



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

(These findings have been de-identified in relation to the name of the deceased and family by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995).

I, Robert Webster, Coroner, having investigated the deaths of CZ and LN

Find, pursuant to Section 28(1) of the Coroners Act 1995, that

- a) The identity of the deceased is CZ;
- b) CZ died as a result of injuries sustained in a two vehicle collision in which he was one of the drivers;
- c) CZ's cause of death was head, neck, chest, abdomen and limb injuries; and
- d) CZ died on 13 August 2020 on Algona Road near Kingston in Tasmania;

Find, pursuant to Section 28(1) of the Coroners Act 1995, that

- e) The identity of the deceased is LN;
- f) LN died as a result of an injury sustained in a two vehicle collision in which she was seated behind one of the drivers;
- g) LN's cause of death was a head injury; and
- h) LN died on 13 August 2020 on Algona Road near Kingston in Tasmania.

Introduction

This investigation concerns a fatal two vehicle crash that occurred on Algona Road near Kingston approximately 900m south of the roundabout which connects Algona Road, Huntingfield Avenue, Channel Highway and the Southern Outlet; which is colloquially known as the "Fork in the Road" roundabout (the roundabout). The collision occurred at approximately 8:39am on 13 August 2020.

The weather at the time of the crash was fine and visibility was good. The road was damp in places especially where shadowing from roadside vegetation covered sections of the road surface. The road surface was in good condition. The speed limit on Algona Road in the vicinity of the crash site is 90km/h. Appropriate speed restriction signs were erected and clearly visible to traffic travelling in both directions.

The crash involved a northbound white 1998 Hino rigid passenger bus registered number XT33AH (the bus) which was driven by Christine Chatterton. The second vehicle involved was a southbound 2006 navy blue Lexus registration number H94AR (the Lexus) driven by CZ. His daughter, LN, was seated behind him in a child seat.

In making the above findings I have had regard to the following evidence obtained in this investigation:

- The Police Reports of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Affidavits of the forensic pathologist Dr Andrew Reid;
- Affidavits of the forensic scientist from Forensic Science Service Tasmania, Mr Neil McLachlan – Troup;
- Medical records of CZ obtained from his general practitioner;
- Electronic patient care report obtained from Ambulance Tasmania (AT);
- Affidavit of OA;
- Affidavit of Carol Mackie;
- Affidavit of Margaret Helm;
- Affidavit of Catherine Priseman;
- Affidavit of Brody Cashion;
- Affidavit of Bradley Cashion;
- Affidavit of Bree Crocker;
- Affidavit of Adriana Lefleur;
- Affidavit of Callum Verdow;
- Affidavit of Luke Wilson, Tasmania Police (rank not stated);
- Affidavit of Sergeant Rodney Busch;
- Affidavit of Detective Senior Constable Michael Manning;
- Affidavit of Sergeant Mark Woodland;
- Affidavit Senior Constable Bridget Verney;
- Affidavit of First-Class Constable Samuel Allen;

- Affidavit of Melissa Bartulovic, Tasmania Police (rank not stated);
- Affidavit of Kelly Cordwell, Tasmania Police (rank not stated);
- Affidavit Senior Constable Adam Hall together with his collision analysis report;
- Affidavit of Wayne Rice;
- Affidavit of Paul Wells;
- Vehicle inspection report of Paul Harman;
- Video record of interview of Christine Chatterton and transcript of that interview; and
- Diagrams, photographs, crash retrieval data and documentation with respect to the police prosecution of Christine Chatterton.

Circumstances leading to death

On 13 August 2020, CZ got up at approximately 6:45am in order to get LN ready for childcare that morning. His wife remained in bed because she had been looking after the couple's youngest daughter with feeds during the night. At approximately 8:35am CZ left home with LN in order to take her to her childcare centre.

At approximately 8:39am, CZ was driving the Lexus south on Algona Road. He was wearing his seatbelt. LN was seated and appropriately restrained in a child restraint behind him. At the same time Ms Chatterton was driving the bus north on Algona Road. She was the sole occupant of that vehicle. Approximately 900m south of the roundabout she came across a line of stationary traffic which was waiting to negotiate the roundabout. She applied the brakes on the bus in order to bring the bus to a stop behind the queue of traffic and the wheels locked. The bus then rotated into the southbound lane where its front right corner collided with the driver's side of the Lexus. As a result of the crash both CZ and LN sustained fatal injuries.

Investigation

Officers from Kingston Police Station were first to attend the accident scene. AT received the call to attend at 8:44am and ambulance officers arrived at 8:51am. Officers from Tasmania Fire Service also attended.

Ms Chatterton was still on board the bus at the time emergency services arrived. She was extricated through the rear window by Tasmania Fire Service personnel and conveyed to the Royal Hobart Hospital for medical treatment and for the purpose of blood tests pursuant to the *Road Safety (Alcohol and Drugs) Act 1970*. Attending police secured the scene and redirected traffic until the arrival of crash investigation and forensic personnel. CZ and

his daughter were removed from the Lexus and taken to the mortuary where they were formally pronounced as deceased and they were both identified.

Senior Constable Hall and Senior Constable Cordwell of Crash Investigation Services arrived at 9:48am. The scene was marked and a scene diagram was prepared. Measurements of relevant incident marks were recorded. Constable Bartulovic from Forensic Services in Hobart photographed the scene at Senior Constable Hall's direction. A preliminary inspection was undertaken of the vehicles involved and they were seized for inspection by mechanics.

From his investigation Senior Constable Hall determined the front driver's side wheel of the bus locked 9m before the front passenger side wheel and as a result, the front of the bus began to rotate into the southbound lane. This movement he says was assisted by the camber of the road which fell to the east.

The vehicles were inspected and found to be in a roadworthy condition prior to the crash. Both vehicles were registered.

Ms Chatterton was an experienced bus driver and fully licensed at the time of the collision. She had worked for her employer, Wisby Buses Pty Ltd, for whom she was working on the day of this accident, for the last 35 years. During the last 10 years she had worked in the office and also as a relief driver. On the day of the crash she had received a call at 6:00am to fill in for a driver who was sick. She had held a driver licence for 45 years and a bus licence for 40 years. She had, apart from the last 10 years, driven school bus runs and she regularly drove buses for school excursions. Ms Chatterton had been providing the Department of State Growth regular medical fitness to drive assessments to the commercial medical standard since 1977 with her last assessment being undertaken by her general practitioner on 31 July 2020 at which time no medical conditions were noted.

On the night prior to the crash she had a normal night's sleep. She completed school bus runs to a number of schools in the Kingston and Blackmans Bay area prior to the crash without incident. While travelling north on Algona Road, in order to return to her employer's depot at Margate, she observed vehicles in her lane either slowing or stopped with brake lights on. She says there was a couple of hundred metres gap between her and the queued vehicles. She did not think she was going to collide with them, and she thought she had enough time and distance to stop safely. She also advised police she did not intend for the wheels on the bus to lock and she did not have any issues with the brakes or the bus generally prior to the collision. She remembers applying the brakes but does not recall the collision.

A speed analysis was conducted, and data stored on the event data recorder of the Lexus indicated the speed of that vehicle from 4.8 seconds prior to impact and impact was a constant speed of 90km/h. There was no evidence from that data to suggest the Lexus braked and slowed at any stage prior to impact. The speed of the bus was determined by analysing the skid marks left on the road surface. At the commencement of the skid marks the speed was calculated at between 81 and 87km/h which is consistent with the speed estimated by eyewitnesses. The speed of the bus at the point of impact between it and the Lexus was calculated at between 35 and 54km/h.

At the crash scene the bus was negotiating a closed sweeping right-hand curve. The site distance through the curve was measured to be approximately 170m. A safe stopping distance for the bus was calculated at between 70 and 114m and therefore the conclusion was the bus should have been able to come to a safe stop prior to reaching the stationary vehicles had the brakes not locked.

After the collision, the Lexus continued approximately 6.2m south. The passenger side wheels then impacted the concrete curb, damaging both the curb and flattening the rear tyre. After colliding with the curb, the Lexus continued southwards approximate 51m to where it crossed into the northbound lane before impacting with the Western Armco railing. The Lexus came to rest 76.8m south of the rear of the bus. Prior to coming to rest the Lexus continued southbound and onto the incorrect side of the road and into the northbound lane where it collided with a Toyota Corolla and then a Kia. The drivers of those vehicles took evasive action but were unable to avoid a collision as the Lexus crossed into their path. After impact with the Lexus the bus continued to travel northward with all wheels locked and sliding, and it continued to cross over the southbound lane. When it reached the eastern side of the road the bus collided with the Eastern Armco railing. As it continued towards its final resting position the front axle rode over the Armco railing with the front passenger side coming to rest approximately 4.8m east of the railing.

Ms Chatterton's blood test returned a negative result for alcohol and illicit drugs.

Toxicological examination of CZ's blood revealed there were no alcohol or illicit drugs present.

Dr Reid performed a post-mortem examination on CZ on 14 August 2020. As a result of that examination and his consideration of the results of a post-mortem CT scan, histological examination, microbiological examination and toxicology he determined that the cause of death was head, neck, chest, abdomen and limb injuries sustained in this crash. I accept his opinion.

Dr Reid also performed a post-mortem examination on LN on 14 August 2020. As a result of that examination and after considering the results of a post-mortem CT scan and the results of toxicology, Dr Reid determined the cause of death was due to a head injury sustained in this crash. I accept his opinion.

Ms Chatterton was charged with two counts of causing the death of another person by negligent driving contrary to section 32(2A) of the *Traffic Act 1925*. Magistrate Duvnjak found those charges proved on 17 June 2022 and on 12 August 2022 her Honour recorded convictions and imposed a sentence. The particulars of the negligence relied upon by the prosecution were that Ms Chatterton:

- (a) Drove at an excessive speed.
- (b) Failed to maintain a safe distance.
- (c) Applied excessive brake pressure; and
- (d) Failed to take all reasonable precautions to avoid a collision.

In finding the charges proved the learned magistrate found only particular (c) of negligence had been made out. That is it was likely that the fact of emergency braking caused the wheels of the bus to lock up and that the brakes would not have locked without such force being applied which was excessive in all the circumstances. In coming to this conclusion Magistrate Duvnjak accepted the evidence of Mr Rice who was a safety and compliance officer with the National Heavy Vehicle Regulator who said the brakes would not have locked without excessive force being applied. In addition, her Honour found a reasonable and prudent driver would have applied less brake force in circumstances where there was enough time and distance to brake more slowly and that in applying excessive brake pressure, Ms Chatterton fell below the required standard of care of a reasonable and prudent driver.

Ms Chatterton appealed and His Honour Acting Justice Martin, on 22 February 2024, upheld the appeal¹ essentially on the basis that missing from Mr Rice's evidence was an explanation of the basis on which he concluded that the wheels would not have locked unless the force applied was excessive. At paragraph 37 his Honour says:

“It appears likely that Mr Rice engaged in hindsight reasoning to reach this conclusion, that is, reasoning from the fact of the wheels locking to a conclusion that the application of force must have been ‘excessive’. The standard applied by Mr Rice against which he assessed the braking as ‘emergency’ or ‘excessive’ is not apparent”.

¹ Chatterton v Tasmania [2024] TASSC 4.

Acting Justice Martin went onto say the following at paragraph 38:

“There is no doubt that the application of the brakes caused the wheels to lock. However, there was no evidence as to the amount of brake pedal force required to lock the wheels. In other words, there was no evidence as to the minimum amount of pedal force the applicant must have applied. All that was known was the amount of force applied by the applicant caused the wheels to lock. It does not automatically follow, however, that the force applied was "excessive" such that the application of the pedal force amounted to negligent driving.”

His Honour therefore allowed the appeal and set aside the conviction and sentence. He recorded a verdict of not guilty. Whether the evidence of Mr Rice is sufficient to establish a civil liability is not for me to determine. That is a matter for the civil courts.

Comments and Recommendations

I am satisfied excessive speed, fatigue, alcohol and/or illicit drug consumption, inattention and/or failing to keep a safe distance between the bus and the line of traffic which was stationary and waiting to enter the intersection did not cause or contribute to this crash. The crash occurred when Ms Chatterton applied the brakes of the bus which then locked the wheels which then led to the crash as described above.

I extend my appreciation to investigating officer Senior Constable Adam Hall for his investigation and report.

The circumstances of CZ’s death and that of his daughter, LN, are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of CZ and LN.

Dated: 23 July 2024 at Hobart, in the State of Tasmania.

Magistrate Robert Webster
Coroner