CITATION: *Inquest into the death of Alfred Firth Thorpe* [2002] NTMC 030

TITLE OF COURT:	CORONERS COURT
JURISDICTION:	Coronial
FILE NO(s):	D0201/2001
DELIVERED ON:	6 August 2002
DELIVERED AT:	Darwin
HEARING DATE(s):	22 July 2002
JUDGMENT OF:	Mr Greg CAVANAGH SM

CATCHWORDS:

Coronial Inquest, death in custody, death from natural causes, prerogative of mercy

REPRESENTATION:

Counsel:

Counsel Assisting: Ms Elizabeth Morris
Counsel for the Northern Territory: Mr David Anderson

Judgment category classification:	A
Judgment ID number:	[2002] NTMC 030
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0201/2001

In the matter of an Inquest into the death of

ALFRED FIRTH THORPE
ON 29 DECEMBER 2001
AT ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered 6 August 2002)

Mr GREG CAVANAGH:

1. This death is properly categorised as a death in custody. At the time of his death, Alfred Firth Thorpe (the deceased) was a person lawfully committed to be detained at the Darwin Prison. The deceased, therefore, was a "person held in custody" within the definition in s.12 (1)(b) of the *Coroners Act* 1993 (NT) ("the Act"). His death is a "reportable death" which is required to be investigated by the Coroner pursuant to s.14 (2) of *the Act*; a mandatory public inquest must be held pursuant to s.15 (1)(c).

2. The scope of such an inquest is governed by the provisions of sections 26 and 27 as well as sections 34 and 35 of *the Act.* It is convenient and appropriate to recite these provisions in full:

> **"26. Report on Additional Matters by Coroner**
>
> (1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner –
>
> (a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to

by injuries sustained while being held in custody; and

(b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.

27. Coroner to send Report, &c., to Attorney-General

(1) The coroner shall cause a copy of each report and recommendation made in pursuance of s 26 to be sent without delay to the Attorney-General.

34. Coroners' Findings and Comments

(1) A coroner investigating –

(a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*; and

(v) any relevant circumstances concerning the death.

(2) A coroner may comment on a matter, including public health or safety or the administration of justice connected with the death or disaster being investigated.

(3) A coroner shall not, in an investigation, include in a finding or comment a statement that a person is or may be guilty of an offence.

(4) A coroner shall ensure that the particulars referred to in subs (1)(a)(iv) are provided to the Registrar, within the meaning of the *Births, Deaths and Marriages Registration Act*.

35. Coroners' Reports

(1) A coroner may report to the Attorney General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

CORONERS FORMAL FINDINGS

3. In accordance with the statutory requirements under *the Act*, the following are my formal findings arising from this Inquest:

i. Identity: The Deceased is Alfred Firth Thorpe, a male Caucasian Australian, who was born on the 1st of November 1944 at Innisfail in Queensland.

ii. The time and place of death: The Deceased died in Royal Darwin Hospital on the 29th of December 2001 at around 0300hrs.

iii. The cause of death: The cause of death was carcinoma of the right lung.

iv. The particulars required to register the death are as follows:

a) The Deceased was a male;

b) The Deceased was a Caucasian;

c) A post mortem examination was carried out on 3 January 2002 and the cause of death was carcinoma of the right lung.

d) The pathologist viewed the body after death;

e) The pathologist was Dr Derek POCOCK, a locum at the Royal Darwin Hospital;

f) The father of the Deceased is Alfred Firth Thorpe;

g) The mother of the Deceased is Elsa Emma Thorpe, formerly Knorre;

h) The Deceased resided at the Darwin Prison at the time of his death; and

i) The Deceased was not employed in any occupation at the time of his death.

The relevant circumstances concerning the death

4. The details of the inquest were advertised in the "Northern Territory News" on the 10th of June 2002. The public inquest was held at the Darwin Magistrates Court, on Monday the 22nd of July 2002. Counsel assisting me was Deputy Coroner Elizabeth Morris. Mr David Anderson sought leave and was granted leave to appear as counsel for the Northern Territory Government.

5. The next of kin were not present at the Inquest, nor were they represented. I quote from Counsel Assisting:

> "The deceased is survived by his mother, an elderly lady who resides in Queensland. I have spoken to her on the phone and

she's also been notified in writing of the inquest. When the deceased passed away, his nominated next of kin, nominated by himself and his mother, to make arrangements in relation to the Coroners Act, was a Mrs Margaret McCory, who lives in the rural areas of Darwin and has known the family and the deceased for many years.

I have also spoken to her on the phone, and she has been in contact with the Coroners Office. Neither of these people are able to attend today for various reasons but do not wish the Inquest to be put off or adjourned. They are happy for it to proceed. I've spoken to them about what issues may be important to them in examining the death of the deceased. Neither had any complaint to make about his treatment, medical or otherwise, whilst in custody".

6. I proceeded to hear the Inquest, in their absence, pursuant to regulation 9 of the Coroner's Regulations.

7. I heard from two witnesses who gave evidence at the inquest. Detective Sergeant Lade, who I congratulate for his excellent work in investigating this particular death and Ms Zoe Marcham, a policy officer with the Department of Justice. In addition to this evidence Detective Sergeant Lade tendered a full brief of evidence. The brief included numerous statements and other documentary records, and was very thorough. The medical and prison records of the deceased were also tendered.

8. From this evidence I find that the deceased was convicted of manslaughter in the Darwin Supreme Court on the 30th of March 1998. He was sentenced to imprisonment for a period of 8 years with a non parole period of six years which was back dated to the 24th of August 1996. He was eligible for release on parole from prison on the 24th of August 2002.

9. In October 1999 the deceased was transported to Adelaide where he had a throat cancer surgically removed. The deceased declined to have radiotherapy to his neck, which may have prevented the return of the cancer to the throat area.

10. In July 2001 the deceased collapsed in the Alice Springs Prison, and was subsequently flown to Adelaide, where a pacemaker was inserted.

11. In August 2001 the deceased was transferred back to Darwin Prison, his condition deteriorated, and a diagnosis of the cancer, which ultimately caused his death, was made. From this time the deceased was treated as a terminally ill patient. Dr Chris Wake, who was contracted to provide medical services to the prison, provided medical care.

12. On the 23rd of December 2001 the deceased was transferred to Royal Darwin Hospital, as he had reached a stage of palliative care where 24 hour a day nursing was required. This could not be provided at the gaol. Whilst still a serving prisoner, due to his weakened condition, no prison guards were provided or necessary, and the deceased was cared for by nursing staff at the Hospital.

13. At approximately 0300hrs on the 29th of December 2001 the deceased passed away in his bed at the Royal Darwin Hospital.

14. There was a coronial investigation, which I find was thorough and comprehensive. It was in accordance with Police Standing Orders. I find that the deceased died from cancer. His death was anticipated.

15. I have no adverse comments to make about anyone in respect of this death. The medical care that the deceased received both within the prison and at the hospital was appropriate and adequate. The prison allowed the deceased special privileges in order to accommodate his condition. This included things such as diet, equipment (a special mattress and a fridge in his room), and exercise. Several prisoners helped care for the deceased, and I commend them for their compassion in doing so.

16. After the deceased's diagnosis of a terminal illness, an application was made to the Administrator of the Northern Territory for the exercise of the prerogative of mercy pursuant to section 115 of the *Sentencing Act*. The

deceased was seeking early release. This application was dated the 24th of October 2001. A reply from the Administrator, with his refusal to exercise such a prerogative, was dated the 12th of December 2001. The Executive Council decision leading to this recommendation was made on the 4th of December 2001.

17. During the Inquest I made the following comment:

> "-if we have a right to seek mercy that's enshrined in legislation, then that right should not be illusory. That is to say, the procedures that occur when a person who has that right seeks to use it, it should be such that it does not make that right illusory. It's the same kind of thing that where a sentenced prisoner appeals against his sentence. If he serves his sentence before the hearing of the appeal it makes the appeal process and his right to appeal illusory, doesn't it."

18. In order to ascertain that this was not an illusory right, Ms Zoe Marcham, the policy officer with the responsibility for the carriage of the matter gave evidence before me. I am satisfied from her evidence, and from the summary of the procedures and processes carried out tendered through her, that every effort was made to expedite the decision making process. The deceased's circumstances were unusual, his criminal record was serious and lengthy, and his proposed place of residence upon release was in a remote location, at least a location remote from Darwin city.

19. I have no comment to make about the correctness or otherwise of the eventual decision or recommendation to Executive Council. The decision was entirely within the province of Executive Government. My concern was to investigate a matter connected with the administration of justice relevant to this death, ie, that the deceased's application for release was properly dealt with. I am satisfied that it was.

20. There are no recommendations arising from this Inquest pursuant to section 26 (2) regarding the prevention of future deaths.

21. I find that there is no evidence of the involvement of any other person or any suspicious circumstances relating to the death of the deceased and, accordingly no report is required under s.35(3) of *the Act*. Furthermore, I find that the deceased did not sustain any injuries whilst being held in custody which caused or contributed to this death.

Dated this 7th day of August 2002

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Greg CAVANAGH

TERRITORY CORONER