Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Ellen Marie Chequer

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

a) The identity of the deceased is Ellen Marie Chequer;
b) Mrs Chequer died as a result of traumatic injuries sustained in a motor vehicle crash;
c) The cause of death was chest and abdominal injuries; and
d) Mrs Chequer died on 2 March 2019 at Dilston, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Chequer’s death. The evidence includes the Police Report of Death for the Coroner, an opinion of the forensic pathologist, toxicological evidence, opinion of the crash investigator and transport inspector, recorded police interview with Mr Brian Chequer, camera footage of the crash, affidavits of police and witnesses, and forensic and photographic evidence.

Mrs Ellen Marie Chequer was born in Brisbane, Queensland on 28 February 1944 and was aged 75 years at her death. She was married to Brian Arthur Chequer in 1964. There are four children to the marriage. Mrs Chequer lived with her husband in West Launceston and, when the children were young, she cared for them on a full-time basis. Mrs Chequer’s health had deteriorated in recent years and the evidence indicates that she suffered from dementia. Her husband, Mr Chequer, was aged 80 years at the time of her death. He held a full drivers licence and had an excellent driving record.

On 2 March 2019, being the day of the crash that led to Mrs Chequer’s death, Mr Chequer awoke early, attended the gym and spent the morning in the garden at their home. During lunch he and Mrs Chequer decided to go for a drive to visit a friend at 1784 East Tamar Highway, Dilston. They left the house in their white Commodore utility at about 1.20pm and drove directly to their friend’s address, travelling in a northerly direction on the East Tamar Highway. Mrs Chequer was a front seat passenger in the vehicle and Mr Chequer was driving.
The other vehicle involved in the crash was a red Toyota Rav4 being driven by Mr Jake Vernon whose wife, Mrs Marilna Vernon, was a front seat passenger. Mr and Mrs Vernon had spent the morning at garage sales in Launceston and the West Tamar area. They had lunch at the Exeter Bakery before driving across the Batman Bridge to travel south on the East Tamar Highway towards Launceston.

Just before 2.00pm, Mr Chequer was driving on a dual lane section of the East Tamar Highway at Dilston. At this time, he moved his vehicle from the left lane to the right lane at a point 800 metres from a break in the flexible wire rope barrier which separated the north/south traffic flow on the highway. The break in the railing measured a distance of 15.7 metres and was for the purpose of allowing access to the driveway of the property at number 1784 East Tamar Highway and access for maintenance personnel to a council pump station. Mr Chequer slowed his vehicle and, without stopping, moved through the break in the centre barrier to commence the turn across the single lane of oncoming traffic into the driveway of his friend’s residence.

As Mr Chequer commenced the turn, Mr and Mrs Vernon were travelling in the opposite direction. The crash investigation and other evidence satisfies me that Mr Vernon was driving at a speed under the specified speed limit of 100km/h at the time. He braked but was not able to avoid colliding with the passenger side of Mr and Mrs Chequer’s vehicle which had travelled into the southbound lane directly in front of his vehicle at a speed estimated by a witness to be 40km/h. Significant damage was sustained to the utility and Mrs Chequer took the full brunt of the impact when the front of the Toyota crashed into its passenger side.

Emergency services, including Ambulance Tasmania, were called and attended the scene quickly. Mrs Chequer, who remained in the vehicle, was declared by paramedics to be deceased.

Mr Chequer sustained five broken ribs and spent two weeks in hospital recovering from his injuries. Mr Vernon suffered internal bruising and Mrs Vernon sustained lacerations and bruising. Mr and Mrs Vernon both spent five days in hospital. Mr Chequer appeared to have no good recollection of the crash when interviewed by police officers on 28 March 2019, although he told the interviewing officers that he would have kept a lookout to ensure that no cars were coming in the other direction so that he could safely execute the turn. He said that he did not see the other vehicle at any time but assumed that it was travelling at an excessive speed. He said that he had made this turn on numerous occasions previously.

A police investigation commenced immediately, with crash investigators attending and examining the scene and taking affidavits from witnesses.
The State Forensic Pathologist, Dr Christopher Lawrence, conducted an autopsy upon Mrs Chequer and determined that the cause of death was chest and abdominal injuries consistent with a motor vehicle crash. The toxicology report indicates that Mrs Chequer had no alcohol or illicit drugs in her system.

The drivers of both vehicles, being Mr Chequer and Mr Vernon, underwent blood tests after the crash. The results of the tests indicated that neither had any alcohol or drugs that would have affected their driving.

All persons involved in the crash, including Mrs Chequer, were wearing their seat belts. Airbags were deployed to protect Mr Chequer, Mr Vernon and Mrs Vernon. An airbag was not fitted to Mrs Chequer’s seating position, but given the heavy side impact, I am not satisfied that an airbag would have materially assisted her.

Both vehicles involved were examined by transport inspector Mr Paul Maclaine and no defects were located that would have contributed to the crash.

At the time of the crash the road was dry, the weather was fine and visibility was excellent. The road surface was good.

As noted above, the location of the crash on the East Tamar Highway has two lanes for north-bound traffic, one lane for south-bound traffic and has a prescribed speed limit of 100km/h. There was no holding bay present in the 15.7 metre break in the barrier that permitted a vehicle to wait for oncoming traffic to pass. Instead there is only a narrow strip of roadway along the length of the gap which does not enable a vehicle to safely wait whilst attempting to cross. A vehicle waiting in this position is at risk of a rear-end collision by a vehicle travelling behind in the overtaking north-bound lanes. This fact may influence a turning vehicle to proceed without sufficient caution.

Additionally, the location of the gap was on a long curve and at the crest of a hill. Crash investigators conducted sightline measurements and found that a vehicle would need to be almost at the gap in the barrier to see whether they could safely turn across the south bound lanes. However, a driver has enough time to make the right turn safely if that driver has looked through and above the wire rope barrier to see oncoming vehicles.

The senior crash investigator, Senior Constable Nigel Housego, re-created the movements of Mr Chequer’s vehicle when approaching and making the turn. In his report Constable Housego
stated he felt uncomfortable when making the turn. He stated “The positioning of the gap in the wire barrier and the line of sight restrictions meant that I had to be at the point of turning before I would clearly see any oncoming south bound vehicles. I felt rushed to make the turn. There was a threat of a north bound vehicle, travelling at 100km/h speed limit colliding with the rear of my stationary vehicle. I have no doubt that this would be the situation for any driver making this turn”.

Dash camera footage from a motorist travelling behind Mr Chequer, and which formed part of the evidence in this investigation, fully captured the crash and clearly showed that Mr Vernon could not have avoided it.

Constable Housego stated that, in his opinion, the two causes of the crash were; firstly, the inattention of Mr Chequer in not seeing Mr Vernon’s vehicle and turning across its path and secondly, the gap in the barrier being in an un-safe position. He concluded that Mr Vernon could not have done anything to prevent the crash. I accept Constable Housego’s conclusions.

The Director of Public Prosecutions reviewed the investigation evidence and determined not to charge Mr Chequer with causing death by negligent driving. In coming to this decision, the Director took into account the fact that Mr Chequer had lost his wife, the express wishes of Mr and Mrs Vernon that he not be charged and the difficulties associated with turning on the highway at that spot.

**Comments and Recommendations**

Constable Housego suggested that consideration be given to removing the opening in the flexible wire rope barrier at 1784 East Tamar Highway at Dilston. He noted that specific, alternative turning areas are positioned within 500 metres of both sides of the crash location.

The Department of State Growth, being responsible for the highway, is in agreement that closing the barrier would be an “ideal outcome” and intends to consult with affected property owners before progressing the works. I am confident that the Department will progress this issue appropriately without the need to make a formal recommendation.

I extend my appreciation to Senior Constable Housego for his very thorough investigation and report into this tragic incident.

The circumstances of Mrs Chequer’s death are not such as to require me to make any recommendations pursuant to Section 28 of the **Coroners Act 1995**.
I convey my sincere condolences to the family and loved ones of Ellen Marie Chequer.

**Dated:** 17 April 2020 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**