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**FINDINGS and COMMENTS** of Coroner Robert Webster following the holding of an inquest under the *Coroners Act 1995* into the death of:

**John Charles Tscherkaskyj**

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## **Record of Investigation into Death (With Inquest)**

*Coroners Act 1995*

*Coroners Rules 2006*

Rule 11

I, Robert Webster, Coroner, having investigated the death of John Charles Tscherkaskyj, with an inquest held at Hobart in Tasmania, make the following findings.

### **Hearing Date**

A case management conference (CMC) was held, pursuant to Rule 22 of the *Coroners Rules 2006*, on 30 October 2023 at which the issues that will arise at the inquest were identified. The matter was then adjourned for inquest which took place on 18 December 2023.

### **Counsel Assisting**

Ms Emily Bill

Ms Kellie-Ann Jay as senior next of kin and wife of Mr Tscherkaskyj appeared on behalf of herself and her family.

### **Notice of This Hearing**

Notice in writing of the CMC was provided to Mr Will Perry, the representative of Mr Tscherkaskyj's employer, on 3 October 2023 however no-one appeared on behalf of the employer at the CMC or the inquest.

Notice in writing of the CMC was provided to Ms Jay as senior next of kin and wife of Mr Tscherkaskyj on 3 October 2003 and she appeared at both the CMC and the inquest.

Notice in writing of the CMC was provided to Mr Kobe McCauley, as the driver of the other motor vehicle involved in the collision with a vehicle driven by Mr Tscherkaskyj, on 5 October 2023 and he appeared at both the CMC and the inquest.

### **Preliminary matters**

*Introduction*

1. John Charles Tscherkaskyj (Mr Tscherkaskyj) died on 8 August 2021, aged 56, on Gordon River Road, near Glenora in Tasmania.
2. Mr Tscherkaskyj's death is subject to the *Coroners Act 1995* (the Act). In this State a coroner has jurisdiction to investigate any 'reportable death'.<sup>1</sup> A 'reportable death' includes a death where the death occurred in Tasmania and it was unexpected, unnatural or violent.<sup>2</sup> Mr Tscherkaskyj's death meets that definition. Because this death occurred while Mr Tscherkaskyj was at his place of work and I am not satisfied his death was due to natural causes, s24(1)(ea) of the Act provides an inquest is mandatory unless the senior next of kin, pursuant to s26A, requests I not hold an inquest. In this case Ms Jay indicated by email of 9 August 2023 she wanted an inquest to be held.
3. In the early hours of 8 August 2021 Mr Tscherkaskyj was driving his employer's 2010 Toyota Hilux utility registration J19EE north on Gordon River Road just north of Glenora in Tasmania. Mr Kobe McCauley was driving a Toyota Hilux registration number E50ZI south on Gordon River Road. At a point on the roadway approximately 1.7 km north of the Bushy Park Road House the two vehicles collided wholly within the northbound lane (the collision). At the time of the collision Mr Tscherkaskyj was working in his occupation as a newspaper delivery driver for his employer B Tranz Pty Ltd. Officers from Bridgewater, New Norfolk and Maydena police stations together with officers from the State Emergency Service (SES), Ambulance Tasmania (AT) and the Tasmania Fire Service attended the accident. As a result of the collision Mr Tscherkaskyj, the sole occupant of the vehicle he was driving, was pronounced dead at the scene. The occupants of the other vehicle, Mr McCauley and Emily Wrigley, were both transported to the Royal Hobart Hospital (RHH) in a critical condition. Officers from Crash Investigation Services (CIS) of Tasmania police arrived at the scene at 3:59am. At that time it was dark, clear, the road was dry, the temperature was -3°C and the road had been closed to all traffic. A scene examination was undertaken by officers from both CIS and Forensic Services (FS) which resulted in the road remaining closed until 11:00am.
4. On the basis of the evidence tendered and the oral testimony given at the inquest I make the following formal findings pursuant to section 28(1) of the Act:
  - (a) The identity of the deceased is John Charles Tscherkaskyj;

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<sup>1</sup> See section 21 of the *Coroners Act 1995*.

<sup>2</sup> See section 3 of the *Coroners Act 1995*.

- (b) Mr Tscherkaskyj died as a result of injuries sustained in a motor vehicle collision involving two vehicles;
- (c) The cause of Mr Tscherkaskyj's death was multiple head, chest and limb injuries following the collision<sup>3</sup>; and
- (d) Mr Tscherkaskyj died on 8 August 2021 on Gordon River Road near Glenora in Tasmania.

#### *A Coroner's jurisdiction and functions*

5. In Tasmania, a coroner's functions are set out in section 28(1) of the Act. By this section, a coroner is required to find the identity of the deceased, how death occurred, the cause of death and when and where death occurred. By section 28(2), a coroner may make comment on any matter connected with the death; and by section 28(3), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter the coroner considers appropriate.
6. Coroners complete their written findings pursuant to section 28(1) of the Act in respect of a reportable death after receiving documentary evidence in the investigation. In a small proportion of reportable deaths, the coroner will hold a public inquest, which almost always involves the calling of oral testimony to further assist the coroner in investigating the death and in making findings. Many of the public inquests held by coroners in Tasmania are made mandatory by the Act.<sup>4</sup> The remaining inquests are held because the coroner considers that a public inquest is desirable in the particular circumstances of the investigation<sup>5</sup>.
7. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial; whereas in criminal or civil proceedings the proceedings are adversarial; that is one party against another. In these proceedings I am required to thoroughly investigate the death and answer the questions (if possible) that s28 of the Act asks. Those questions are set out in paragraph 5 and the answers to those questions are set out in paragraph 4. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions.

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<sup>3</sup> See exhibit C6.

<sup>4</sup> S24 (1) of the Act.

<sup>5</sup> S24 (2) of the Act.

8. A coroner does not have the power to charge anyone with a crime or an offence. In this case I have no power to charge anyone with any driving offences arising out of the death the subject of the investigation. I note charges have already been preferred and dealt with in this case so to be clear there will not be any further charges laid arising out of the inquest process. Nor is it my role to review what the Director of Public Prosecutions did or did not do or how the charges which were laid were dealt with by the Court. A coroner also does not have power to determine issues associated with an inheritance or other matters arising from the administration of deceased estates.
9. As noted, one matter that the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation which is imposed upon a coroner by section 28(1) (b) of the Act.
10. A coroner may comment on any matter connected with the death into which he or she is enquiring. The power to make comment “arises as a consequence of the [coroner’s] obligation to make findings ... It is not free ranging. It must be comment “on any matter connected with the death” ... It arises as a consequence of the exercise of the coroner’s prime function, that is, to make “findings”.<sup>6</sup>
11. The standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.<sup>7</sup>

#### *Issues at this inquest*

12. Given s28 of the Act, the scope of this inquest was as follows:
  - (a) the identity of the deceased; and

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<sup>6</sup> See *Harmsworth v The State Coroner* [1989] VR 989 at 996.

<sup>7</sup> (1938) 60 CLR 336.

- (b) how death occurred; and
- (c) the cause of death; and
- (d) when and where death occurred.

Findings with respect to paragraphs (a), (b), (c) and (d) are set out in paragraph 4. Further findings in respect of paragraph (b) are set out below.

### **Evidence in the investigation**

- 13. The documentary evidence at this inquest comprised exhibits C1 to C40. The exhibit list is annexed to this finding.
- 14. At the inquest Mr Kobe McCauley, Ms Emily Wrigley, Ms Haylee Madden and Constable Jared Gowen provided oral testimony on oath. Ms Kellie-Ann Jay made an unsworn statement to the court at the conclusion of the proceedings.

### **Background**

- 15. Mr Tscherkaskyj was born on 3 January 1965 at the old Queen Alexandra Hospital in Hobart to Ruth and Serge (known as Charlie) Tscherkaskyj. His mother and father were born in Germany and Ukraine respectively. Mr Tscherkaskyj was educated in Hobart and attended Rosetta High School.
- 16. Ms Jay met Mr Tscherkaskyj at the Glenorchy ice rink in 1989 where he used to play ice hockey. They subsequently formed a relationship and were married. They have 13 children together who range in age from 7 to 33 years.
- 17. When Ms Jay first met Mr Tscherkaskyj he worked at Sheridan Textiles as a colour matcher. He resigned from that job when Ms Jay's mother was diagnosed with cancer so that Ms Jay could look after her mother and Mr Tscherkaskyj could look after the 7 children they had at the time. Ms Jay's father passed away in January 2005 with her mother passing away two months later. In April 2005 Ms Jay commenced a work course while Mr Tscherkaskyj continued to look after the couple's children.
- 18. In 2009, although Ms Jay and Mr Tscherkaskyj separated, it was not the end of their relationship because Mr Tscherkaskyj would still attend the family home to assist with the children. It was also at about this time he commenced his employment with Ayres Transport

which was later purchased by B Tranz Pty Ltd in or about 2018 and which company employed Mr Tscherkaskyj at the date of his death. Mr Tscherkaskyj's employer is a distribution company dealing predominantly in newspaper delivery. The company covers the majority of Tasmania.

19. Ms Jay says her husband was, in his employment, responsible for delivering newspapers from Hobart to Queenstown which he would deliver to shops and houses along that route. She says he worked 6 nights in a row for about the last 10 years and during January and February each year he might work 7 nights in a row for a period of about 4 to 6 weeks. Ms Jay says her husband knew the road to Queenstown very well and on the return journey to Hobart he would usually stop at Mount Arrowsmith for half an hour or so to sleep because he knew it was dangerous to drive to Queenstown and return immediately. She says he would normally get up at around 10:30pm to 10:45pm and then go to work. After returning from Queenstown he would potter around for a couple of hours to wind down before going to bed. Ms Jay says the latest he ever arrived home after a journey to Queenstown was at about 12:00pm and that was due to very poor weather conditions which included snow and ice and which resulted in him driving at very slow speed.
20. Ms Jay says Mr Tscherkaskyj was a safe and slow driver who did not take risks. He always planned his trips and therefore he studied the weather applications so he would know where black ice and snow might be on the roadway during the winter months.
21. In so far as Mr Tscherkaskyj's health was concerned Ms Jay says he was prescribed medication for high cholesterol, diabetes and high blood pressure. The records obtained from his general practitioner<sup>8</sup> confirm those conditions together with gastro-oesophageal reflux disease<sup>9</sup>. Those records indicate Mr Tscherkaskyj's last attendance at his general practitioner prior to his death occurred on 16 July 2021 at which time he was treated for gastroenteritis. The general practitioner's records commence on 8 December 2000 and show apart from the conditions already mentioned Mr Tscherkaskyj suffered from a number of common ailments for example infected wisdom teeth, low back pain, a sore throat, colds, urinary tract infections and he underwent some standard investigations. Otherwise he was a well person. There is nothing in the records of the RHH<sup>10</sup> which suggests otherwise. Mr Tscherkaskyj was prescribed

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<sup>8</sup> Exhibit C7a.

<sup>9</sup> Gastro-oesophageal reflux disease (GORD) is a common condition, where acid from the stomach leaks up into the oesophagus (gullet). GORD cause's symptoms such as heartburn and an unpleasant taste in the back of the mouth.

<sup>10</sup> Exhibit C7b.



temazepam<sup>11</sup> to assist him to sleep given his occupation required him to drive for up to 5 nights per week.

### **The Events Leading up to Mr Tscherkaskyj's Death**

22. On the evening prior to the crash Ms Jay was working. She left home at approximately 5:00pm to attend her place of employment. She says Mr Tscherkaskyj was, at that time, asleep having gone to bed at approximately 1:00pm. She says he is a deep sleeper. Ms Jay contacted him by telephone at approximately midnight just prior to him leaving for work. Not long thereafter Mr Tscherkaskyj loaded his vehicle at the Hobart Print Centre located at Prince of Wales Bay after which he departed.
23. The time stated by Ms Jay in the last paragraph is probably incorrect as Mr Tscherkaskyj's supervisor Mr Rick Lonergan<sup>12</sup> saw Mr Tscherkaskyj when he arrived at work at about 11:40pm. Mr Lonergan, who had just returned from Launceston with the northern papers, took some of them over to Mr Tscherkaskyj for his run. Mr Lonergan says Mr Tscherkaskyj seemed his usual self and they had a joke and a laugh. Mr Lonergan observed Mr Tscherkaskyj drive out of the depot at approximately 12:40am.
24. Mr Tscherkaskyj's employer says his duties included undertaking a number of pre-start vehicle checks in accordance with an app confirming:
  - he was fit to complete the tasks required to complete the run;
  - he was not under the influence of drugs or alcohol and if he had consumed prescription medication he was permitted to drive while taking that medication;
  - he had sufficient rest since his last shift;
  - he was licensed to drive the vehicle he would be driving on the run;
  - his licence was free of any restriction, suspension or cancellation;
  - he confirmed he had been inducted in the last 12 months;

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<sup>11</sup>Temazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain which permits sleep. This medication was first prescribed on 10 July 2009 and it was last prescribed on 19 March 2021. The rationale for its prescription is contained in a note of a consultation on the general practitioner on 2 August 2011.

<sup>12</sup> Exhibit C12.

- he stated, to the best of his knowledge the vehicle he was driving was roadworthy and registered;
- he confirmed the tyres on the vehicle were not damaged, were correctly inflated and there was no damage;
- fluids in the vehicle were contained and there were no signs of leaks under the vehicle;
- all lights, indicators and the horn were working;
- the seat, mirrors and seatbelt were not damaged and were functional;
- the vehicle to be used had the capacity to carry the weight of the run and was fit for purpose;
- he would load the vehicle in accordance with axel load limit regulations and requirements;
- he would ensure the load was appropriately restrained;
- he would demonstrate safe and responsible driving behaviour at all times; and
- he would take the necessary rest breaks in accordance with his employer's fatigue management policy.<sup>13</sup>

In addition he indicated he would load media publications at his employer's depot into his allocated vehicle in accordance with his employer's procedures and that he would deliver both bulk and individually wrapped publications between Granton and Queenstown and return. This route was known as the west coast run.

25. After leaving the depot the next sighting of Mr Tscherkaskyj was captured on CCTV footage at 1:38am at the Bushy Park Road House. There are 3 cameras at that Road House which are all equipped with an audio feed. Mr Tscherkaskyj was filmed driving into the forecourt, delivering a load of newspapers and driving away, at 1:39am, in a general westerly direction towards Glenora.

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<sup>13</sup> This policy, along with a number of others, was provided with the WorkSafe Tasmania investigation; see exhibit C38.

26. On 7 August 2021 Ms Wrigley was with her then friend, Mr McCauley, at her house in New Norfolk. Late in the evening she received a call from her friend, Ms Madden, who asked if both she and Mr McCauley wanted to go for a drive up to Lake Repulse. Ms Wrigley and Mr McCauley agreed so they drove to Ms Madden's house in Ellendale in Mr McCauley's vehicle. When they arrived Mr McCauley, Ms Wrigley and Ms Madden got into a vehicle driven by Tristen Post who drove them to Lake Repulse. Ms Wrigley says they were not going there for any particular reason but they knew there was a party being held at the location. They left Ms Madden's house at approximately 12:30am and arrived at the Lake 10 to 15 minutes later. On their arrival police were just leaving because somebody had been hit by a vehicle. There were about 20 to 30 people present however Ms Wrigley says the four people in Mr Post's car remained in that vehicle and spoke to their friends through the windows. They left about 30 minutes later and Mr Post drove them back to Ms Madden's home. On arrival they sat in Mr Post's vehicle for approximately five minutes talking before Mr McCauley got out and started his car in order to operate the demisters to clear the windscreen because it was very cold. They talked for a further five minutes before Mr McCauley commenced the return journey to Ms Wrigley's home. Not long into that journey Ms Wrigley says she fell asleep.
27. Ms Madden says after Ms Wrigley and Mr McCauley left she received a text message at 2:03am from Ms Wrigley which indicated they had crashed. Ms Wrigley messaged her back thinking she was joking but received another message at 2:08am from Ms Wrigley indicating she was in a bad way. Ms Madden then called Mr McCauley on his phone at 2:12am and Ms Wrigley answered and said they had crashed and she needed Ms Madden *"to come down."* Ms Wrigley sent Ms Madden her location on Snapchat. She heard Mr McCauley in the background who appeared to be in a lot of pain and she heard another person in the background who she later became aware was Mr Hall. Mr Post and Ms Madden went to the accident scene where they met Mr Hall. Ambulance and police were on the scene when they arrived. Ms Madden says she did not speak to either Ms Wrigley or Mr McCauley while at the scene. She messaged her mother and asked her to send her the number of Ms Wrigley's mother. She then advised Ms Wrigley's mother of the accident.
28. At 1:40:24am the northern and southern CCTV cameras in the Bushy Park Road House record a thud which I find was the impact of the vehicle driven by Mr McCauley colliding with the vehicle driven by Mr Tscherkaskyj.
29. Emergency services were contacted and Tasmania Fire Service personnel were first on the scene. It was reported both Mr McCauley and Ms Wrigley were trapped in the vehicle driven by

Mr McCauley whereas Mr Tscherkaskyj was deceased. Once paramedics arrived Mr Tscherkaskyj was pronounced deceased and no attempts were made to extract him or to provide cardiopulmonary resuscitation (CPR).

### Investigation

30. There is a 000 call made by Ms Wrigley at 1:48am to AT lasting approximately 24 minutes. At the commencement of the call when asked by the operator where on the roadway she is Ms Wrigley says she is not sure but she says that she and Mr McCauley had been involved in a head-on collision. Mr McCauley can be heard throughout the call yelling out in distress. They are both hurt and Ms Wrigley says she is trapped in the vehicle. She confirmed nobody else was in their vehicle, they were both awake and she observed serious bleeding on Mr McCauley's face. She could not determine whether there was anybody outside the vehicle and she could not see the other vehicle. Ms Wrigley did not know whether they had passed Bushy Park although she was able to say they were travelling from Ellendale to her home at New Norfolk. She is given advice about what to do by the operator. Ms Wrigley was advised multiple units were on the way from AT, police and the fire brigade. She was encouraged to continue to speak to the operator. She confirmed that both she and Mr McCauley had their seat belts on, she could not see the other vehicle and she could not see the headlights of the other vehicle although the headlights of Mr McCauley's vehicle were still on. Ms Wrigley was not sure if her head hit the windscreen. Just over 18 minutes into the conversation another vehicle pulls up and another male can be heard speaking to the operator. I infer this is Mr Hall whose evidence is mentioned below. Shortly thereafter a paramedic speaks to the operator and then attends to Mr Tscherkaskyj. Ms Wrigley then says the phone is about to die and not long thereafter the phone call ends.
31. Constables Hatton and Davidson<sup>14</sup> were despatched by the police radio room to attend this motor accident at approximately 2:00am. Police were aware that personnel from AT, Tasmania Fire Service and the police helicopter had also been dispatched to attend the scene. While on their way to the location the police officers were advised that the driver of one of the vehicles was deceased. On their arrival at approximately 2:35am, paramedics, fire officers and the police helicopter were already present. Paramedics were attending to Mr McCauley and Ms Wrigley and police confirmed Mr Tscherkaskyj was deceased. These two police officers secured the scene until Constable Gowen and Senior Constable Hall from CIS and First-Class Constable Walker from FS arrived.

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<sup>14</sup> See exhibits C16 and 17.

32. Constable Hatton took a statement at the scene of the collision from Mr Lachlan Hall<sup>15</sup>. Mr Hall says he had been at Lake Repulse from about 7:00pm until 1:30am with 20 to 30 people. During the evening he dropped someone off at their house in Westerway. He was returning to his home at Magra and was driving down Glenora Road when he observed hazard lights operating. He pulled over and saw there had been a collision between two vehicles. He went over to one of the vehicles and observed Mr Tscherkaskyj who appeared to him not to be breathing. He then went to the other vehicle and recognised Ms Wrigley from other friends he had on Facebook although he says he did not know her personally. He did not know the driver Mr McCauley. He thinks at the time he observed Ms Wrigley she was on the phone to emergency services. He says not long thereafter the SES and ambulance personnel arrived.
33. At approximately 2:20am Constable Gowen was advised of this collision as he was the on-call crash investigator for the Southern District of Tasmania Police. He arrived at the scene at 3:59am at which time he says it was cold, dark, clear and the road was dry. On his arrival he observed two Toyota Hilux vehicles which had collided near head on in the northbound lane. He observed a male person who he later became aware was Mr Tscherkaskyj in the driver's seat of the northbound vehicle. He also observed a male and female, who he later learned were Mr McCauley and Ms Wrigley, being extracted from the south bound vehicle by emergency services.
34. Constable Gowen remained at the scene until daylight at which time he commenced a thorough inspection, marking and measuring of the scene. He conducted a scene survey and was present when a drone, operated by Sergeant Archer, took photographs which enabled him to create a 3-D photogrammetric map of the scene. Sergeant Archer also obtained video and overhead photos of the crash scene. Constable Gowen downloaded the survey data and produced a scene survey<sup>16</sup>. He also prepared a collision analysis report<sup>17</sup>.
35. First-Class Constable Walker was directed to attend the accident scene at 3:05am and on his arrival he was briefed by another officer. He made a number of observations of the scene, the vehicles involved and their respective positions on the roadway. During his examination he took a series of photographs. He completed his examination and left the scene and 11am<sup>18</sup>.

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<sup>15</sup> Exhibit C14.

<sup>16</sup> Exhibit C27.

<sup>17</sup> Exhibit C26.

<sup>18</sup> Exhibit C18.

36. In addition to the personnel at the scene identified by Constable Hatton, Constable Gowen says officers from the State Emergency Service were also present. Constable Gowen attended with Senior Constable Adam Hall also of CIS. The temperature on their arrival was -3°C and the road was closed until 11:00am during which time a thorough examination was undertaken by both FS and CIS.
37. Constable Gowen says in his report Gordon River Road is a winding road that runs in a general east/west direction between Rosegarland to the east and the Gordon Dam to the west. It is a rural road which is predominantly flanked by farmland between Rosegarland to Westerway where-after it is surrounded by dense forest west of Maydena. The speed limit where this collision occurred is 100 km/h. The road surface at the scene consists of bitumen aggregate which was in a fair condition at the time of the accident.
38. At the accident scene the road has a north/south orientation. There are two marked lanes, the northbound lane measuring 3.4 m from the centre lines to the road edge and the southbound lane measured 3 m from the centre lines to the road edge. The road edges were constructed of soft dirt and gravel shoulders with no marked fog lines on either side. A road side drain was present on the southbound side of the road 2.9 m from the road surface. The centrelines at the crash location consisted of a solid white line on the southbound lane and a dashed white line on the northbound lane. At a distance 10.2 m south of the crash location the centrelines are double solid white lines.
39. There is no overhead street lighting on this section of roadway. On the western side of the road are a row of large conifer trees which run from the edge of the verge back into an adjacent paddock. These trees are positioned in a row at 90° to the road which obstructs the view of the road ahead for drivers in both directions.
40. Upon his arrival Constable Gowen spoke to attending police who had secured the scene and who advised all evidence remained undisturbed prior to his arrival. Constable Gowen noted both vehicles had collided and come to a final resting point in the northbound lane adjacent to the row of conifer trees. The vehicles had collided head-on with very minimal offset to the passenger side of both vehicles by approximately 100 mm. There was no evidence of emergency braking by way of skid marks or tyre scuffs on the road by either vehicle prior to the collision. There was no visible separation of the vehicles after they collided. Although there was no tyre scuffing on the road to support the vehicles rotating at impact overhead photography indicates the vehicles had rotated slightly clockwise with the rear left wheel of

Mr Tscherkaskyj's vehicle coming to rest on the western road edge. Constable Gowen says this is most likely due to the rear of both vehicles becoming slightly airborne during impact.

41. Constable Gowen observed a debris field of glass, metal and plastics predominantly around the front ends of both vehicles. The grey plastic canopy covering the tray of Mr Tscherkaskyj's vehicle had shattered and separated from the vehicle, coming to rest on the ground next to the left side doors of his vehicle. A chainsaw had been ejected from the tray and was resting on the road next to the rear right wheel of his vehicle.
42. The spare tyre from the undercarriage of Mr McCauley's vehicle had dislodged and was lying on the road behind his vehicle. A large toolbox had been ejected from the tray and this was also on the road, 3.8 m behind the vehicle. The rear doors of Mr McCauley's vehicle had been removed by emergency services to assist in extracting both him and Ms Wrigley. These doors were laid on the eastern verge adjacent to Mr McCauley's vehicle.
43. Underneath the vehicles Constable Gowen observed engine fluid on the road's surface. He also observed a small gouge in the road 10 cm behind the gearbox of Mr Tscherkaskyj's vehicle which he attributed to the transfer case. He says the transfer case became dislodged as a direct result of the collision and was forced downward into the road creating the gouge. This he says suggests Mr Tscherkaskyj's vehicle travelled only 10 cm further north after the transfer case impacted the road surface. There were no other scrapes and/or gouges located on the roadway which could be attributed to by the height in the undercarriage of both vehicles being substantially high enough to not have been forced into contact with the road surface at impact.
44. Constable Gowen notes the CCTV footage depicts Mr Tscherkaskyj making a newspaper delivery at the Bushy Park Road House, which is 1.7 km south of the accident scene, at 1:38:21am. The footage shows his vehicle's headlights, LED driving lights and an LED light bar all activated. As he opens the door it can be seen he does not have a seatbelt across his shoulder however he may have uncoupled the seatbelt moments prior to stopping; that not being captured on the footage. He is observed to complete his newspaper delivery, re-enter his vehicle and he departs at 1:39am without fastening his seatbelt. The vehicle is then observed to head towards Glenora with the same lights as previously mentioned operating. At 1:40:24 a sudden thud can be heard on the CCTV footage which in the absence of any other explanation is concluded by Constable Gowen to be the two vehicles colliding. I agree with that conclusion.

45. Constable Gowen calculated that 84 seconds expires between Mr Tscherkaskyj leaving the Road House and the sound of the loud thud on the footage. Using a distance over time calculation Constable Gowen says Mr Tscherkaskyj's average speed over that 1.7 km distance is 72 km/h which I note is well below the speed limit. This calculation assumes the speed of his vehicle remains constant over the distance travelled and it does not indicate the speed of Mr Tscherkaskyj's vehicle at the time of impact.
46. The vehicle Mr Tscherkaskyj was driving was registered to his employer. It was a 5 speed manual with an electronic odometer which could not be read due to damage sustained in the collision. Maintenance documentation found inside the vehicle indicates that on 6 August 2021, 2 days prior to the collision, the vehicle had travelled 230,006 km. It had sustained catastrophic front end damage. Both frontal airbags had deployed, the centre instrument panel had dislodged and was severely misaligned. The firewall had been pushed rearward and was pinning Mr Tscherkaskyj by the right leg. Both front seat backs were twisted outward toward their respective sides, both sun visors were in the *up* position and there was an empty mobile phone holder on the dash under the centre rear vision mirror which had detached from the windshield. A mobile phone was located in Mr Tscherkaskyj's shirt pocket. On his left wrist was a smartwatch which had sent an impact message to Ms Jay at 1:44am which is approximately 3.5 minutes after the loud thud is heard on the CCTV footage. Constable Gowen suspects there could well have been a difference in the time depicted on the CCTV footage and the time on the watch. The speedometer needle was stuck at around 80 km/h and the RPM needle displayed approximately 1900 RPM. The gearstick appeared to be in 4<sup>th</sup> gear and the handbrake was off. The driver's seat belt was locked in the retracted position which indicates that the pre-tensioner had fired while the seatbelt was retracted. This suggests Mr Tscherkaskyj was not wearing a seatbelt at the time of the collision. This evidence is consistent with the CCTV footage which shows him departing the Road House without putting his seatbelt on. On the plywood floor were approximately 16 bundles of flat pack newspapers and about 30 rolled single newspapers. They were unsecured and had been propelled forward at impact into the rear of and between the front seats.
47. On 13 August 2021 the vehicle Mr Tscherkaskyj was driving was inspected by Mr Paul Wells who is a transport safety and investigation officer employed by the Department of State Growth. He is a qualified diesel mechanic with 25 years' experience in the motor trade. During the course of his employment as a transport inspector he has inspected a number of vehicles



involved in serious and fatal crashes. He says in his affidavit<sup>19</sup> the vehicle was in a well-maintained condition however it was un-roadworthy due to a number of compliance issues in that it had non-compliant seating and seatbelt reduction that is the rear seats and centre seatbelt inclusive of coupler and the outer belt couplers had been removed without certification by an approved vehicle certifier. Constable Gowen was of the opinion the removal of the rear seat and seatbelt components in no way contributed to the cause of the collision. I agree with that conclusion.

48. The south bound vehicle was registered to Mr McCauley and it had a 5 speed manual transmission but the mileage could not be determined due to impact damage. As with the vehicle Mr Tscherkaskyj was driving this vehicle had suffered catastrophic front end damage. The engine assembly was misaligned rearward, as was the bull bar, bonnet and winch assembly. All front lights including 2 aftermarket driving lights were totally destroyed. The windscreen was shattered and totally destroyed. The left and right B pillars had been severed by emergency services to extract Mr McCauley and Ms Wrigley. Seatbelts were present in the extended position and had been cut by emergency services indicating they had been worn at the time of the collision. The passenger front airbag deployed however the steering wheel airbag failed to deploy. The speedometer was stuck at around 68 km/h with the engine RPM needle stuck at around 1800 RPM.
49. On 9 August 2021 Mr McCauley's vehicle was inspected by Mr Wells. He found the vehicle to be in an un-roadworthy condition prior to the collision due to a number of compliance issues namely:
- non-compliant applied film tint to all side windows;
  - non-compliant applied film tint to the front wind screen in the wipers path in an upper and lower band configuration;
  - non-compliant vehicle height/lift as a result of a non-compliant tyre rolling diameter;
  - non-compliant wheel track at the rear (the front was unable to be assessed due to damage);
  - non-compliant suspension modifications;

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<sup>19</sup> Exhibit C21.

- non-compliant rear brakes left and right (friction surface contaminated with differential oil);
  - non-compliant driver's airbag which failed; and
  - non-compliant driver's seat belt (frayed).
50. Constable Gowen noted Mr McCauley's vehicle was on the incorrect side of the roadway when the collision occurred. Mr McCauley had up until this inquest, as is his right, declined to make a statement and explain why this was so.
51. Constable Gowen noted the distance from Ms Madden's home to the scene of the collision was 20.1 km. The weather was fine, clear and the road was dry. There were centre lines that were clearly marked which differentiated the north and south bound lanes. On the day of the collision Senior Constable Hall and Constable Gowen established a maximum line of sight which measured 55 m either side of the area of impact, meaning the driver of one vehicle should have been able to see the other vehicle when they were 110 m apart. This was established visually at the crash scene in daylight hours and therefore did not take account of the ability to observe approaching headlights, perhaps at a greater distance, in a night time environment.
52. On 17 October 2021 Constable Gowen and Senior Constable Hall conducted drive-through testing during daylight hours to determine the deviation in the path of travel for a south bound vehicle that was not being controlled that is when the driver was asleep or unconscious. Five drive-throughs were conducted at speeds between 60 and 80 km per hour using an unmarked police Ford Ranger. Senior Constable Hall drove the vehicle while Constable Gowen filmed from the rear seat. In all five drive-throughs Senior Constable Hall released control of the steering wheel prior to the approximate point of impact to establish the direction of travel an uncontrolled vehicle would take. It was found that without steering input to the right the vehicle veered toward the eastern (left) road edge, and significant steering input to the right was required to maintain the vehicle's position in the southbound lane, or to position the vehicle in the northbound lane. This indicates for Mr McCauley's vehicle to have manoeuvred into the incorrect lane, steering input to the right by Mr McCauley needed to be deliberate. There is no evidence therefore to support the hypothesis that he was asleep and/or unconscious just prior to this collision. The evidence does however support the hypothesis he cut the corner by steering into the northbound lane, taking what is

commonly known as a “racing line” through the corner. A racing line can be best described as the fastest line or arc through a corner which is achieved by actively steering toward the apex of a curve to reduce the time and distance taken to negotiate the corner or curve. For a right-hand curve on a two-way road, this would require the driver to actively steer into the opposing lane.

53. On 10 December 2021 night time drive-through testing was conducted by police at the scene to establish the effect of headlights on opposing drivers. These tests were conducted using both low beam lights and high beam lights with ancillary lights operating. This test was conducted on a dry road in darkness, and in similar environmental conditions to the night of the collision. The vehicles used were similar in height and lighting configuration to the vehicles involved in the collision. The following four tests were conducted:
- 60 km/h – low beam lights on;
  - 60 km/h – high beam lights with spotlights on;
  - 70 m/h – high beam lights with spotlights on; and
  - static visibility tests at 10 m, 20 m and 30 m from the approximate point of impact with high beam lights and spotlights on.
54. All tests were filmed using Go Pro video cameras, mounted on the respective drivers’ heads with a harness, to provide a driver’s perspective. In the low beam drive-through at 60 km/h no visibility concerns were identified for Mr McCauley’s direction of travel. In the second and third drive-throughs where the lights were on high beam with spotlights activated at 60 and then 70 km/h it was noted that although a brief moment of centreline obscurity occurred when the headlights crossed the view of the opposing driver, the eastern road edge and reflective guideposts were always visible to the southbound driver. Testing showed there was no apparent reason why an attentive southbound driver should not have been able to keep the vehicle wholly within the southbound lane.
55. Both vehicles were fitted with an event data recorder which was housed within the airbag control module (ACM). Both ACMs were removed from the respective vehicles at the scene, before the vehicles were towed. Constable Gowen suggests a suitably qualified officer would utilise any extracted data to attempt a speed analysis if that was possible although it was not

thought excessive speed on the part of either driver caused or contributed to this collision. No data was able to be extracted.

56. Constable Gowen noted Mr Tscherkaskyj was very familiar with the roadway having carried out the Hobart to Queenstown run for his employer on 6 nights a week for in excess of 10 years.
57. Mr Tscherkaskyj had a full active Tasmanian driver licence with no licence conditions attached as at the date of this collision. Mr McCauley held an active P1 licence which was issued on 11 January 2021 and which expired on 10 January 2024 and therefore he had less than 7 months of unsupervised driving experience prior to this collision.
58. Based upon his investigations Constable Gowen is of the opinion this accident occurred when Mr McCauley took what is known as a racing line through the curve thereby crossing the centre line and driving into the northbound lane occupied by Mr Tscherkaskyj's vehicle and this led to the collision. Speed did not cause or contribute to the collision. The condition of the vehicles also did not cause or contribute to the collision. I accept Constable Gowen's opinion.
59. The forensic pathologist Dr Andrew Reid conducted a post-mortem examination on 9 August 2021. As a result of that examination and after considering the results of radiology, toxicology and microbiology he determined the cause of death in this case was head, chest and limb injuries following a motor vehicle collision in which Mr Tscherkaskyj was one of the drivers involved. The injuries Dr Reid observed had a pattern of blunt force trauma consistent with injuries sustained in a motor vehicle collision. Dr Reid says three prescribed medications were found to be present on toxicology and he says none of them caused or contributed to the collision. He says concentrations of cardiac drugs for hypertension/angina (amlodipine) and dyslipidaemia (rosuvastatin) were detected within reported therapeutic ranges. Temazepam was detected at a concentration below the reported therapeutic range. That drug has the potential side-effect of drowsiness and patient information relating to its consumption contains a warning not to drive. Dr Reid says it is however unlikely the sub therapeutic concentration of temazepam in Mr Tscherkaskyj's blood caused either drowsiness or contributed to the circumstances in which the motor vehicle collision occurred. I agree with this comment particularly when one considers that at the time of the collision Mr Tscherkaskyj's vehicle was entirely within its correct lane. I accept Dr Reid's opinion as to the cause of death.

60. Mr Tscherkaskyj's mobile phone was located and seized by police and submitted for download by forensic personnel. Due to the damage to the USB port it was unable to be downloaded. Police and Mr Tscherkaskyj's family were unable to obtain the password to unlock the device. Having been located in his shirt pocket, there is no evidence to suggest Mr Tscherkaskyj was using his mobile phone at the time of the collision.
61. Mr McCauley's mobile phone was seized from his vehicle at the scene and submitted for download. Mr McCauley supplied the passcode to his phone to enable a successful download by police forensics officers. The downloaded data revealed his phone was not being used to make voice calls or send SMS/MMS messages in the lead up to the collision and supports Ms Wrigley's statement that she attempted to use Mr McCauley's phone after the collision to call "000".
62. A Call Charge Record (CCR)<sup>20</sup> obtained by investigating officers indicates the first call attempt to "000" (shown on the CCR as "0112" – another valid number for emergency services) being made at 01:43:55. The CCR shows that between 00:01:03hrs and the first attempt to call "000" the phone was using 3G and 4G data sources, but it is not able to be determined what this data use consisted of. Mobile phones regularly download data in the background as they bounce off mobile phone towers, play music or are used for navigation, amongst other uses. The SMS messages and then call to Ms Madden are also recorded.
63. A blood sample was taken from Mr McCauley pursuant to the provisions set out in Division 2 of Part II of the *Road Safety (Alcohol and Drugs) Act 1970*. That sample was analysed at Forensic Science Service Tasmania and it was determined the sample contained no alcohol or illicit drugs. The sample did contain ondansetron which is an antiemetic drug used to control nausea and vomiting in post-operative patients and in those people receiving chemotherapy and radiotherapy for cancer. It is also often administered by paramedics following motor vehicle crashes and in this case the evidence discloses it was used by the paramedics who treated Mr McCauley at the scene of this crash<sup>21</sup>.
64. The Worksafe investigation<sup>22</sup> considered the systems of work implemented by Mr Tscherkaskyj's employer to determine whether it had complied with its statutory obligation to do everything reasonably practicable to ensure Mr Tscherkaskyj's health and safety<sup>23</sup>.

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<sup>20</sup> Exhibit C37.

<sup>21</sup> Exhibit C9.

<sup>22</sup> See Exhibit C38.

<sup>23</sup> S19 *Work Health and Safety Act 2012*.

Worksafe was unable to comment on the condition of the vehicle driven by Mr Tscherkaskyj as that was in the possession of police. My investigation has determined the vehicle was unroadworthy due to some compliance issues however those issues neither caused or contributed to this collision.<sup>24</sup>

65. The Worksafe investigation determined Mr Tscherkaskyj had been inducted and as part of that induction he was informed about the hazards posed by other drivers on the road and he was directed to ensure that he drove to local conditions and adhered to all Road rules. It was noted Mr Tscherkaskyj was a very experienced driver and held a full driver licence. At the time of the collision the employer had:

- risk assessments for the job being undertaken by Mr Tscherkaskyj;
- guidance material for “delivering safely”;
- information had been provided to Mr Tscherkaskyj with respect to his job description, work health and safety policies and the fatigue management policy;
- the employer had deemed him to be competent to fulfil the role; and
- he had been provided with instruction with respect to employing safe work methods during night time delivery operations.

66. Mr Tscherkaskyj took heed of the fatigue management policy given Ms Jay’s evidence that her husband would normally stop at Mount Arrowsmith on the return journey for 30 minutes or so.<sup>25</sup>

67. Worksafe concluded there was no evidence to suggest inadequate systems of work had in any way contributed to this collision. Despite this it was noted the employer had undertaken a thorough investigation and had reviewed the circumstances surrounding the collision, risk assessments and systems of work in order to identify any measures that could be employed in order to eliminate or reduce the risk of a recurrence. As a result it had updated its inductions, hazard notification forms, operational policies and its work health and safety manual. Worksafe says if an employer requires an employee to drive regularly in the course of his or her employment then the relevant legislation requires the elimination of all risks so far as it is

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<sup>24</sup> See paragraph 47.

<sup>25</sup> See paragraph 19.

reasonably practicable to do so. In this case Worksafe was satisfied the systems put in place by the employer complied with that obligation. That organisation quite properly concluded it was not reasonable to require an employer in this case to eliminate the risks posed by other road users who might drive negligently as the employer has no ability to control the driving behaviour of other road users.

68. Mr McCauley was charged on complaint 530/2022 with one count of causing the death of Mr Tscherkaskyj by negligent driving contrary to s32(2A) of the *Traffic Act 1925* and one count of cause grievous bodily harm to Ms Wrigley by negligent driving contrary to s32(2B) of the *Traffic Act 1925*; both offences alleged to have occurred on 8 August 2021. He pleaded guilty to both charges in the Hobart Magistrates Court and he was sentenced on 31 October 2022. Mr McCauley was convicted of both charges and sentenced to 5 months imprisonment which was wholly suspended for a period of 12 months on the condition that he not commit another offence punishable by imprisonment. He was also disqualified from driving and ordered to pay court costs.

#### **Oral Evidence at the Inquest not Otherwise Referred to Above**

##### *Evidence Leading to the Collision*

69. At the inquest Mr McCauley said he obtained his P1 licence in January 2021. However, it appeared that he drove a reasonable distance daily (approximately 2 hours) for his work as a labourer (roofing) around greater Hobart from his home in Brighton. The majority of this driving was in the daytime and not at night. He gave evidence he had the vehicle involved in the collision for about three months prior to its occurrence.
70. Mr McCauley said he had been up late the night before, but denied being tired, nor having consumed any alcohol or drugs that evening. He said he used his phone at the start of the journey to select some music to play through the stereo but was not using his phone prior to the collision.
71. Mr McCauley said he had driven this road two or three times prior to the collision. Earlier in the journey, about 20 minutes from Ellendale and 20 minutes before the collision, his vehicle slipped on some black ice. As a result he was driving at approximately 70-80km/h before the collision, less than the speed limit of 100km/h, although there was no ice near the collision. He said there was some patchy fog on the journey.

72. Mr McCauley was unable to recall or explain why he was on the wrong side of the road, but accepted that he was. He denied being tired or falling asleep. He denied knowingly navigating into the wrong lane, or that there was any hazards that caused him to do so.
73. Ms Wrigley gave evidence she fell asleep about five minutes into the journey from Ellendale to New Norfolk. She awoke on impact and as a result was not able to comment on what occurred immediately before the collision.
74. Ms Wrigley indicated she had been in the car with Mr McCauley numerous times and had no concerns with his driving. He lived in Brighton and often came to stay at her house. She had never driven with him at night-time before the evening of the collision.
75. Ms Wrigley and Ms Madden both gave evidence that none of the people in their car got out at the party at Lake Repulse, drank any alcohol or took any drugs that evening, including Mr McCauley. Neither made any observations that he appeared to be tired or otherwise unfit to drive. Ms Madden indicated she told him to drive safely, as something you normally did when someone was driving late at night.
76. Both Ms Wrigley and Ms Madden also spoke about how cold it was that evening and in the early hours, and that it was icy. Ms Madden said Mr Post had commented the road was “slippery” when driving back to Ellendale from Lake Repulse. Ms Wrigley said it was a cold night but could not recall whether there was ice on the road. Ms Madden, who attended the scene after Ms Wrigley contacted her, did not observe ice on the road but she did say it was very cold.
77. Constable Gowen indicated that, in his opinion, ice or an icy road did not contribute or cause the collision. He said when he attended there was no ice on the road, and that he had consulted the relevant weather records to establish the conditions at the time of the collision. His evidence was there was very little or no rain (insufficient to create ice on the road) and that the temperature had actually fallen between when the collision occurred at approximately 1:40am and his arrival at 3:59am.
78. This evidence indicates Mr McCauley was a youthful and an inexperienced driver, travelling on an unfamiliar rural road late at night. All these factors likely contributed to him travelling into the incorrect lane.



79. As pointed out by counsel assisting a matter of concern for Mr Tscherkaskyj's family was whether he was wearing a seatbelt at the time of the collision. He was by all accounts generally a safe and careful driver, and knew this road particularly well.
80. Ms Jay made a general statement to the court that Mr Tscherkaskyj had a practice of taking his seatbelt off before opening his door, and he would put it on after he started driving. She reiterated his careful driving and his desire to get back home safely to his family.
81. Constable Gowen said he formed the view Mr Tscherkaskyj was not wearing a seat belt at the time of the collision. Mr Tscherkaskyj was in the vehicle when he attended the scene, and Constable Gowen observed the driver's seatbelt was fully retracted against the B pillar of the vehicle. He gave evidence that the pre-tensioner of a seatbelt is activated when there is significant force, locking it in place. (This force also triggers airbags, which had been activated in Mr Tscherkaskyj's vehicle). The location of the seatbelt indicated it was fully retracted on impact, and therefore Constable Gowen concluded it was not worn by Mr Tscherkaskyj.<sup>26</sup>
82. This is supported circumstantially by the CCTV at the Bushy Park Road House, which captures Mr Tscherkaskyj's vehicle arriving at 1:38am, where he stops the vehicle and gets out to deliver papers. As he arrives he does not appear to be wearing a seatbelt. He enters the car again and departs. The footage again suggests he does not put his seatbelt on at this stage.
83. Constable Gowen's opinion is also supported by photographs taken by Constable Walker who attended the scene at 3:05am, and made the observation that Mr Tscherkaskyj was not wearing his seatbelt. The Police officers who first attended the scene at 2:35am do not make specific comment about this, but police body worn camera footage indicates they did not disturb the interior of the vehicle.
84. Further, the pathologist's affidavit says Mr Tscherkaskyj was not wearing a seatbelt. This may have been a repetition of the police facts provided to the pathologist, but it nevertheless does not appear to be inconsistent with the affidavit in that there is no description in that affidavit of any marks or abrasions left by a seat belt which are sometimes seen in cases such as this.
85. On the contrary there is a reference in AT's records which states as part of a checklist about the circumstance of death in a vehicle collision that Mr Tscherkaskyj was wearing a seatbelt. There is a further possible reference to this issue but it is unclear whether it is a reference to the

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<sup>26</sup> If for some reason there had been a fault in the seatbelt and it unlatched, Constable Gowen would expect to see the seatbelt locked in an extended position.

occupants of Mr McCauley's vehicle only, or to both vehicles. The evidence indicates the attention of paramedics was focussed on those in Mr McCauley's vehicle, as they were in significant distress and Mr Tscherkaskyj appeared to be already deceased. It is highly unlikely paramedics would have removed Mr Tscherkaskyj's seatbelt, and if they did it would have been cut and that event would have been noted. In light of the other evidence, and particularly Constable Gowen's evidence about the operation of seatbelts, the reference in AT's records is not determinative of this issue. The weight of the evidence suggests the contrary. I therefore conclude Mr Tscherkaskyj was not wearing his seatbelt at the time of this collision.

86. None of the evidence in paragraphs 69 to 85 alters my conclusions set out in paragraphs 58 to 67.

### **Conclusions**

87. The findings required by s28 (1) of the Act are set out in paragraph 4.
88. Mr Tscherkaskyj was working in his role as a newspaper delivery driver, and he was performing his usual west coast run in the early hours of 8 August 2021. He had rested and was in good spirits before he commenced his run. Mr Tscherkaskyj was very familiar with the road on which he was driving. The weather was fine, the road was dry, the winds were very light and it was not foggy at the time of the collision. CCTV captured Mr Tscherkaskyj delivering newspapers at the Bushy Park Road House minutes before the collision. Mr McCauley was driving south on Gordon River Road. His front seat passenger was Ms Wrigley. Mr McCauley has failed to keep to the left of the centreline whilst rounding a right curve in the road for a southbound driver. His vehicle was completely in the northbound lane. Mr Tscherkaskyj's vehicle was in its correct lane, heading north. The vehicles collided head on and had only a slight clockwise rotation after impact. The sound of the collision was captured on CCTV. Mr Tscherkaskyj was killed in the collision. He was not wearing a seatbelt. The speed limit for this section of Gordon River Road is 100km/h. Excessive speed and the consumption of alcohol and/or drugs did not cause or contribute to this collision. Although both vehicles were un-roadworthy at the time of the collision the defects did not cause or contribute to this collision.
89. Drive through testing revealed an unsteered southbound vehicle would not divert into the northbound lane. Night-time visibility testing revealed that a southbound driver should be able to successfully negotiate the curve in the road when confronted with low or high beam lights. I find the southbound Toyota has been steered by Mr McCauley into the northbound lane, effectively taking a racing line through the curve, and this has resulted in the collision. I also find

the row of conifer trees obstructed the view of each vehicle to each driver until it was too late for either driver to make any meaningful manoeuvre to avoid the collision. Had Mr McCauley maintained his vehicle's position in the southbound lane, the collision would not have occurred.

#### **Comments and Recommendations**

90. I extend my appreciation to investigating officer Constable Jared Gowen for his thorough investigation and report.
91. Given my findings it is not necessary for me to make any further comments or recommendations.
92. In concluding, I convey my sincere condolences to the family and loved ones of Mr Tscherkaskyj.

**Dated:** 8 January 2024 at Hobart in the State of Tasmania.

**Robert Webster**  
**Coroner**