

CITATION: *Inquest into the death of Tracey Karadji* [2007] NTMC 010

TITLE OF COURT: Coroner's Court

JURISDICTION: Coroners

FILE NO(s): D0134/2005

DELIVERED ON: 26 February 2007

DELIVERED AT: Darwin

HEARING DATE(s): 28<sup>th</sup> August 2006 (Daly River)  
29<sup>th</sup> August 2006 (Darwin)

FINDING OF: Mr Greg Cavanagh SM

**CATCHWORDS:**

Motor vehicle fatality, police involvement

**REPRESENTATION:**

*Counsel:*

Assisting:	Ms Helen Roberts
Northern Territory Police:	Ms Penny Turner
Senior Constable Joseph Hart:	Mr Alan Woodcock
Family:	Mr Powell
(instructed by):	Mr Peter Pohlner of NAAJA

Judgment category classification: B

Judgement ID number: [2007] NTMC 010

Number of paragraphs: 25

Number of pages: 11

IN THE CORONERS COURT  
AT DARWIN IN THE NORTHERN  
TERRITORY OF AUSTRALIA

No. D0135/2005

In the matter of an Inquest into the death of

**TRACEY KARADJI**  
**ON 27<sup>th</sup> JULY 2005**  
**AT DALY RIVER**

**FINDINGS**

26 February 2007

Mr Greg Cavanagh SM:

1. Tracey Karadji (“the deceased”) died on the 27<sup>th</sup> July 2005 at Daly River after being struck by a police vehicle. At the time, the police vehicle was being driven by Senior Constable Joseph Hart, the officer in charge of the Daly River Police Station. The deceased was on the Nauiyu Community access road, after spending the evening at what is known as the “drinking paddock” an area set aside for legal consumption of alcohol located along the riverside between the Daly River pub and the (alcohol) restricted area of Nauiyu Community. The deceased’s death clearly fell within the definition of a “reportable death” pursuant to s.12 of the *Coroners Act* as it was a death which resulted directly from an accident or injury.
2. The deceased was not in police custody at the time of her death and therefore the holding of this public Inquest is not mandatory but is at the exercise of my discretion pursuant to s.15(2) of the *Coroners Act*.
3. The investigation into the death was conducted by police pursuant to the General Order D2 “Deaths in Custody and Investigation of serious and/or Fatal Incidents Resulting from police contact with the Public”. That General Order is intended to ensure that such investigations are of a particularly high standard and level of independence, due to the fact that the

actions of a police officer were closely and directly involved with the death. I say at the outset, that this investigation was conducted in a thorough and timely fashion and to a high standard.

4. The Inquest commenced on 28 August 2006 at Daly River (Nauiyu) Community. There, I heard evidence from a number of Aboriginal community members that were present on the night that the deceased died and I heard evidence from an Aboriginal Community Police Officer (“ACPO”) Mark Casey. The Inquest then resumed in Darwin the following day and I heard oral evidence from Dr Sinton, who conducted the post mortem examination on the deceased, and from Senior Constable Hart.
5. Mrs Mandy Karadji, the mother of the deceased, attended the proceedings in Darwin and she would have attended the proceedings in Daly River if she had not had some transport problems on that day. I noticed on the day in Darwin that Mrs Karadji spoke in a friendly manner with Senior Constable Hart outside the courtroom before he gave evidence.
6. Section 34(1) of the *Act* details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

“(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

(v) any relevant circumstances concerning the death”

7. 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.”

## FORMAL FINDINGS

8. Pursuant to s. 34 of the *Coroners Act*, I find, as a result of evidence adduced at the public Inquest the follows:
  - (a) The identity of the deceased is Tracey Anne Karadji (also known as Tracy Garadji) an Aboriginal female who was born at Daly River, Northern Territory, on 11 February 1970.
  - (b) The time and place of death was 10:30pm on 27 July 2005 at the Nauiyu Community Access Road.
  - (c) The cause of death was multiple injuries resulting from a motor vehicle accident in which the deceased was run over whilst lying on a roadway by a Nissan Patrol 4WD police vehicle driven by Senior Constable Josef Keith Hart.
  - (d) Particulars required to register the death are:
    1. The deceased was a female.
    2. The deceased’s name was Tracey Anne Karadji also known as Tracy Garadji.
    3. The deceased was an Australian resident of Aboriginal origin.
    4. The death was reported to the Coroner.
    5. The cause of death was Multiple Injuries.
    6. The Forensic Pathologist was Dr Terence John Sinton and he viewed the body after death.
    7. The deceased’s father was Joseph Garadji.

8. The deceased's mother was Mandy Garadji Namorwali.
9. The deceased resided at Nauiyu Community, Daly River.
10. The occupation of the deceased was CDEP worker.
11. The deceased was born on 11 February 1970 and was 35 years old at the time of her death.

### **Relevant Circumstances Concerning the Death**

9. The deceased had lived most of her life in the Daly River area. On the night that she died, she was drinking alcohol in an area that has been referred to as the "drinking paddock" with a number of other family members.
10. Senior Constable Hart was driving along the road adjacent to the paddock at a speed of about 55 kilometres per hour. The road is sealed (with dark tar) and is in regular use by vehicular traffic. He gave evidence that he always drove slowly in front of the paddock because there were people drinking in the paddock on the left hand side of the road and he anticipated people wandering out onto the road from the left. He explained that as he came towards the vicinity of the drinking paddock he saw three people walking on the left hand side of the road who shielded their eyes from his lights. He "dipped his high beams" leaving his headlights in a normal position. He next saw two people sitting on the left hand side of the road ahead of him and looked at them because he thought they might be juveniles. His evidence in chief was as follows (transcript p89-90):

"MR WOODCOCK: Now when you say you saw them, are you – how far ahead or were they alongside you? Where were they, in relation to - - -?---They were in front of me. I don't know, probably – I'd be guessing – 50 metres, 100 metres in front of me.

All right, and did you pay any attention to that group?---Yeah, I did, 'cause I thought they were juveniles. They were very small statured people. But I kept looking at them but just flicking – I kept front

vision as well, looking at them as well and I recognised one of them as Rosie Denham. That's when I realised that they weren't juveniles.

All right, now you're looking at them and they're a fair bit ahead, as you've said. Did at any stage you take your eyes off the road?---No.

What happened next?---Once I saw that it was Rosie Denham, something caught my eye in the middle of the road, a bright – I don't know what it was, and then when I focused on what was on the road I saw the silhouette of a head and yeah, I kept driving and unfortunately I swerved and ran over a lady that was lying in the middle of the road.

CORONER: Why did you swerve?---To try and miss her.

Right. So you swerved to try and miss her?---Yes, I did, sir.

MR WOODCOCK: All right, and did you do something after that had happened?---Yes, I stopped the car up from the lady, reversed back a short distance, got out of the car, had a look at the lady. I could see she wasn't bleeding. Sorry, she wasn't breathing. There was a large amount of blood. Her chest wasn't rising or falling and she never reacted to any of my verbal stimuli.

Did you form any conclusions at all?---Yeah, I thought the lady was deceased.

CORONER: Did you know the lady?---At that time, I didn't recognise her, sir, but when two other ladies come down they told me what her name was and that's when I knew her.

MR WOODCOCK: And what happened next?---The two ladies come down and one of them was Rosie Denham. The other lady, I'm pretty sure, was Christine Yambin but I don't know Christine that well. I asked them who was it and Rosie told me that it was Tracey and then I asked them two if they would sit with the lady while I went and got help.

Okay. Where did you go?---I drove into the community, straight – the first house that I come to was Mark Casey, my ACPO. I yelled at him and told him what had happened. He – I don't think I even waited for him to come out of the house. He just got into a car and – and went down and I then went to Mark Phillips who was our senior health officer. I went to his house.

What did you do there?---Told Mark what had happened and Mark had the ambulance at his house, luckily. He jumped in the ambulance and went to the health clinic to get some more gear. While I was at his house, the phone system at the police station, sir, if you don't transfer the phones to the houses, it only rings at the station, so I had to ring my home so I could get my second number out, who was at home. His name's Steve Rankin.

All right. Now while this is happening, how are you marshalling your communications? How do you do it?---I was on the radio – as I was driving to town I was ringing on the radio to our police communications section.”

11. Dr Sinton's evidence was that the deceased had a combination of injuries which were consistent with her being struck quite severely by a motor vehicle with the result that her body was knocked along the road. That is, rather than being “run over” she was struck by a wheel of the vehicle and moved from her position. The striking and then the movement caused a combination of significant internal injuries.
12. Dr Sinton's evidence was that the deceased would have died within minutes of suffering the injuries. He would not go so far as to say that the injuries were unequivocally “non-survivable” however he certainly said that they were significant injuries and certainly very likely that she died either straight away or within a few minutes. At the time of her death, she had a blood alcohol content of 0.267%, which clearly would have impaired her judgment.
13. One of the issues in this case was the question of whether the deceased was in fact lying down on the roadway in a manner in which Senior Constable Hart described, rather than sitting up or even standing up. There was one witness who alleged in his recorded statement that he saw her standing up on the road prior to her being struck by the police vehicle. That witness was summonsed to appear and did not appear before me in Daly River so that his evidence could be tested. Furthermore, he placed himself in a position in the drinking paddock on that night from which it would have been difficult,

if even possible, for him to have observed what he said he did. I note here that after hearing oral evidence on the morning of the 28<sup>th</sup> August 2006, I went to the area where the accident happened and I had a look at the drinking paddock with the assistance of Detective Sergeant Henry's pointing out features. I was able to gain a good perspective of what could be seen by the witnesses on the night in question, albeit that our observations were obviously made during the day time.

14. Further, Dr Sinton was of the opinion that the deceased was not standing up. Had she been standing up he would have expected her to have injured her legs, which were uninjured. He was of the view that the injuries were most consistent with her lying down, or sitting up. There is no suggestion in the evidence that she was sitting up. I entirely accept the recollection of Senior Constable Hart as to the position in which the deceased was on the roadway when his vehicle hit her. That is to say, I find that the deceased was lying on the sealed portion of the roadway in a horizontal position.
15. A further related question was the speed that the police vehicle was travelling at the time. Senior Constable Hart was clear that he was travelling at about 55 kilometres per hour at the most. He was on the lookout for people potentially wandering out from the left hand side of the road. A number of witnesses described the police vehicle as going "fast". Obviously, estimations of speed are notoriously unreliable, in particular in circumstances in which the observer is drunk, and is observing a car going along an unlit roadway from a seated position in a nearby field. The witnesses heard the noise of the accident and were, of course, extremely shocked by what happened. I find that most of the witnesses that gave evidence before me at Daly River were making a genuine effort to give reliable evidence, however, their evidence as to speed does not result in my finding. that Senior Constable Hart was travelling faster than 55 kilometres per hour.



16. The investigation into the death was commenced very shortly after the incident occurred. Senior Constable Hart immediately advised his supervisors via communications of what had happened. Adelaide River Police and Port Keats Police arrived to assist with the scene. The investigation led by Detective Sergeant Henrys commenced soon afterwards. The witnesses were all interviewed on tape over the ensuing two or three day period. The investigators interviewed Senior Constable Hart, who participated in the interview willingly despite having spent a sleepless night and feeling physically unwell. He also went to the scene and pointed out where things had occurred, and further participated in a video taped “reconstruction” a couple of days later in the evening. The fact that his version of events was obtained at the first available opportunity also assists me in being able to accept it as an accurate and complete recollection from him. All of this evidence confirmed that the death was accidental and no fault lay with Senior Constable Hart.
  
17. The final issue, with respect to his manner of driving, is the fundamental issue of whether he ought to have seen the deceased before he hit her. The evidence obtained from the witnesses has not put me in a position to be able to make a clear finding as to how it was that the deceased ended up on the road in the position that she did. In general terms, it appears that she had decided she wanted to leave and some friends were going to walk with her. They became distracted saying goodbye to people and it seems the deceased went on ahead. I do not know whether she tripped, or intentionally lay on the road or was asleep. I am not able to say how long she was in that position before she was struck by the vehicle, because the witnesses are unable to be clear as to time. Senior Constable Hart gave evidence that he was expecting that there would be people on the left hand side of the roadway walking on the verge and possibly the roadway. The question was whether Senior Constable Hart ought to have seen the deceased (who I find

was lying from the middle to the right hand side of the road) sooner than he did; and thereby been in a better position to take better evasive action.

18. The submission from Mr Powell, on behalf of the mother, is that Senior Constable Hart “could have been more prudent” by which he meant driven more slowly and “taken a little bit more care”. I accept that Senior Constable Hart could glance to the left and identify the two women (who he originally thought might be juveniles) while still looking forward and keeping a proper lookout. Given the lighting situation and the unexpected position of the deceased on the road, I find that the unfortunate event was an accident.
19. One can always be more careful when driving (especially in hindsight), however, a driver on the sealed road in question regularly travelled by ordinary traffic could not be expected to make allowance in my view, for someone lying across the road in the dark. It was simply unexpected.
20. In addition to Senior Constable Hart participating fully in the investigation after the incident, he also participated in a meeting with the deceased’s mother before he left the community (transcript p99-100):

“His Honour raised this, sergeant. You said that you had a conversation with the mother of the deceased the day that you were moving from Daly River Station?---That’s correct.

And was that by mutual arrangement or one or other of you arranged that?---No, we both wanted to talk to each other.

And what did you talk about?---What had actually happened. The mother had given me some information about Tracey’s perceptions that night, and where we’d go – how we’d go forward. She actually invited me out to the outstation at Emu Point, to come back and get some wallabies for the family and, yeah.

So it was a – taking into account the context, it was a positive conversation overall between you?---Yes, it was. My little girl actually come over and sat with us and that was quite good. We shed a few tears together.

CORONER: You all shed a few tears together?---Yes.”

21. Senior Constable Hart is an experienced bush police officer, who, since this accident, has been on non operation duties in Darwin. ACPO Casey’s impression of him as a policeman was “big hearted”. This is consistent with all the general tenor of all of the evidence, that he was well liked within the community.
22. At the commencement of the Inquest a letter was tendered by Counsel Assisting which was written to the Nauiyu Community Council under the hand of two directors of the North Australian Justice Agency (at that time NAALAS) on 2 September 2005. The letter included this paragraph:

”While none of your Council members may have provided statements, there were a number forthcoming from other members of the community. The information provided to NAALAS lawyers clearly demonstrated a heavy handed approach by police to threaten and intimidate community members prior to the upcoming coronial inquest. They will be forwarded to the Northern Territory Police Commissioner for his action where necessary.”

I raised this at the outset of the inquiry with Mr Powell, who is instructed by NAAJA. He took some instructions and initially indicated to me (on 28<sup>th</sup> August 2006), that some relevant witness statements were available and were going to be faxed down to Daly River.

23. Subsequently on Tuesday 29<sup>th</sup> August 2006, Mr Powell indicated then that he had had the opportunity to see the relevant file and there were no actual statements complaining of the police “approach” in relation to the coronial Inquest. Mr Powell told me, in fact, that although there were a couple of complaints on the file, they had no relevance to the death of this deceased, and were just complaints which were “made around the same time”. There was therefore no basis to the allegation that the coronial investigation was somehow proceeding along improper lines or that the police were attempting to influence witnesses in anyway at all. Further, there were no statements

sent to the Northern Territory Police Commissioner as foreshadowed in the letter dated 2 September 2005.

24. I have already noted that the “drinking paddock” in the Nauiyu / Daly River area has, since this death, been relocated. Had that not been the case, I would certainly have made a recommendation about it. The drinking paddock has now been significantly reduced in size, and moved from adjacent to the road to much closer to the river. That means that the most direct means of walking back to the community is along the river rather than along the road as there is a designated dirt track along the riverside which comes straight into the community. It is obvious that that is significantly safer.
25. In view of my findings, I have no recommendations or other comments to make.

Dated this 26<sup>th</sup> day of February 2007

---

GREG CAVANAGH  
TERRITORY CORONER