his keys to the front door immediately inside the door and on the ground with the apparent explanation for so doing of not wishing to forget or to lose them.

EWAN MACKENZIE stated that he was given, by PARKER either on the Thursday or Friday - the 7th or the 8th September 1995 - a video, "Apocalypse Now" DEAN COSTA, who was working on the building site next door to the block of units occupied by the

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26052006 D.20 T4/WJS M/T BRIS38 (Halliday, Coroner) deceased said that on the 7th September 1995 - that is the Thursday - PARKER came onto the site at about 9.30 a.m. and enquired as to whether there was anybody available to fix his damaged front door that he had kicked in.

The door was subsequently fixed by a Alan TAYLOR. Mr COSTA said that the door was glued back and the lock refitted, and the deceased was to paint the door himself. COSTA says he went back to the unit that afternoon, about 4 p.m. He says that both he and PARKER consumed two stubbles of VB beer on the balcony of the unit.

COSTA went back to the unit on the Friday about midday to collect a couple of cartons of beer which were to recoup for the cost of the repair to the door. He knocked on the door; he received no response. He heard loud music - "Jimmy Hendrix" - coming from inside. He used his own telephone to telephone the Deceased and he could hear the phone ringing inside the premises. He says that he drove past the premises on his way to work on the Friday and noticed that the two empty stubbies of beer which were left out on the patio table were still there on the balcony.

Alan TAYLOR, a carpenter who fixed the door, worked with COSTA on the building site, said he was requested by COSTA to fix the door. He says that on the afternoon of the Thursday after the door was fixed he was given a six-pack of beer apparently by a male occupant of the unit who brought them to his car which was parked at the kerb.

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Mrs Margaret GRIMMARD who was an employee of Chopperline said that on the 6th of September 1995 PARKER gave her two letters and asked for them to be posted. He returned on the 7th and had a conversation with her and was concerned that the letters had not been posted.

Mrs Margaret HARDY, also an employee of the Chopperline. said PARKER had told her that if anybody enquired as to his presence or whereabouts at the flying school she was not to mention his presence to them or for her to say that she knew of his whereabouts in the event of anybody telephoning. She says that on the Wednesday the 6th September 1995 PARKER gave to her two letters that he wanted posting. One was to a firm of solicitors who she identified as being Boyce, Garrick and Easton. She said that she gave the letters to Ms GRIMMARD as I understand the evidence - for them to be posted. She overheard a conversation between the deceased and Ms GRIMMARD that one of the letters was very important.

The letter was, in fact, very important because it was a letter addressed to Alan THOMPSON, a police officer with the Western Australian Police Service and it was placed into evidence. That letter contained a letter, an envelope inside an envelope, the inner envelope being addressed to a police officer CLAY and containing photographs of persons who have been identified at the Inquest as including KIZON, CHRISTIAN and others against whom the deceased was prepared to give evidence. 20

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That letter found its way in the normal course of mail to Sgt Alan THOMPSON of the Western Australian Police, and it is quite clearly dated or post-marked at the North Coast the 7th of September, 1995 and franked at the Sunshine Centre.

A further witness, who was given anonymity during the Inquest and was referred to as "Witness B", said that he was a resident of Western Australia and had regular telephone contact with PARKER whilst he was in Queensland and on the Thursday, immediately prior to his death, there were two phone calls from PARKER to him, the latter call confirming that PARKER was to transfer \$5,000 of some \$15,000 held in cash, such money to be deposited to the bank of that witness, the Commonwealth Bank in Perth. Such money was to be deposited the next day on the Friday and that PARKER would ring him that is, the witness - immediately prior to his attempting to deposit the moneys so that the witness would know that the moneys were on the way.

Evidence placed before the Court following research undertaken by Mr Grealy, Counsel Assisting, shows from telephone records obtained from the relevant authority that on the 7th of September 1995 there were three phone calls made by PARKER from a geographic area referred to as the Sunshine Coast at about 6.30 p.m. One was to Trevor Victor GORDON, which corroborates the evidence of GORDON; one phone call to Sergeant Alan THOMPSON of the Western Australian Police which corroborates the evidence of THOMPSON in that regard and

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26052006 D.20 T4/WJS M/T BRIS38 (Halliday, Coroner) another to "Witness B", just referred to, which corroborates the evidence of that witness.

On the 7th of September 1995 there were three calls also made at about 9 p.m. from a base which is referred to as the land base, Brisbane Station. All three calls were made to one Peter FLEMING, a witness who, despite enquiry and search, has been unable to be found or located. Evidence would seem to indicate though, that such witness was not residing in the Caloundra area at the time and therefore could not be the receiver of the calls that were made.

But what the calls do indicate is that between 6.30 p.m. when calls were made from the North Coast, the deceased apparently travelled to Brisbane where there were calls made at 9 p.m. on the 7th of September 1995. The last call that has been recorded emanating from the phone of the deceased, was one from the Sunshine Coast Land Station for an early reminder call to be made to him for Friday the 8th at 1207. This call was made at 1207 on 8 September 1995. No other phone calls have been logged to that phone other than when it was used at the unit scene by members or a member of the Queensland Police Force following the discovery of the body.

Further evidence shows (Exhibit 11) that there was a sum of \$350 withdrawn from the Caloundra branch of the Commonwealth Bank from the account held by the deceased at 6.58 p.m. on the 7th of September 1995, although the record would appear to show that that transaction is recorded as being the 8th of

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26052006 D.20 T4/WJS M/T BRIS38 (Halliday, Coroner) September, the discrepancy being the date that such debit was administratively actioned by the Bank.

A Stephen BUSH who was the occupant of a unit block directly opposite that of PARKER said that on the Thursday evening as he was preparing a meal he looked out the window and he observed the deceased and two other males sitting on the balcony of PARKER'S unit drinking what appeared to him to be beer. Such evidence is in conflict with other evidence as to who was with PARKER at such time and the number of stubbies that were actually found on the patio.

Police evidence from Constable WEIR of the Queensland Police Service said that at about 8.30 a.m. on 11 September 1995 he attended at unit 6, the relevant unit occupied by PARKER in company with Constable AMBROSE. He noticed that the front door had been damaged but it was still locked and secure. Police had been summoned in response to the occupant of that unit not answering the door upon request. There was a knocking by police on the door; there was no response.

Constable AMBROSE subsequently is said to have forced his way into the unit by kicking at the door. WEIR observed the deceased situated in the middle of the living room on the floor on his face and knees and he was naked. He observed that there were no forced signs of entry and he later located a number of cannabis plants behind a plastic partition in the garage of the unit. In the unit there was located an empty syringe with the needle - initially thought to be missing -

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26052006 D.20 T4/WJS M/T BRIS38 (Halliday, Coroner) lying on the table near the deceased. The police observed what appeared to be a puncture mark in the right inner arm of the deceased, a swab packet and tissue were found, the latter having a small amount of blood upon it. It was found in the deceased's right hand. There were some five cannabis plants and a water pipe located in the unit; no other illicit drugs were located. There appeared to be no sign of violence to the deceased and no sign of violence within the unit. A set of keys were found on the floor inside the front door.

As a consequence of the view formed by AMBROSE, that there were 'suspicious circumstances' surrounding the deceased's death, he thought there ought to be a special examination requested. There was further evidence that the main bedroom of the unit was in an untidy state and the stereo was operating in the doorway of the main bedroom. AMBROSE said that he looked through the unit; he saw the syringe on the table and swabs on the chair. He contacted the Caloundra Police Station to obtain instructions and to arrange for the attendance of the CIB and the Scenes of Crime. He also made mention of the keys inside the door on the floor. He said that all the windows were secured by security screens, a matter which is of some relevance. He noticed that there was no needle evident within the syringe and he formed the view that it might have been still within the arm of the deceased. He noticed a number of empty stubbies of beer on the table on the balcony.

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26052006 D.20 T4/WJS M/T BRIS38 (Halliday, Coroner) A Sergeant LIVERMORE attached to the Scenes of Crime Unit arrived; he tested the stubbies for fingerprints. He was of the view that fingerprints would not have been able to be obtained from the syringe as he thought that if any finger print powder was applied it might interfere with any further more expert investigation of that instrument. As his evidence is appreciated the taking of fingerprints from the syringe was a matter for Brisbane forensics.

The witness explained how he physically walked the interior of the unit and he described that process by which he viewed various items, and formed a view as to whether there were any that would indicate to him that they were a suitable candidate for the taking of fingerprints.

At the end of the day, he was of the view that only the stubby bottles were the only relevant and significant objects to be fingerprinted.

There was a witness protection card on display in the unit but, the witness apparently, either did not notice it or he did not feel that that was relevant to be photographed.

50 Something rather amazing occurred in relation to the syringe. It was conveyed in the normal course of events, through police channels, to the John Tonge Centre where it was presented for routine analysis, and in the course of such analysis process,

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24052006 D.24 T5/MPS M/T BRIS38 (Halliday, Coroner) the needle which had been broken off, and which had been 1 reinserted into the syringe, expelled itself and disappeared in the examination process. Miss Semple, in the process of extracting the needle, described how it became lost, and despite a search by numerous staff as she said, "for hours", 10 it could not be found.

The syringe was required to be analysed with a view to determine not only its content but the strength of such. A quantitative analysis was unable to be undertaken upon the syringe due to the loss of the needle but it was determined from the qualitative search of the syringe that it contained heroin.

Another witness who gave evidence was a Mr McARDLE who was a solicitor with Boyce Garrick and the solicitor for PARKER. He was first consulted by him on the 19th of June 1995 in relation to charges of assault and of wilful damage, and in the process of that consultation, a statement was prepared and subsequently forwarded to PARKER for correction and signature. At that initial consultation, PARKER told Mr McARDLE that he was on the witness protection program and he gave the name of Detective Allan THOMPSON of the Western Australian police as a means of confirmation, and on the 11th of September, Mr McARDLE was contacted by Mr THOMPSON.

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24052006 D.24 T5/MPS M/T BRIS38 (Halliday, Coroner) On the 3rd of August 1995 a draft statement was forwarded by MCARDLE to PARKER at Chopper Line. On the 23rd of August 1995, a second statement was received and amended and a further statement sent, apparently on the 8th of September, 10 and was not returned.

On the 11th of September 1995, a communication was received by him from Detective THOMPSON at 12.04, and Mr McARDLE was advised of the death of PARKER.

Subsequent inquiries were made by THOMPSON as to whether a letter had been received by Mr McARDLE from the woman who had mailed it, and a later call on the same day at 3.10 to 30 THOMPSON and a note that THOMPSON had apparently spoken to the deceased on the Thursday.

THOMPSON and AMBROSE gave evidence that the mobile phone of PARKER was used by the police and that three phone calls were **40** made from such phone. There were two explanations given for such occurrence. The first one was that police were unable to use the police radio/phone as the police vehicle was situated in a "black spot" area and secondly, that police did not want 50 to use the police phone because the media might 'intercept' the call, as do tow truck drivers, and attend at the scene.

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24052006 D.24 T5/MPS M/T BRIS38 (Halliday, Coroner) In any event, it is quite clear that by the use of PARKER's phone, an important part of the scene of crime had been interfered with.

An important matter for consideration by the inquest has been 10 the condition of the lock or locks on the front door immediately prior to the entry by the police. I have already referred to how the door had been previously damaged on the Thursday and had running repairs carried out upon it. 20

Police Officer LIVERMORE recalls, as he said, thinking at the time as part of his general assessment of the scene that for somebody to have been in the unit they would have had to have been either let in by somebody already inside or to have had a key to enter and then for the door to have been locked and they would have to have had a key to do so.

Mr PETRELIS Senior asked an interesting question of the 40 witness, "If he needed a key to lock the door, how would he (the deceased) lock himself out?" To which the police officer replied, "I can't explain that. Interesting point. There are two locks. There is the bottom lock and the deadlock above that so the bottom lock is such that you could pull the door closed without the key and it would lock. It is the top lock I am suggesting that you would need a key to deadlock that."

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24052006 D.24 T5/MPS M/T BRIS38 (Halliday, Coroner) Detective Sergeant Dale THOMPSON said in his evidence that he did not look at the front door locks but he looked at the photographic evidence of the lock and he described such as illustrating that the deadlock had been in operation at the 10 time that the door was forcibly forced open, and he described that he arrived at that conclusion by referring to the tongue as protruding behind the door, on the side of the door, in the photograph.

THOMPSON also said that he can remember the police having to kick their way in, and there was also evidence given by Police Officer AMBROSE in relation to the lock and his evidence was to the effect that the door was locked and had to be forced open.

Mr TAYLOR, who actually repaired the door on the first occasion, said that he did not have to repair any deadlock.

It is clear, however, from the photographic evidence produced to this Inquest, that there is no specific photograph of the locks. There is much photographic evidence of other items but none of the door locks and one might reasonably ask and expect that a police photographer would have considered it reasonable to have been requested to take and/or to have taken a photograph of the locks supposedly securing a door in the particular circumstances of this case.

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24052006 D.24 T5/MPS M/T BRIS38 (Halliday, Coroner)

I now turn to the medical evidence. Before so doing, I refer to the need for medical evidence in a case such as this.

Medical evidence consists, in cases such as this, normally, of **10** an initial autopsy, and it has been said that

"the autopsy is an examination carried out to identify pathological processes and anatomical abnormalities at a 'point in time', namely at death. It is only when these findings are integrated with information about the death scene and the individual's medical history and lifestyle that the information obtained from the autopsy can be put into a proper context. In many cases, this background information is essential for the pathologist to arrive at the cause of death. It follows that, ideally, all the stages of a death investigation should be available to the pathologist when formulating his or her autopsy findings."

[Freckelton and Ranson "Death Investigation and the Coroner's 30 Inquest" (pages 315 - 316)]

It has been further said in such text that

"at the completion of the forensic medical examination
the medical practitioner arrives at a conclusion
regarding the significance of the injuries and the other
medical and pathological findings"

[Page 477]

and also that

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"there has been considerable debate among forensic pathologists as to what factors should be taken into account when arriving at a medical cause of death. Should the pathologist rely only upon objective findings from the autopsy? Or should the pathologist integrate circumstantial information provided by the police or other investigators with the medical evidence? The 1
24052006 D.24 T5/MPS M/T BRIS38 (Halliday, Coroner)

danger with the latter approach is that the pathologist has no way of validating information provided by others."

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There were two doctors who were called who gave viva voce evidence, Dr NAYLOR and Dr HOSKINS. Dr NAYLOR, being a Pathologist with the John Tonge Centre and Dr HOSKINS, being a Director of Clinical Forensic Medicine with the Queensland Department of Health. Both doctors, from their qualifications as supplied to the Inquest, are extremely experienced in their respective medical fields.

There has also been placed before the Inquest, a report given to Mr Robert-Smith, QC, by Dr COOKE, the Chief Forensic Pathologist of the Western Australian Centre of Pathology and Medical Research, and there has also been brought to the attention of the Inquest certain views expressed by Dr POCOCK, a former Chief Forensic Pathologist for Western Australia.

The Court intends only to refer to the viva voce evidence at this stage because the evidence of Dr COOKE, in its main, would appear to support that of Dr NAYLOR, although it ought also be commented that although Dr COOKE had not seen the report of Dr POCOCK, he expressed the view, "It would be mischievous, however, to conclude that the findings in Mr PETRELIS's case could indicate murder."

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24052006 D.24 T5/MPS M/T BRIS38 (Halliday, Coroner) I do not intend to refer to all of the evidence of Dr NAYLOR but only to the more salient parts. The doctor was asked this, "What do you mean by opiate toxicity?" And the answer was, "Opiates form a class of drugs which include heroin, 10 morphine and codeine and toxicity simply means that the substances in question were present at levels such as to have a toxic effect on the individual." Question, "How would they have a toxic effect on an individual typically?" Answer, "Typically, opiates may cause suppression of breathing." 20 Question, "Can you form an opinion as to how the opiate toxicity would have, in effect, caused his death?" Answer, "Well, I believe that one of the factors that probably operated in this case was aspiration but that's a very common 30 finding in these kinds of death and I think that would have operated with the effect on respiration."

And later, Question, "What was the basis of your finding that death was due to opiate toxicity?" Answer, "The drug or **40** compound must be at levels which are known to be capable of causing death in other cases. ... One would like to see changes in the body that are typically associated with toxicity from that particular drug, for example, although it's 50 non-specific, congestion of the lungs, that is engorgement of the lungs with blood is a common feature of toxicity from opiates ... it is totally non-specific but is a common finding in these kinds of death."

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And later, after referring to the relevant toxicity report which shows the respective readings of morphine within the system of the deceased, he said:-

"These figures are well within the range of what is encountered in living drivers. Nevertheless, looking at it the other way, these figures are also well within the range of the kind of levels that one sees in death attributed to morphine".

## And later -

"The next question, I suppose, is whether there are any other explanations possible for the deceased's death, and in my view, the findings, which I recount in my post mortem report, indicate that the answer to that is 'No,' there is no alternative, at least none obtained from the examinations that I conducted ... although this is not particularly strong evidence, the positive findings, if I can put it that way, are consistent with death from drug toxicity, and I mention congestion of the lungs which, although it is non-specific, is a common feature of death from drugs, and I have noted on page 2 of my report that the lungs are intensely congested".

He was then asked, "If you leave out of consideration death by drug toxicity, you wouldn't have been able to form an opinion as to any other cause of death?" And he answered, "Precisely". Question, "From what you found?" Answer, "Yes. That does not mean, of course, that there isn't one. I mean -I suppose, I can't rule out the possibility that someone had smothered him with a pillow, for example".

And further, Question, "But your findings weren't in fact consistent with any other course?" Answer, "That's right." 10

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26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) Reference was then made by the doctor of the presence of the 1 syringe by the body and of the existence of the needle puncture sites in both left and right antecubital fossae from which, following examination, it was concluded by Dr NAYLOR that there had been substance injection into both arms at some 10 indeterminate time prior to death, but "within" hours thereof.

Dr NAYLOR was further asked, "All that you can say is that on at least two occasions there was an injection of morphine into the left and one into the right arm?" Answer, "Yes, I think I can say that as a minimum but I suspect, from the foreign material and the giant cells, one is probably looking at, at least four injections".

I ought to add, that in the course of the evidence of Dr NAYLOR reference was made to various articles which he made available to the Inquiry, one being by one Dr Drummer, a leading forensic scientist not only in Melbourne and **40** Australia, but of international reputation.

In an article entitled the "Forensic Pharmacology of Drugs of Abuse" there appears therein the following extract:-

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"Since blood morphine concentrations are largely uninterpretable as a cause of death, there is little value in just measuring concentrations of morphine in the blood." 26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) Following the earlier evidence of Dr NAYLOR concerning his 1 being unable to rule out the possibility that someone had smothered the deceased further medical opinion was sought and a train of medical inquiry was put into place and in such regard, Dr HOSKINS was consulted in the light of what appeared 10 to be markings on the wrists of the deceased as shown within the photographic evidence.

Following such consultation, Dr HOSKINS advised the Inquiry that the markings that he viewed on both the left and the right wrists may well have been suspicious.

In relation to the markings on the left wrist, Dr HOSKINS was of the view that they were explicable by a combination of the position of the hand combined with post mortem hypostasis. There was nothing in the appearance of the left wrist that would lead one to be suspicious of it independently.

In relation to the markings on the right wrist, it was the concluded view of Dr HOSKINS, as appreciated, that such markings were consistent with being applied by some form of restraint; perhaps a ligature; perhaps handcuffs. But his preferred view was a restraint by a ligature of some sort. The markings identified in the photographs were suggestive, he said, of restraint but were not diagnostic.

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26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) In addition, Dr HOSKINS diagnosed some darkening on the side of the right wrist, which could be a bruise of some few hours old or a few days old and anywhere, as he said, in between. He was further of the view that such bruise was of extremely limited evidentiary value.

In relation to the levels of opiate detected in the blood, such, he said, were consistent of being present in persons who were still living and driving on our roads, and there was nothing that would indicate to the witness that the opiate level found in the deceased was of a toxic level as opposed, as he said, to the next person.

Dr HOSKINS further stated that in the particular case there were other findings which are commonly found in relation to heroin deaths; namely, congestion of the lungs and the presence of petechiae due to venous engorgement.

In the course of his evidence Dr HOSKINS further stated that at the time of his writing of his reports of the 22nd of March (Exhibit 89) and the 31st of August (Exhibit 92) he did not agree with the opinion expressed by Dr NAYLOR as to the cause of death and that he was of the view that "asphyxiation" appeared to be a reasonable possibility as it was his understanding that asphyxiation did cause the appearances that were found at autopsy, but that he had discussed the matter

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26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) with Dr NAYLOR subsequently, that he resiled from such an opinion and he deferred to the opinion of Dr NAYLOR.

At the time that he gave his written opinions, Dr HOSKINS disagreed, and it would appear strongly, with that of Dr NAYLOR; he was of the view that asphyxiation appeared to him to be a reasonable possibility being consistent with the post mortem findings by Dr NAYLOR.

Subsequently Dr HOSKINS, on his evidence, conferred with and discussed with Dr NAYLOR not only Dr NAYLOR's findings, but also his own belief of there being asphyxiation.

Dr NAYLOR was further asked in the course of his evidence, the actual signs observed at autopsy being the petechiae haemorrhages were confined in a way that would not normally lead to any suggestion that this was a death by asphyxiation. And Dr NAYLOR said, "That's exactly right". Question, "You have never claimed that these signs were present that would lead in that direction?" Answer, "Exactly so".

At the end of the day, as the evidence of Dr NAYLOR is appreciated, he is unable to exclude death by smothering, and as referred to by him, some other causes such as electrocution, epilepsy, drowning and insulin overdose. But, as he said, on the balance of probabilities, he is of the view

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26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) that death due to opiate toxicity is the reason concluded by him as to the cause of death.

When one views the evidence of Dr NAYLOR it is important to keep in mind the observations that I have expressed in 10 relation to the standard of proof and to the role of a medical practitioner and expert in a proceeding such as this.

The next matter I want to canvass is, could the death of the deceased have been caused by any other person? During the course of this hearing there have been various hypothesis expressed in one way or another.

It is quite clear and glaringly obvious that there are two persons at least who have both motive and reason to cause the death of the deceased. Those persons being KIZON and RIPPINGALE.

As will appear from matters referred to shortly, it may be said that KIZON deliberately and intentionally set up an alibi by withdrawing himself from circulation in Perth and by admitting himself to hospital for what would appear, on the face of it, to be not a significant medical complaint. It is clear that at the time of the death of PARKER, Mr KIZON was in hospital in Perth.

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26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) As regards RIPPINGALE, there is no evidence to indicate that he was in fact in Queensland at the relevant time. However, from my observations of RIPPINGALE, he was a most unsatisfactory witness and the same may also be said in 10 relation to KIZON.

I now refer to the evidence of KIZON. He says that he was told of the death of the deceased by KARAGEORGE some three or four days after the death. He says that he did not know where 20 the deceased was at the time of his death. However, upon his hearing of it he rang his solicitor and he rang his coaccused, RIPPINGALE.

KIZON further said that he was looking for 'Andrew' at one stage, as he said, so that Andrew could come and consult his lawyer.

He says that he knew in about April or May of '95 following a **40** conversation with THOMAS, that 'Andrew' was on the witness protection program. He was asked, "Did you know before that?" He said, "I think so". He said he was looking for Andrew after he, KIZON, was charged.

He says that he experienced symptoms of a minor ear infection and he probably attended the Sir Charles Gairdiner Hospital on Friday the 8th of September 1995. He said he ended up driving 1

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26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) to the hospital himself. He said he was treated with a couple 1 of tablets and he drove home; he relaxed and woke up the next morning and he felt dizzy and he went straight back to the same hospital on the Saturday morning. He said that there was a massive waiting list, and so he went to the Murdoch Private 10 Hospital where he was admitted for a period of some two days.

He said that after his discharge from the hospital and probably on the Tuesday, he went to an establishment called "The Audiocom" a place at which KARAGEORGE was working or had some association, and he was told by him of the death of the deceased.

30 WIZON further stated, as appreciated, in a taped conversation with THOMAS, that he was told that THOMAS and the deceased were in Queensland, whilst the deceased was on the protected witness program. He further stated that he wanted to see PETRELIS. He did not ask any of his colleagues to assist in that regard as he said that he was "the best man for the job".

He was asked, "Is it possible that you may have become aware that PETRELIS was living in Queensland before his death?" And he answered, "Yes".

He admitted the contents of an intercepted telephone conversation between himself and RIPPINGALE on two occasions; 20

26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) the first one being on the 22nd of November 1994 when he said, 1 "I'm going to wring his fucking neck" referring to PETRELIS. And on the 26th of November, "I'm going to kill him". And his reaction or response for his reason to using those words was that they were merely "a figure of speech".

There was evidence given by the journalist Alison <u>Fan</u> (McLoren) concerning her contacting KIZON at a time when she had been told that he had suffered a heart attack and was either in hospital or was demised, and she made attempts to contact him by telephone and subsequently spoke with him, at which time he said that he was alive, but that PETRELIS was not. During the Inquiry the issue arose as to when such conversation took place.

The witness FAN initially said that the conversation occurred on a Sunday evening because she had received advice from her place of employment and she was at home.. She subsequently changed that evidence and said, no, it was on a week night, and she explained her reasons for that, and she then designated that the occasion was on a Wednesday evening. And she recalled that day and evening of the week, having regard to the fact that immediately after the phone call she felt 'miffed', to use my words, because she had spoken to a fellow journalist, Robyn CASH a freelance journalist in Perth, and had inquired about the death of PETRELIS from her, and then the following day she was 'concerned' to find that her story

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26052006 D.24 T6/BH M/T BRIS-38 (Halliday, Coroner) had been used in an article written by such journalist in the local paper - The West Australian.

So it is quite clear from the date of the publication of the article that the relevant conversation occurred not on the Sunday but on the Wednesday evening, and subsequent to the finding of the body of the deceased on Monday 11 September 1995. Such evidence is relevant to the rebutting of any inference that KIZON knew of the death of the deceased prior to the time of the finding of the body.

It is quite clear - as I have indicated - that KIZON had a reason, a very good reason, a substantial reason to have PETRELIS out of the way and unable to testify against both himself and RIPPINGALE at the pending criminal trial.

However one may speculate, and however one may guess and surmise, there is at the end of the day, having regard to the relevant standard of proof, no evidence before this Inquest sufficient to implicate KIZON with the death of the deceased.

As regards RIPPINGALE, he was a most unimpressive witness and such will be apparent from the following extract from his evidence:

"Do you remember where you were between the period the 7th and the 11th of September '95?-- No, I don't. No idea?-- No. Were you in Queensland?-- Sorry, I was in Queensland. I

came over here for a football game. I'm not sure on what

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26052006 D.24 T7/KH M/T BRIS38 (Halliday, Magistrate)
date, but you asked if had been in Queensland. I had 1
come to Queensland for a football match.
What? During that period?-- Yes, that is correct.
What was the football match?-- Collingwood and the
Brisbane Bears.
Where was it held?-- At the Gabba - or I think it was
actually - might have been at the Gabba.
Carrara?-- Carrara.
You had been to the North Coast from Brisbane,
Caloundra?-- Yes."

Later on, he admitted being in Brisbane, meeting his cousin 20 who lives at Noosa, but he denied seeing the deceased in Queensland.

I might interpose there to say that I can take judicial notice of the fact that Carrara, at that time, was, and still is, on **30** the south coast of Queensland - on the Gold Coast. Caloundra is on the north coast. Both being surfing beaches.

Let us see what happened when KIZON stood up to cross-examine the witness:

"You might have got confused between the 7th of September '95 and the 11th of September '95. Andrew PETRELIS died in Queensland on the reports, that weekend?-- Yes. Were you in Queensland at that time?-- No, I was not, no. CORONER: Listen, how is your memory?-- It's not - it's **50** not going too well at the moment."

Well, at the end of the day, not only is RIPPINGALE a most unsatisfactory witness, but there is once again, no evidence **40** 

26052006 D.24 T7/KH M/T BRIS38 (Halliday, Magistrate) before this Inquest sufficient to implicate RIPPINGALE with the death of the deceased.

What about CHRISTIAN? Well, on the material before this Inquest CHRISTIAN is an associate of KIZON and his photograph has been identified in evidence adduced before this Inquiry and being within the material forwarded by the deceased to Western Australia a few days prior to his death and in the context of his being prepared to give further evidence against KIZON and others.

CHRISTIAN has apparently not been interviewed by any person in relation to this matter. He has not been interviewed by the Western Australian Police, the Queensland Police or by any other agency or law enforcement agency in relation to any of the information which has been placed before this Inquiry. Further, it would appear that he was not interviewed by any of the authorities or Inquiries set up in Western Australia. In particular, it would appear he was not interviewed in relation to the Robert Smith Inquiry. There is no evidence before this Inquest to implicate CHRISTIAN with the death of the deceased.

A witness of some great interest to this Inquiry and who gave evidence and who in my view knows far more about this matter than has been displayed to date, is Colleen THOMAS.

Visits have been made by coronial police investigators to Perth with a view to locating THOMAS and others. All such 10

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26052006 D.24 T7/KH M/T BRIS38 (Halliday, Magistrate) inquiries and attempts to locate and interview THOMAS have proved to no avail.

It seems to me to be extraordinary that in a place such as Perth a person such as THOMAS is unable to be located. By such comment I am not intending to be critical of the Western Australian Police, but reports made to this Inquiry have indicated that a female person residing at the residence known to Queensland Police when they visited same to interview THOMAS, was seen to be spirited away in somewhat bizarre circumstances, and I refer to the evidence of Detective Sergeant ARCHER in that regard to this Inquest.

What is the relevance of THOMAS? The relevance is this: following her giving of evidence in February of 2001, she became physically and visibly upset at a certain line of cross-examination put to her by Counsel for the next-of-kin. One must ponder and seriously consider the reason behind the subject matter of such a line of cross-examination.

Following such cross-examination, the witness consulted Senior Sergeant Turpin, then coronial police assistant, and she had this conversation with him which has been placed into evidence:

"I would have told you a whole lot more, except for that bastard, but I don't want to end up with cement blocks on my feet."

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26052006 D.24 T7/KH M/T BRIS38 (Halliday, Magistrate) It is relevant to note that subsequent to the crossexamination of THOMAS the next-of-kin decided to be selfrepresented.

It is quite clear that the witness, THOMAS knows much more about this matter than she has been prepared to tell to date and it is for this reason that many attempts have been made to further locate her with a view to her being further interviewed and the recalling of her but all such attempts have failed.

There are some other matters that should be mentioned and placed upon public record.

Former police officer, Peter Coombs, gave evidence and in certain respects his evidence was not at all satisfactory. He said that it had come to his knowledge that KIZON knew that PETRELIS was PARKER before his death and that such information was in the possession of the Western Australian Police Internal Affairs and the National Crime Authority. 40

Although this Inquiry has requested from such entities all relevant information within their possession, no such evidence as referred to has been either located, or if it has been located, been produced to this Inquest.

Further, any such contention by Mr COOMBS, was not mentioned to the special investigation conducted by and contained within the ACC report. 50

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26052006 D.24 T7/KH M/T BRIS38 (Halliday, Magistrate)

The Crime and Corruption Commission (WA) was represented by Counsel who informed the Inquest that it possessed no further material and Coombs was cross-examined as to his credit.

It should also be noted that this Inquest has sought by way of summons all information of a relevant nature from the Australian Federal Police and some files and relevant material have been produced in respect thereto.

The Inquiry has also been informed that some files have been destroyed since the issue of that summons and they were not and could not be produced. However, the Inquest, on the evidence that has been placed before it, has been assured that the material that was so destroyed was of "no relevance" to this Inquiry.

It is abundantly clear that unless an Inquest such as this receives full and utter cooperation from statutory law enforcement agencies and other police authorities, that its inquiries are made more difficult.

There is no other evidence before this Inquest to suggest that there was at any time any material in existence and which has been so destroyed which was of relevance.

A request was made of the Queensland Police Service in relation to the production of all relevant documents and in

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26052006 D.24 T7/KH M/T BRIS38 (Halliday, Magistrate) particular what has been referred to as reverse Call Charge Records.

There is evidence that has been placed before this Inquiry to suggest that such had been requested, that they would be forthcoming and that once they were forthcoming, the report of Detective Sergeant THOMPSON would be completed.

There is no evidence placed before this Inquest to indicate that any such records were in fact requested and if they had been requested, there is no evidence that they were in fact obtained or received. And further, to make matters worse, if they had been received, they have not been produced to this Inquest by the Queensland Police Service. Furthermore, the suggestion was made during the Inquest that any such request for such records may well have been a ploy to put a stop to the "barking dogs" who were requesting or inquiring as to why the report was taking so long to finalise.

And for completeness on this subject reference is made to the Report of Detective Inspector ELLOY concerning the presence or otherwise of the reverse Call Charge Records.

An issue arose during the Inquest whether the report from then Detective Sergeant Allan POTTS (W.A.) was ever received and or viewed by Detective Sergeant THOMPSON (Qld).

The Report from POTTS is a matter of relevance and considerable importance because it is clear that it contains 30

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26052006 D.24 T7/KH M/T BRIS38 (Halliday, Magistrate) most relevant information concerning the death and possible circumstances surrounding the death of the deceased.

It is stated in evidence that upon its receipt in Queensland it would have been passed down the line, so to speak, through the hierarchy and higher echelon of the Queensland Police Service until it found its way on to the desk of THOMPSON and the Inquiry was told by senior police officers that, in the normal course of events, that document would have so found its way eventually into the hands of THOMPSON.

When THOMPSON came to compile his report for submission to the Coroner in Caloundra, there is no mention whatsoever made of the allegations contained within the report from POTTS and one would ask why. Either THOMPSON was completely negligent and incompetent in such regard and failed to turn his mind to it, or he did not receive it.

We have in our law, a presumption of regularity, found in the Latin maxim "Omnia praesumitur rite et solenniter esse acta", which means, "All acts are presumed to have been done rightly and regularly." Now, that is a presumption which may be rebutted by evidence to the contrary. Irrespective of such maxim, and presumption, it is not proposed, in this particular 50 case, to apply it.

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26052006 D.24 T8/NF M/T BRIS38 (Halliday, Coroner) On balance, irrespective of what criticism one may or may not level at THOMPSON, it is clear that he has carried out quite an extensive investigation illustrated by the number of witnesses he interviewed. It is beyond reason for him to 10 deliberately refrain from mentioning such Report when it contains such important material.

On the last occasion when THOMPSON gave evidence, he stated quite emphatically that the first time he saw the Report from 20 POTTS was when it was shown to him in the witness box. His evidence in that regard is accepted.

It is apparent that there has been a failure in the internal administrative procedures of the Queensland Police Service to 30 ensure that a document of such importance is brought to the attention of an investigating police officer, and for there to be an appropriate record of that fact.

One would reasonably expect that at the very least the normal 40 procedure of recording the circulation of correspondence between Police personnel should have been strictly followed in this case.

50 Reference is made to the concern of the Inquest relative to the production of relevant material by the then Criminal Justice Commission (Qld). The Commission had been requested, through its present entity, to produce every relevant document

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26052006 D.24 T8/NF M/T BRIS38 (Halliday, Coroner) and any material that it may have in relation to this Inquiry. It appears that no substantial material has been produced of any relevance.

10 In that regard, reference is made to the contents of paragraphs 928, 933 and 1340 of the Roberts-Smith Report, and of the comment made by the learned Royal Commissioner. This Inquest is also unable to resolve the apparent divergence of opinion, although reference ought also to be made to part of 20 Exhibit 96 of the Western Australian Police file, which includes as appreciated an extract from the personal papers of the deceased and which contain the 24 hour phone number of the CJC, and reference to Operation Dice, and which appear to be 30 in the handwriting, it is said, of the deceased. For similar reasons to the learned Royal Commission this Inquest is unable to reconcile such divergence of opinion.

For the purpose of this Inquest reference and comment ought to 40 be made upon the following matters:

## The Quality of the Witness Protection Program.

It is abundantly clear that the program failed the deceased, as, amongst other things, he was without appropriate safeguards in place, a completely inappropriate person to be placed on such a program, having regard to his affiliation with, and his penchant for, drug use and abuse. It was the

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26052006 D.24 T8/NF M/T BRIS38 (Halliday, Coroner) view expressed by then Detective Sergeant Allan POTTS that the 1 deceased was used as bait to catch others.

Further, it is clear that at no relevant time whilst the deceased was in Western Australia or in Queensland, was he adequately supervised by those who were responsible for his physical and health well-being. And, in that sense, reference is not made specifically to any common law duty of care, but to the commonsense fact that, if a person is placed on such a program, such a person must surely be so protected. That is and must be the very purpose of the program, and it has failed. If such is not the purpose and intent the whole program is misconceived and inadequately administered as clearly evidenced in this particular case.

Further, the deceased was let down, grossly, by the program by his being permitted to remain with his then identity when it was known, to those in 'authority', that that identity had 40 been compromised. And reference in such report is made to the "hacking" into of the Western Australia Police Computer System.

50 Further, the deceased ought not to have been permitted by relevant law enforcement agency or authority to remain at any place of residence or relocation once such identity had in any way been compromised.

26052006 D.24 T8/NF M/T BRIS38 (Halliday, Coroner) Further, by permitting the deceased to drive, at any time, a motor vehicle which was reasonably clearly identifiable as a former police vehicle with Western Australian plates, just beggars any reasonable belief or appreciation.

## The Quality of the Queensland Police Investigation.

It is quite clear from the evidence that the unit in which the deceased was found, was not secured or kept secure by police and ought strictly to have been treated as a "scene of crime" and appropriately regulated and assessed. It is also clear that the unit was not protected from external interference. It is clear that objects identified at the time of the finding of the body were interfered with and moved and that certain photographs taken at the scene did not faithfully represent the condition of the premises at the time of entry by police.

Further, the mobile phone of the deceased, which forms "part" of the 'scene of crime', was deliberately used by police, to 40 make 'police' phone calls.

It ought to be brought home to members of the Police Service why there are such things as "scenes of crime", and the importance of them. And in such regard reference is made to the following extract from Freckleston and Ranson:

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26052006 D.24 T8/NF M/T BRIS38 (Halliday, Coroner)

"While the strict rules of evidence and procedure do not apply in Coroners' hearings, this does not mean that it is not necessary to ensure that evidential material from a crime scene is documented, collected, transported, stored and analysed in accordance with the rules of the criminal justice system. Indeed, the rules and procedures required by the criminal justice system in relation to physical evidence from a crime scene have a sound scientific, as well as a legal basis and are therefore appropriate to any scientific or medical inquiry that may be instituted by a Coroner. In general terms, then, any death scene should be considered to be a potential crime scene, and even if, on an initial assessment, no criminal act appears to be involved, basic crime scene management principles should still be applied." (p.197)

#### And, further

"In order to ensure that the evidence collected from a crime scene or a death scene can be used in Court it is necessary to be able to show that the evidence is reliable and truly reflects the material present at the death scene or involved in the death - there needs to be a continuity of evidence or a clear 'chain of evidence'. To this end it is essential that the death scene is effectively secured and controlled. There should be no possibility that the evidence from the scene could have been interfered, altered or adulterated. (at p.201) (emphasis added)

And possibly to add 'insult to injury', there is some evidence that a member of the Western Australian Police Service brought to the attention of a Queensland Police Officer present at the scene the need to so secure the scene.

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As referred to at an earlier time an issue developed as to the relevant condition of the door lock to the unit. Not one relevant photograph of the lock had been taken when one would 10

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26052006 D.24 T8/NF M/T BRIS38 (Halliday, Coroner) reasonably expect that such a relevant issue would have been fully appreciated at the time and such relevant evidence obtained. Such a lack of procedure in the present case is just not good enough for a potential Coronial Inquiry and ought to have been fully appreciated by relevant police in attendance.

FURTHER, there is evidence in the unit of the existence of items of clothing in the vicinity of where the deceased was found; coats and the like. There has been no evidence placed before the Inquest as to the owner or the identity of the person who was the owner of those items, or their association with the deceased. It is clearly apparent that there is no evidence of any police inquiry in such regard and once again such is clearly insufficient for a potential Coronial Inquiry.

If enquiries had been so made at the time, it may well have resulted in ascertaining the identity of any person or persons 40 who may have been either at the unit or with the deceased at the time of his death.

FURTHER, there are certain items shown in photographs produced to the Inquiry and taken by police at the unit and which, apparently, have just simply "disappeared" - such as the CD player and the computer. One would reasonably anticipate and expect that a computer might be of some "forensic use" and

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26052006 D.24 T8/NF M/T BRIS38 (Halliday, Coroner) "information" to a police officer investigating a scene of crime, to test, for example, its hard drive. There is no evidence to suggest any person knows where any such piece of equipment has gone, and it would also appear such do not appear on the inventory of property returned to the next-of-kin.

FURTHER, there was evidence of being found by police in the unit a video described as being of a "pornographic nature", but it also has "disappeared" in the sense of not being either seized by police or being able to be produced to the Inquest. Such video might well have some relevance, having regard to the state of nakedness of the deceased, as to what may or may not have been occurring at the time of his death. And that might well have been a matter for example that Dr NAYLOR might well have liked to have professionally considered in order to assist him in his forensic inquiry.

FURTHER, there were certain items found in the bathroom of the unit which are shown in the photographs, such as dental floss, two separate and distinct items of dental floss and of deodorant. No examination whatsoever was undertaken by police as to the owner or the identity of those who might possess such items so as to ascertain or identify any "third person" who may have been a 'visitor' to the unit. Having regard to the description of such items so found it could reasonably be

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26052006 D.24 T8/NF M/T BRIS38 (Halliday, Coroner) expected that a seizure and appropriate investigation concerning such items ought to have been undertaken.

## Queensland Police Computer

Evidence has been disclosed that the Queensland Police computer had been sourced in respect of the deceased PARKER, and was so sourced subsequent to his arrival in Queensland. Such, on its face, is a serious matter and may well, in the absence of any explanation, fall within the same category and be dealt with in the same way as the fiasco that occurred in Perth in relation to the 'hacking' into the Western Australian Police Service computer. Such a sourcing would be of concern in this particular case if there were not an adequate explanation offered. There has been an explanation so offered as to the reason for such sourcing, the sourcing having been done by police traffic officers, and having regard to the evidence in that regard, there appears to be nothing sinister or anything untoward that may be gleaned therefrom.

# The quality of the initial Coronial Investigation. In

hindsight, it is difficult to be critical of the actions of the Acting Coroner/Coroner, having regard to what was perceived from the Report of Detective Sergeant THOMPSON as such did not refer to the significant matters contained within the Report from then Detective Sergeant POTTS. If such had occurred one might have reasonably have expected a Coronial Inquiry and Inquest to have been conducted.

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## The Identity of the Deceased

The deceased was 'identified' by one Allan MARTIN, previously referred to as being an instructor at the Air Training School, who, on the Form 4 stated that he had known the deceased for some six months. On an appreciation of the evidence that could not be so. Having regard to the photographic evidence of the Deceased as viewed when found by police it puzzles how on the 'initial' evidence that was placed before the then 'Coroner' and subsequently before this Inquiry, how any person could, from where MARTIN said that he was standing, just from inside the front door, that he could reasonably and adequately "identify" the deceased in accordance with accepted and reasonable practice.

It is clear that such initial identification does not satisfy the procedures then in place by the Queensland Police Service, such relevant procedures having been placed before the Inquest 40 and which provide in part that

"Where the death of a person is referred to a Coroner, it will, in all cases, be necessary to identify that body to the satisfaction of the Coroner concerned. <u>Generally</u>, <u>visual identification by a relative</u> will be used as a means of identification. In some cases, this will <u>not</u> be appropriate.

Appendix 8.1 outlines methods of identification which have been used to successfully identify bodies." (Par 8.4.5 of Exhibit 98). (Emphasis added)

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26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner) In this case we have a person who is called upon, who is not a relative of the deceased, and being relied upon by the Queensland Police Service to identify the deceased when it knew from its inquiry that there was a relative of the deceased on the Gold Coast. Having regard to the initial 10 evidence of MARTIN as to where he was standing when he 'identified' the deceased it is difficult to appreciate how such was able to reasonably establish the identification of the deceased. Furthermore, having regard to the initial evidence possessed by relevant authorities as to 20 identification it is difficult to appreciate how the body of the deceased was permitted to leave this State for burial.

Further, on the issue of identification, reference is made to what was said by the witness, LISANDRO who gave evidence to the effect that within a 'short time' prior to the death of the deceased he and THOMAS were at her residence in Perth. The witness described him, as appreciated, as dissipated and in a poor physical state, the inference being that he was suffering the ravishes of drug addiction.

It is clear from the evidence of Dr NAYLOR, that if the evidence of LISANDRO is correct, then the person who attended at her home and who she believed to have been PETRELIS was not 50 the body of the person who was at the John Tonge Centre and upon whom a post mortem examination was performed.

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26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner) In the light of the issue as to identification further evidence was sought from Mr PETRELIS who at a late stage in these proceedings provide a statement to police [Ex 88].

"I cannot recall exactly what day it was, but between the 10 12th and 21st of September 1995, I went to the Funeral Directors with my wife. At this location we were shown the body of a male person. I was able to identify this body as my son Andrew Nicholas PETRELIS."

On the face of such evidence there is seen no reason not to accept it. One might and would expect that in normal circumstances a father of a deceased child would be able to readily identify such child. Such evidence is accepted and it is determined that the deceased is in fact <u>Andrew Nicholas</u> <u>PETRELIS</u>. If there had not been such evidence, there might well have been a different outcome to this proceeding. Such comment is so made in order to bring home to the Queensland Police Service the importance of proper identification procedures being strictly and professionally followed in all cases.

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## Quality of Forensic Investigation

It is necessary to comment upon the quality of the forensic investigation conducted at the John Tonge Centre. Firstly, in this day and age it is difficult to appreciate how a vital piece of medical evidence such as a needle from a syringe can go missing in a forensic laboratory. One might even say that it lacks professionalism. The personal and professional

26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner) concern of the witness SEMPLE is appreciated but the occurrence cannot be accepted or condoned in a professional institution. It is abundantly clear that there must be steps put in place whereby a repetition of a similar type of incident is unlikely to occur again.

Further, Dr NAYLOR gave evidence that during the course of his post mortem examination procedures, he received certain information from a police officer in attendance, which he thought was of relevance to the course of his examination. However, he had no notes or other record of what he was so told so as to assist the Inquest. It is important and crucial that <u>all</u> things upon which an expert witness so relies to form an opinion or a course of procedure is recorded so that there may be a permanent record thereof.

# CONCLUSION:

I am reasonably satisfied and so find that the body found 40 within the unit and upon which a post mortem examination was conducted is and was that of Andrew Nicholas PETRELIS.

I am reasonably satisfied and so find that the only reasonable medical evidence as to the cause of death is the fact of there being found within the blood of the deceased, an amount of morphine, at a level which is indicative of opiate toxicity.

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26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner) 1 The door of the premises, I am satisfied was in a locked state, which had to be broken down by police in order to gain entry. The windows to the unit were guarded. The position of the body and its state of undress was bizarre and suspicious. 10 There is no evidence to suggest that the death of the deceased was due to any cause other than the injection of heroin. Although one may well speculate as to the circumstances in which such injection occurred, there is no evidence to suggest that the injection was other than self administered. 20 Furthermore, there is no evidence that such administration was with the necessary intention of taking his own life. (vide inter alia the dicta of Lord Widgery CJ in R v. H.M. Coroner for the City of London, ex parte Barber (1975) 1 WLR at 1310 30 and James J, as his Honour then was, in Cardiff City Coroner, Ex parte Thomas (1970) 1 WLR at 1478.)

## FORMAL FINDINGS

I make the following formal findings:

#### A. The identity of the deceased person.

The deceased was Andrew Nicholas PETRELIS, who was born on the 27th of January 1970 and who, at the time of his death, was residing at Unit 6 Windsurfer Units, 9 Leichhardt Street, Golden Beach, Caloundra in the State of Queensland;

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26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner)

I further find on the evidence that has been placed before me that the occupation of the deceased at such time was that of student pilot;

#### B. Date and Place of Death

I find that the deceased died at Caloundra in the State of Queensland between the 7th and the 11th September 1995.

## C. Medical Cause of Death

I find that the medical cause of death was opiate toxicity;

I further find that there is no evidence which would reasonably suggest that the cause of death was other than by self administration;

Pursuant to the provisions of the Coroners' Act, the Coroner in appropriate cases is entrusted with the public duty of committing for trial any person or persons who on the evidence ought to be charged with any of the offences referred to in Section 24 of the Act.

I further find that no person or persons will be committed for trial.

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# RECOMMENDATIONS

It is a further requirement of an Inquest to make recommendations in an appropriate case, which may be necessary 10

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26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner) for the prevention of a similar type of occurrence in the future.

It has been said that it is the paramount duty of any State to protect the lives of its citizens. To this end it is 10 important that the coronial system monitor all deaths and particularly that it provides to the community a review of the circumstances surrounding deaths, that may appear to be preventable and every effort should be made to obtain 20 recommendations which might prevent similar deaths in the future. It is the role of an Inquest, as it has been said, to speak for the dead in order to protect the living.

I make the following recommendations.

<u>Firstly</u>, in relation to witness protection. It is recommended that there be implemented by relevant law enforcement agencies a system of protocols for the securing of the safety and 40 personal wellbeing of persons placed upon a witness protection program.

<u>Secondly</u>, in relation to the conduct of post mortems. It is recommended that there be a keeping of notes and the recording of all that is said at a post mortem examination by a witness to the pathologist, so that there is a record of the matters upon which the pathologist so acts.

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26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner) Thirdly, recording of records and the continuity of reporting of police officers. It is clear that in this particular case, there was no written record of the receipt of the report from POTTS, indicating that it found its way via Assistant 10 Commissioner MACKAY of the Western Australian Police to Superintendent STOLZ, Queensland and thereafter to Police Officers OLIPHANT, BOURKE, and eventually to THOMPSON. It is recommended that there be implemented and adopted an internal protocol within the Queensland Police Service whereby the 20 dispatch and receipt of documents may be readily administratively tracked so as to indicate the receipt of the same by relevant personnel.

30 Fourthly, investigations into the death of protected witnesses and the like. During the course of this inquest, the only evidence which has been submitted to it involving any investigation into the death of the deceased, other than the report by POTTS, has come from the investigations carried out **40** by THOMPSON. It is clear that the deceased was a most important and crucial witness in the criminal proceeding contemplated in Western Australia.

Relevant crime authority bodies interested in the deceased as 50 being a prospective witness were the National Crime Authority, the Australian Federal Police and the Western Australian Police. It seems quite unusual that in the event of the death of such an important witness, in suspicious circumstances,

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26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner) that law enforcement agencies of such stature would not thoroughly investigate the matter both in the terms of the relevant death and with a view to the prevention of further deaths of a similar nature in the future.

It is therefore recommended that in the event of a death of such an important witness as a protected witness that such death be thoroughly investigated by the relevant law enforcement agency.

Fifthly, identification and removal of bodies, interstate. There were statutory provisions in place for the satisfaction of the Coroner as to the identity of a deceased before burial may take place, and for a body to be removed interstate. It is recommended that the statutory requirements in that regard be

strictly adhered to and enforced.

Before I close the inquest, I wish to place on public record my appreciation, my personal appreciation and that of this Court, for the great assistance that has been given to the Inquest by Counsel Assisting, in particular, Mr Grealy; and also, Detective Sergeant ARCHER who was attached and seconded, upon request made to the Queensland Police Service, to the Coronial unit to carry out the extensive investigations that have been undertaken in this matter. And for that, the cooperation of the Queensland Police Service is greatly appreciated. The degree of dedication to research and to detail of investigation by Mr Grealy and Detective Sergeant

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26052006 D.24 T9/RC M/T BRIS38 (Halliday, Coroner) ARCHER was quite exemplary and I wish to place on record all due appreciation in that regard.

It is directed that a copy of these Reasons once transcribed and revised be made available to all interested parties upon request so made.

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The Inquest is now closed.

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