CITATION: *Inquest into the death of Jethro Ngalarra Dhamarrandji-Baker* [2016] NTLC 021

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D124/2015
DELIVERED ON:	5 September 2016
DELIVERED AT:	Darwin
HEARING DATE:	15 August 2016
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**School sports carnival accident, "Troopy Pull" activity, children too close to vehicle, child run over by vehicle, the distance between the vehicle and the participants was unsafe, failure to prepare a proper risk assessment**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
NT Christian Schools:	Jodi Truman of Counsel
Family of the deceased:	Claire Deane (NAAJA)

Judgment category classification:	B
Judgement ID number:	[2016] NTLC 021
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D124/2015

In the matter of an Inquest into the death of

JETHRO NGALARRA DHAMARRANDJI-BAKER
ON: 6 AUGUST 2015
AT: GAWA CHRISTIAN SCHOOL, GAWA HOMELAND OUTSTATION, ELCHO ISLAND, NORTHERN TERRITORY

FINDINGS

Judge Greg Cavanagh:

Introduction

1. The deceased was born on 30 July 2003 at Gove District Hospital in Nhulunbuy to Sylvia Mulurrku Bukulatjpi and James Baker. His birth certificate records his name as "Gethro Nalarra Bukulatjpi". However he was known as Jethro Ngalarra Dhamarrandji-Baker.

2. His mother raised him in Galiwinku for the first four years of his life. She then took him to live with his Grandparents Cathy Gudtha and Colin Baker in the Gawa Homelands which is at the Northern tip of Elcho Island. She took him there so that he would escape the troubles of Galiwinku and so that he would get a good education. She visited most weekends.

3. He started school at the Gawa Christian School at the age of five years. He wasn't always the best student at the school, but he excelled in hunting and fishing. His grandmother taught him in the customary ways and he was recognised by those around him to have outstanding skills. He willingly passed them on to friends and family.

4. He was in year seven at the school when on 6 August 2015 he died from head, chest and abdominal injuries when run over by a Toyota Landcruiser Troop Carrier (Troopy) while involved in an activity conducted during the school carnival. He was just 12 years of age.

Leave to Appear at the Inquest

5. The inquest was held on Monday 15 August 2016. The evidence before the Coroner included twenty six statements, medical records, photographs and a video recording. Five witnesses were called to give evidence.

6. At the commencement of the Inquest a number of persons sought leave to appear pursuant to section 40(3) *Coroners Act*. The sub-section is in the following terms:

> "(3) A person who, in the opinion of the coroner, has a sufficient interest may, at an inquest, appear or be represented, call and examine or cross-examine witnesses, and make submissions."

7. Counsel for NT Christian Schools, Ms Jodi Truman, sought leave to represent the School and to call and examine or cross-examine witnesses and to make submissions. In my opinion the school had a sufficient interest and I granted that leave.

8. Similarly the family sought leave to be represented through their lawyer, Ms Claire Deane. In my opinion the family had a sufficient interest and I granted leave to Ms Deane also.

9. Mr Mark Thomas of Counsel sought leave to appear on behalf of the Work Health Authority (the Authority). This is the first time that I can recall in my twenty years as Coroner, that the Authority has sought leave in an inquest relating to a workplace death. I refused leave. I was not of the opinion the Authority had a sufficient interest relevant to the *Coroner's Act* at the inquest.

10. The Authority has its own charter, responsibilities and staff to conduct their own inquiry, and usually does. In my view a Coronial inquiry is not the forum for the Authority to make up for deficiencies in, or as in this case, a lack of a workplace investigation into the accident that led to the death.

11. The Authority has the ability to brief Counsel with a "watching brief" and may liaise with Counsel Assisting the Coroner in relation to relevant questioning of witnesses. I have always allowed such cooperation. Indeed that is what happened in relation to the Coronial inquiry into the death of Zoe Woolmer at Kings Canyon. The Authority thereafter launched a successful prosecution.

12. Over the years my Office has cooperated with the Authority in allowing access to evidence collected by Coronial Constables and the Authority has allowed access to their own investigations. I trust that this will continue.

The Sports Carnival

13. The Gawa Christian School had since 2009 conducted an Annual Sports Carnival. Students, Staff, Volunteers and Community Members participated and by all accounts it was a friendly and fun time.

14. Those participating were divided into two teams, red and blue. Community Members came dressed in the colours of their team.

15. From 2012 one of the favourite events was the "Troopy Pull".

16. A rope was attached to a Troop Carrier and the teams took turns pulling the vehicle about 80 metres as fast as they could to a finish line. The team that did so in the fastest time was the winner.

17. The engine in the vehicle was turned off. There was a person in the vehicle for the purposes of steering and applying the brakes.

18. When the event was first added to the Sports Carnival various safety measures were adopted. One of those was to have a strap attached to the front of the Troop Carrier. From a picture provided to the inquest the strap looks to have been about five metres long. To the other end of that strap was attached the rope. It was said that those pulling could position themselves on the rope but not the strap.

19. However the person conducting the event in 2012 and 2013 left before the arrival of the new sports teacher in 2014. There was no opportunity for a handover.

20. A photograph of the event in 2013 shows the strap being used between the vehicle and the rope.

21. The photographs of the 2014 Troopy Pull are inconclusive as to whether the strap was used. In that year the rope was attached to the Troopy by a person who had assisted in previous years.

22. On 6 August 2015 at the 2015 Annual Sports Carnival the sports teacher and a volunteer set up the Troopy for the pull.

23. They did not use the School Troopy as had been done on previous occasions. Rather they used the closest available Troopy. That was the vehicle of a volunteer helper at the Carnival. He was asked if his Troopy could be used and also that he find a rope to attach to it.

24. He found a rope about 29 metres long. When the sports teacher and the volunteer came to attaching the rope they found that it had a knot in it. They couldn't undo the knot. They were attempting to thread the rope around the bull bar of the Troopy and through a loop at the ropes end. However the knot would not fit through the loop.

25. That left two lengths of rope coming from the vehicle. The sports teacher reasoned that was possibly safer than just the one length. He thought that

rather than pulling the rope in front of the vehicle, the participants would be able to pull while out to the sides.

26. The sports teacher was unaware of the practice that had been used at least in the first two years of the event of using a strap between the vehicle and the rope as a "no go zone".

27. The previous year the Troopy Pull had been the highlight of the sports carnival and so was much anticipated in 2015.

28. When the blue team pulled the Troopy the sports teacher sat in the driver's seat to steer and apply the brakes. He felt the children were a little close to the vehicle during that part of the event.

29. At the end of the blue team's effort he backed the Troopy to the starting line for the red team. He was a part of the red team and so he left the driver's position and asked the volunteer to drive while he assisted to pull the vehicle. In doing so the volunteer recalls that the sports teacher made comment that it was "scary" having the children running so close to the front of the vehicle.

30. The time was about 12.30 pm.

31. The sports teacher said that to remedy the children being so close to the vehicle he placed himself in front of the vehicle on the right hand length of rope and asked the small children to pull from the end of the rope furtherest from the vehicle. He estimated that he was positioned two to three metres in front of the vehicle.

32. On the right hand length of rope were a number of students. The second from the vehicle was Jethro. Just behind him was one of his friends.

33. The sports teacher gave evidence that he ensured that he was closest to the vehicle and made sure persons on each of the lengths of rope were in front of him.

34. The red team had pulled the Troopy about 30 metres and to an estimated speed of about five kilometres per hour when Jethro fell. His friend attempted to assist him but there was no time and the front left tyre of the Troopy rolled over him.

35. There was at that time a school teacher taking photographs of the event. The photographs show the smiles and laughter of the participants. They show that the participants were pulling on the two lengths of rope directly in front of the vehicle, they show that the sports teacher was about three metres in front of the vehicle but behind him on the other rope were at least three students.

36. The last of the series of photographs shows Jethro falling. His right hand is still on the rope. But he is on the ground on his left side directly in the path of the left tyres of the Troopy. He is unlikely to have been even two metres in front of the vehicle at that point.

37. If the vehicle at that point was travelling at the estimated speed of five kilometres per hour, it was covering the ground at 1.4 metres per second.

38. A normal driver is said to have a reaction time of 1.5 to 2.3 seconds. If the driver had seen him fall it is unlikely that he could have applied the brakes, let alone stopped prior to running over Jethro.

39. As it was he didn't see Jethro fall and although he felt a bump, he didn't realise that may have been a person until he heard screaming from the spectators.

40. Jethro went under the first wheel of the troop carrier. Spectators then describe how he seemed to manoeuvre under the vehicle attempting to avoid the second tyre.

41. The evidence as to whether he went under the second tyre is less certain.

42. The volunteer applied the brakes when he realised something bad had happened. He looked in the rear vision mirror and saw Jethro getting to his feet and stumbling a few metres before collapsing.

43. The sports teacher asked him why he had stopped. Teachers and spectators rushed to Jethro. He had a large 9 x 3 centimetre laceration to his head where the skin and flesh had been removed down to the bone and he was bleeding from his nose and mouth.

44. Moments after the accident the emergency number for the Marthakal Homelands Health Service was called by the school principal.

45. The Health Manager, Jannie Kraayenhof, of the Marthakal Clinic recorded the call as being received at 12.38pm. She knew their doctor and gear was in the Homelands so she called the Ngalkanbuy Clinic. That Clinic had a doctor and gear available. She drove to the Clinic picked up the doctor and gear and headed for the Galiwinku airfield.

46. The Health Manager and the doctor were in the plane and headed for the Gawa airstrip within 20 minutes of receiving the first call.

47. At Gawa School a first aid kit was obtained and Jethro's head was bandaged. At that point he was conscious and responsive. A teacher held his hand and told him to remain calm.

48. School staff went to the house of the grandfather of Jethro to advise him of the accident and transport him to Jethro's side.

49. Jethro's pulse became weaker and his breathing shallower. He stopped breathing at 1.15pm. Cardio pulmonary resuscitation was commenced.

50. The doctor and nurse arrived at his side at 1.27pm. However it was obvious he had been deceased for some minutes. He was declared deceased at 1.40pm.

Issues

51. His death was an absolute tragedy and his family, the school and the Community suffered a significant period of grieving.

52. In the next few days the Chief Executive Officer of NT Christian Schools, flew to Elcho Island and conducted a review of the incident and the school's policies, processes and procedures.

53. The Coronial Investigation was carried out by the Major Crime Squad. The Officer in Charge, Justin Scott prepared a comprehensive brief of evidence. It was an excellent investigation and I thank him for his efforts.

54. What the evidence shows is that the distance between the children and the vehicle they were pulling was insufficient and obviously so. The manner of the Troopy Pull on that occasion was manifestly dangerous.

55. The Principal of the school was attending to other duties and did not see the Troopy Pull event. However two days later she was loading the pictures of the event onto her computer. She wrote in her statement to the Coronial Investigators:

> "This morning I was loading a USB on to my computer so that the police could view some photographs of what happened. I was shocked at how close the children were to the front of the vehicle, it hadn't been like this in previous years."

56. It is clear that there were a number of lapses that lead to the dangerous setup of the rope attached to the Troopy on that occasion:

- "The failure to have a written risk assessment of the event at any time was obviously a significant factor;
- The failure to handover how it had been operated in previous years mitigated against the safety mitigation of earlier years being passed to the new teacher; and

- The failure of the sports teacher to identify the obvious risks to both himself and the children running so close to the front of the vehicle."

57. The Chief Executive Officer of Northern Territory Christian Schools provided a comprehensive statement and gave evidence of the changes that the organisation has made in response to Jethro's death:

- "The Troopy Pull has been cancelled;
- A review was commissioned of risk assessment practices across all of their schools;
- Their policy and procedures were amended to require a formal written risk assessment for all non-routine activities whether conducted on school grounds or elsewhere.
- A process of central approval was put into place for all potentially high risk activities."

58. It was obvious from the documents and the evidence presented to the inquest that Northern Territory Christian Schools and its staff took responsibility for the death of Jethro.

59. The evidence given was considered and frank. I detected no defensiveness in the evidence of any of the staff and I commend them for that. It is clear that the death of Jethro has had considerable impact on the staff, the school and the organisation within which it operates.

Cause of Death

60. An autopsy was performed by Forensic Pathologist John Rutherford. He listed the main pathological findings as:

- Laceration to the left side of the scalp
- Bruising to the left side of the face
- Internal bruising to the right rear aspect of the scalp

- Basal skull fracture
- Multiple right sided rib fractures
- Bruising to the lower lobe of the right lung
- Rupture of the liver, and
- Haemoperitoneum.

61. He concluded that the death of Jethro was due to head, chest and abdominal injuries.

62. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Jethro Ngalarra Dhamarrandji-Baker born on 30 July 2003, in Gove District Hospital.

(ii) The time of death was 1.15pm on 6 August 2015. The place of death was Gawa Christian School, Gawa Homeland Outstation, Elcho Island, Northern Territory.

(iii) The cause of death was head, chest and abdominal injuries.

(iv) The particulars required to register the death:

1. The deceased was Jethro Ngalarra Dhamarrandji-Baker.
2. The deceased was of Aboriginal descent.
3. The deceased was a student at the time of his death.
4. The death was reported to the coroner by the deceased's Grandfather, Colin Baker.
5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.
6. The deceased's mother was Sylvia Mulurrku Bukulatjpi and his father, James Baker.

63. Section 34(2) of the *Act* operates to extend my function as follows:

> "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."

64. The death of Jethro occurred in circumstances where a great deal more care should have been taken for his safety.

65. There is sufficient evidence to demonstrate that there had been a recognition of the hazard that the vehicle posed to those pulling it.

66. However the risk assessment was not done as it should have been. It was done during the event by the sports teacher who was also a participant.

67. If a formal written assessment had been undertaken at the time the Troopy Pull was introduced to the Carnival and reassessed on each occasion the safety mitigation processes set up are far more likely to have been followed.

68. Leaving it to one person to determine safety during the event was not appropriate or adequate. It was unfair to the sports teacher and dangerous for the participants.

69. That failure demonstrated an incomplete understanding of the hazard detection and mitigation processes required by the Work Health and Safety Legislation.

70. It is of concern that an organisation invested with the care of the most vulnerable in our community did not fully understand the formal procedures to ensure compliance with their statutory duties.

71. It is such a tragedy that it took the death of this child for the organisation to realise it shortcomings and fully understand its duties.

Dated this 5th day of September 2016.

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JUDGE GREG CAVANAGH
TERRITORY CORONER