FINDINGS and COMMENTS of Coroner Robert Webster following the reopening 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 reopened the investigation into 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 5 March 2025 at which the issues that will arise at the reopening of this inquest were identified. The matter was then adjourned for a further hearing which took place on 16 June 2025.

Counsel assisting

Ms Letitia Fox

Mr Andrew Gaggin acting for Ms Kellie-Ann Jay the senior next of kin and wife of Mr Tscherkaskyj.

Notice of this hearing

Notice in writing of the CMC was provided to Mr Andrew Gaggin, of Murdoch Clarke Lawyers by email of 27 February 2025. Mr Gaggin appeared at the CMC and sought leave to appear at the reopening of this inquest. Leave was granted. He subsequently appeared on 16 June 2025.

Notice in writing of the CMC was provided to Dobson Mitchell Allport, Lawyers, (DMA) who had previously written to the Chief Magistrate on 18 September 2024 indicating that firm acted for the Motor Accidents Insurance Board (MAIB) in relation to a number of civil claims arising out of the motor vehicle accident in which the late Mr Tscherkaskyj received fatal injuries. That firm sought leave to appear as an interested party. At the reopening of the inquest a representative of that firm appeared at the CMC on 5 March 2025. At that time I granted leave for DMA to appear for the MAIB at the reopened inquest and I directed the MAIB to file and serve proofs of any witnesses to be relied upon, and to summons those witnesses to attend the hearing. By letter of 2 April 2025 DMA advised their client no longer wished to take part in the reopened inquest and leave was sought to withdraw from these proceedings and for the directions made against it to be vacated. That leave was granted, and the directions were vacated.

Notice of the CMC was also provided to Mr William Harvey of Blumers Personal Injury Lawyers (Blumers). That firm had previously written to the Chief Magistrate in this matter indicating it acted for Emily Rigley in her personal injuries claim arising out of the motor vehicle accident wherein Mr Tscherkaskyj lost his life. Ms Rigley was a passenger in the other vehicle involved in this accident which was driven by Mr McCauley. Mr Harvey appeared at the CMC but did not seek leave to appear at the reopened inquest. He was excused from further attendance

Reopening of the investigation

Power to reopen

Section 58(1) of the *Coroners Act* 1995 enables the Chief Magistrate to reopen an investigation and direct a Coroner to reexamine some or all of his or her findings if the Chief Magistrate is satisfied that:

a) the investigation was or may have been tainted by fraud; or

b) the investigation was not sufficiently thorough or was compromised by evidentiary or procedural irregularity; or

c) there are mistakes in the record of the findings; or

d) new facts or evidence affecting the findings have come to light; or

e) the findings were not supported by the evidence; or

f) there is another compelling reason to reopen the investigation.

The Chief Magistrate's power can be exercised on the Chief Magistrate's own initiative or by the application of a person who the Chief Magistrate considers has a sufficient interest in the findings of the investigation.[1]

Section 58(5) of the Act provides that a Coroner who is re-examining some or all of the findings of an investigation that has been reopened under s.58 may do any of the following:

a) affirm the findings;

b) quash the findings;

[1] See s.58(2) of the Act

c) vary the findings.

<u>The basis for the exercise of the Chief Magistrate's power in this case</u>

By letter dated 26 August 2024 Mr Gaggin wrote to the Chief Magistrate confirming that his firm acted for Ms Jay, the widow of Mr Tscherkaskyj. He indicated that his client made application for the investigation to be reopened pursuant to s. 58 of the Act, "*particularly that:*

a) there are mistakes in the record of the Findings;

b) new facts or evidence affecting the Findings have come to light;

c) the Findings are not supported by the evidence;

d) there is another compelling reason to reopen the investigation."

He referred to paragraphs 79 – 86 of my findings which dealt with the issue as to whether Mr Tscherkaskyj was wearing a seatbelt at the time of the accident. Mr Gaggin noted that I found Mr Tscherkaskyj was not wearing his seatbelt at that time.

Mr Gaggin's letter enclosed a statutory declaration declared by Mr Edward Larner on 26 August 2024. Mr Gaggin advised Mr Larner is a senior paramedic who was the first responder on the scene (apart from lay SES volunteers). "*Mr Larner provided treatment/attention to Mr Tscherkaskyj whilst he was in his vehicle and you will note the clear evidence of Mr Larner is that Mr Tscherkaskyj was wearing his seatbelt. Mr Larner reached across Mr Tscherkaskyj and unbuckled the seatbelt whilst he was trying to extract him from the vehicle.*

Mr Larner prepared a contemporaneous report which appears to be Exhibit C8 (and which is attached to his statutory declaration). In that report Mr Larner noted that all three patients at the scene were unconscious on arrival but all were wearing their seatbelts. Somewhat surprisingly, Mr Larner was not asked to provide a statutory declaration for the purpose of the inquest nor to give evidence.

The evidence clearly establishes that at the time of the collision Mr Tscherkaskyj was wearing his seatbelt. Ms Jay therefore submits that the findings made as a consequence of the inquest held can therefore not be maintained and the investigation should be reopened with the findings varied to the extent that Mr Tscherkaskyj was wearing his seatbelt at the time of the accident."

The Chief Magistrate wrote to Mr Gaggin on 20 February 2025 and advised that she considered Ms Jay has sufficient interest in the findings of the investigation. She noted that she had considered my

findings, the coronial file and Mr Larner's statutory declaration which Mr Gaggin had forwarded to her under cover his letter of 26 August 2024. She also indicated she had received correspondence from Mr Knight at DMA and Mr Harvey at Blumers and noted that she understood Mr Gaggin had also received copies of their letters. After detailing the evidence, the Chief Magistrate indicated that if I had the benefit of Mr Larner's statutory declaration at the inquest it was open that I might have reached a different conclusion about the seatbelt. Accordingly, she was of the view there was new evidence that has come to light which is capable of affecting my findings and the investigation into Mr Tscherkaskyj's death should be reopened and the findings in relation to whether Mr Tscherkaskyj was wearing a seatbelt re-examined. She indicated the matter would be referred to me to re-examine the findings as to whether Mr Tscherkaskyj was wearing a seatbelt.

Evidence in the reopening of the investigation

The following further affidavits and/or statements were obtained:

a) Statutory declaration of Edward Larner declared 26 August 2024

b) Statement of Edward Larner dated 12 January 2025

c) Affidavit of Lachlan James Hall sworn 21 May 2025

d) Affidavit of Robert Frederick Douglas Shoobridge sworn 4 June 2025

e) Affidavit of Senior Constable Adam Hall sworn 13 June 2025

f) Affidavit of Nathan Ransley sworn 4 June 2025

g) Affidavit of Dr Andrew Reid sworn 5 June 2025

These affidavits and statements were marked as exhibits C41, C41A, C14A, C42, C43, C44 and C6A respectively.

The exhibit list has been amended accordingly and it is attached to these findings.

The evidence

As indicated in my initial findings at paragraph 79 to 86 Mr Tscherkaskyj was by all accounts generally a safe and careful driver and he knew the roadway where the accident occurred very well. Ms Jay had indicated Mr Tscherkaskyj had a practise of taking his seatbelt off before opening his door, and he

would put it on after he started driving. She emphasised at the initial inquest he was a careful driver and he always wished to return home safely to his family.

One of the Tasmania Police crash investigators, Constable Gowen formed the view that Mr Tscherkaskyj was not wearing a seatbelt at the time of the collision. On Constable Gowen's arrival at the scene he observed Mr Tscherkaskyj in the vehicle and 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 also been activated on Mr Tscherkaskyj's vehicle. The location of the seatbelt indicated it was fully retracteded on impact and therefore Constable Gowen concluded it was not worn by Mr Tscherkaskyj. If there had been a fault in the seatbelt and it unlatched as a result of the collision, Constable Gowen would expect to see the seatbelt locked in an extended position.

Constable Gowen's opinion was circumstantially supported by the CCTV footage at the Bushy Park Road House, which captured 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.

In addition, Constable Gowen's opinion was 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. This evidence appears in Constable Walker's affidavit which is Exhibit C18 and photograph number 18; the photographs having been taken by him. The police officers who first attend the scene at 2.35am do not make specific comment about the seatbelt but police body worn camera footage indicates they did not disturb the interior of Mr Tscherkaskyj's vehicle.

Further, I indicated in my findings, Dr Reid's affidavit says Mr Tscherkaskyj was not wearing a seatbelt. I said this may have simply been a repetition of the police facts provided to him, 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 seatbelt which is sometimes seen in cases such as this.

I then dealt with the inconsistency with this evidence which is highlighted in Ambulance Tasmania's records which state as part of a check list about the circumstances 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 occupants of Mr McCauley's vehicle only, or to both vehicles. The evidence indicates the attention of paramedics was focused on those in Mr McCauley's vehicle, as they were in significant distress and Mr Tscherkaskyj appeared to be already deceased. I indicated in my initial findings at paragraph 85 that it was 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. I concluded 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. I indicated the weight of the evidence suggested the contrary and I therefore found Mr Tscherkaskyj was not wearing his seatbelt at the time of this collision.

Mr Larner says in his statutory declaration he is employed by Ambulance Tasmania as an intensive care paramedic in Emergency and Medical Services. As at the date of this accident on 8 August 2021 he had been a paramedic for 9 – 10 years and had worked within the Intensive Care Unit for about a year. That Unit is a dedicated intensive care response unit for significant accidents.

He noted he was generally based in Hobart but over the night of 7 – 8 August 2021 there had been a number of serious motor vehicle accidents which had required attendances away from the depot. He was driving a specifically adapted SUV which is stocked almost like an ambulance but it has no stretcher capability. He indicated it is more or less a back up resource for attending accidents. He was the only occupant. He recalls that a number of emergency vehicles were driving back to Hobart in a line. It was then he received a call about this accident. He therefore turned around and headed out to the accident scene which was near Gretna.

When he arrived, he went to Mr Tscherkaskyj's vehicle. He observed Mr Tscherkaskyj was slumped forward, unresponsive and he did not appear to be breathing. He recalls Mr Tscherkaskyj was trapped. Importantly, he says at paragraph 11:

> "*I recall that Mr Tscherkaskyj was wearing a seatbelt. I recall that I reached over and around him to his lefthand side and unbuckled the seatbelt whilst I was trying to extract him.*"

Mr Larner goes onto say he could not move Mr Tscherkaskyj so he opened his airway to see whether he could breathe and also checked his pulse. He could not find any pulse or breath, so it seemed to Mr Larner Mr Tscherkaskyj was probably deceased. Mr Larner left Mr Tscherkaskyj and went to the other vehicle where other people were injured. He indicates at a later stage he returned to re-examine Mr Tscherkaskyj to confirm his initial findings and to do the necessary checks to declare that life was extinct. Mr Larner subsequently prepared a report in relation to the accident which notes he received the call at 1.55am to attend this accident on 8 August 2021 and he arrived at 2.20am. He notes on that report which was attached to his statutory declaration but is also Exhibit C8 that "*seatbelts worn by all pts*", ("pts" being patients). He says this included Mr Tscherkaskyj. He says the report was prepared at 5.34am on 8 August 2021 and he says he would have prepared the report either when he had a break or when he had returned to the depot in Hobart.

In addition, he says the following:

a) He was the first paramedic to arrive on the scene.

b) He does not recall whether there was more than one SES volunteer responder when he first arrived.

c) He does not recall if the driver's door of Mr Tscherkaskyj's vehicle was open or whether he had to open it.

d) Although Mr Tscherkaskyj was trapped he cannot recall whether this was from the steering wheel on his chest or the dashboard on his legs.

e) He does not recall whether the seatbelt was contracted, whether he pulled it or left it in position. He says it was a busy accident scene as other ambulances had turned up and a helicopter had been arranged for patient transport.

In his statement of 12 January 2025 Mr Larner says he received a call to attend this accident when he was near the Mystate Arena on the Brooker Highway in Hobart. He was one of three emergency vehicles that had attended an incident at Repulse which involved a motor vehicle and which resulted in a rescue helicopter being called to convey an injured person to the Royal Hobart Hospital.

When he arrived at the accident scene there was a badged emergency vehicle already on the scene which he thinks might have been an SES or TFS vehicle. Apart from that vehicle he was not aware of any other vehicles but then says there may have been others west of the accident scene. His focus was on the two vehicles involved in the collision and particularly on the occupants of those vehicles. He says Mr Tscherkaskyj was slumped forward. He had to check whether he was breathing and to do that he had to lift his head. He does not recall whether he lifted Mr Tscherkaskyj's head with one or both hands. When the head was lifted he then listened to see whether Mr Tscherkaskyj was breathing including whether his chest was rising and falling. He also checked his pulse. He concluded the signs were incompatible with life.

He says he arrived at the accidence scene at 2.20am and attended Mr Tscherkaskyj's westbound vehicle at 2.21am. It took him a matter of seconds to determine the initial signs were not compatible with life. He then immediately went to the occupants of the other vehicle and assessed their situation.

As to seatbelts he says at paragraph 11:

a) *"I am unable to say whether the male driver of the eastbound vehicle or the female passenger in that vehicle were wearing seatbelts when I first attended them.*

b) *Despite my statutory declaration which was made more than 3 years after the subject accident I am unable to definitively say whether the driver of the westbound vehicle was wearing his seatbelt.*

c) *In the 3 year period between the subject accident and my statutory declaration I estimated that conservatively I attended at least 150 motor vehicle accidents involving persons who were injured, some of which were fatal."*

He says the following at paragraph 12:

> *"Given that my focus upon arriving at the accident scene was on the occupants of the vehicles involved in this collision, I accept that it is possible that I was mistaken as to whether or not the driver of the westbound vehicle was wearing his seatbelt.*"

In addition, Mr Larner says that after commencing his shift at 7.00pm on 7 August 2021 he attended a number of incidents in addition to the Repulse incident and this accident.

Mr Hall was likely the first person on the scene of the accident given Mr Shoobridge's affidavit. Mr Hall says he came across the accident scene and observed the driver of the westbound Hilux to be slumped forward over the steering wheel. He indicates he did not appear to be breathing. He says he did not notice whether he was or was not wearing a seatbelt.

Mr Shoobridge says in his affidavit he is the Brigade Chief of the Bushy Park Fire Brigade and he attended this accident in that capacity. He says that he was at home when his pager went off advising of a motor vehicle accident which appeared to be a relatively short distance from his home. He drove toward the Bushy Park Fire Station where he knew other members of the Brigade would be gathering. As he drove down the road he came across the accident scene. In the westbound lane there were two vehicles which had obviously collided head on. He says there was another vehicle parked on the left-hand side of the road slightly west of the accident scene which was not involved in the collision. He went across to the westbound vehicle which was entirely on its correct side of the road and he opened the door. The driver side seat was leaning back a bit, the vehicle did not have a backseat and there were newspapers everywhere. He says the driver was leaning forward and was slumped over with both arms draped down. He says the seatbelt was in a vertical position against the door pillar. "*The driver was definitely not wearing his seatbelt.*" He walked to the other vehicle to check the occupants

and then went to the third vehicle and told Lachlan Hall that assistance was on its way and that he should not go over to the two vehicles involved in the collision. He then drove to the fire station whereby he organised equipment to attend the scene before he drove back to the scene and parked on the road slightly west of the accident scene with his hazard lights on. When he returned a paramedic, Nathan Ransley was present. Mr Ransley said he had checked on the driver of the westbound vehicle and confirmed he was deceased.

On the morning of 8 August 2021 Mr Ransley was working as a volunteer ambulance officer and a first responder within a community response team in the Derwent Valley. At around 2.00am he was returning from an incident at Lake Repulse and was tasked to attend this motor vehicle accident. When he arrived at the scene there was only one other person present a young male "*who appeared to have stumbled upon the crash whilst out driving*". I find this young male to be Lachlan Hall.

Mr Ransley observed both vehicles in the westbound lane. He went to the westbound vehicle and observed the driver to have come forward and hit the windshield at high speed before slumping back into his seat. The male was displaying no signs of life. He cannot specifically recall whether the male was wearing a seatbelt, but he does recall not being hindered by a seatbelt whilst checking for an airway occlusion or while applying an ECG with assistance of paramedics sometime later when they arrived. He says he is confident he did not remove the seatbelt because something that significant he would have noted or remembered.

Senior Constable Hall says in his affidavit he attended this two-vehicle collision on Gordon River Road at Glenora in the company of Constable Gowen and they arrived at 3.59am. He assisted with the vehicle inspections at the scene and observed the driver's seatbelt of Mr Tscherkaskyj's vehicle to be retracted and locked against the B pillar. There were no identifiable burn marks or stretching he could see on the seatbelt to indicate it was worn at the time of the collision however, as it was retracted a full inspection of the seatbelt was not possible. He says the seatbelt being retracted and locked indicated the seatbelt pretensioner had fired at some stage during the collision event.

Senior Constable Adam Hall explains that many vehicles have an event data recorder (EDR) installed to record technical vehicle and occupant information for a brief period of time before, during and after a crash for the purpose of monitoring and assessing vehicle safety system performance. This data is often stored within the airbag control module (ACM). The ACM's primary function is to control the deployment of supplementary restraint devices fitted to the vehicle. This normally includes seatbelt pretensioners and front, side, knee, curtain and rollover airbags if fitted. The recording of data within the ACM is a secondary function.

Senior Constable Hall goes onto say:

"*The ACM contains accelerometers and a microcontroller and depending on the module it may measure acceleration both longitudinally through the vehicle and laterally across the vehicle. Combined with ancillary or satellite sensors the ACM senses a developing collision, decides if any devices need to be deployed and deploys devices as appropriate based on the programming of the microcontroller.*

ACM's may record both deployment and non-deployment crash events. A deployment event is generally one where an airbag or seatbelt pretensioner is deployed. Deployment events are locked and the data cannot be overwritten by subsequent events. Non-deployment events can be overwritten by subsequent events. Generally, most ACM's will record both pre-crash and crash data and will record pre-crash data up to five seconds which is transmitted to the ACM by various vehicle control modules via the vehicle's communication network. This data may include cruise control settings, vehicle speed, engine speed, accelerator pedal position, throttle percent, break switch status, gear position, steer angle and tyre pressure."

He says both vehicles involved in this collision had ACM's fitted and they were removed at the scene by Constable Gowen and himself and the data later downloaded.

In the case of Mr Tscherkaskyj's vehicle the report which was downloaded indicated the recording status was "complete" which means the data had been saved and was valid. On page 5 of the report the "time to deployment command" is listed and it indicates the time between recording the trigger establishment and the determination of the airbag or pretensioner deployment. In this case it shows the front driver and passenger airbags were recorded as deploying 7 milliseconds after recording the trigger establishment, and the front pretensioners deployed at the same time as the airbags.

From this information Senior Constable Hall concluded:

"*From a seatbelt pretensioner perspective this data indicates the seatbelt pretensioner deployed very early during the collision event and as the seatbelt was locked and tight against the B pillar during inspection at the scene, I can conclude the seatbelt was not worn by the deceased at the time of the collision*".

Finally, Dr Andrew Reid says in his affidavit sworn 5 June 2025 that he accepted the reported facts in the police report and forensic examination summary. He says the nature and degree of the chest injuries sustained by Mr Tscherkaskyj were caused by a combination of him not wearing a seatbelt,

possibly being thrust forward by forces from behind his seat and forces with the momentum in the opposite direction generated by the airbag deployment.

He says there were no typical seatbelt injuries. His opinion was supported by autopsy evidence of blunt force trauma consisting of abdominal wall bruises and abrasions that were not typical for a seatbelt injury to the driver of a right-hand drive vehicle. He says the blunt force trauma bruises and abrasions where on the left-hand side of the abdomen and costal margin (edge of the chest). He says typical seatbelt injuries were not seen on the right-hand side of the abdomen.

Conclusion

The only evidence which suggests Mr Tscherkaskyj was wearing his seatbelt is that of Mr Larner as set out in his statutory declaration declared on 26 August 2024. The evidence in his subsequent statement puts that position very much in doubt.

The evidence of Constable Gowen, Constable Walker, Dr Reid and the CCTV footage referred to in paragraphs 79 to 86 of my initial findings is contrary to the evidence set out in Mr Larner's statutory declaration. That contrary evidence has now been confirmed by Mr Shoobridge, Senior Constable Adam Hall and Dr Reid. I am therefore satisfied to the requisite standard that Mr Tscherkaskyj was not wearing his seatbelt at the time of this motor vehicle accident. Accordingly, pursuant to s. 58(5) of the Act, I affirm my findings with respect to the seatbelt issue.

Comments and recommendations

The affirming of my finding with respect to whether or not Mr Tscherkaskyj was wearing his seatbelt makes no difference to the findings I previously made and which I am required to make in accordance with s. 28(1) of the Act. Those findings are set out in my initial decision which is reported at [2024] TASCD 14. No further comments or recommendations are therefore necessary.

I extend my appreciation to Sergeant Orr of the Coroner's Officer for marshalling the additional evidence which I required to complete this investigation.

I also thank Ms Fox of the Office of the Director of Public Prosecutions for assisting me at short notice once the solicitors for the MAIB indicated they were instructed not to appear.

I also thank the witnesses who provided further affidavits who are referred to above.

In concluding, I convey, once again, my sincere condolences to the family and loved ones of Mr Tscherkaskyj.

Dated 7 July 2025 at Hobart in the State of Tasmania.

Magistrate Robert Webster
Coroner

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

LIST OF EXHIBITS

Record of investigation into the death of John Charles TSCHERKASKYJ
As at 07.07.2025

	TYPE OF EXHIBIT	NAME OF WITNESS
C1	REPORT OF DEATH	Petra SCHNIERER (since resigned)
C2	MORTUARY AMBULANCE ID	Anthony CORDWELL
C3	AFFIDAVIT OF IDENTIFICATION	Cst Alisha BARNES
C4	AFFIDAVIT LIFE EXTINCT	Dr Zachary ROBINSON
C5	TOXICOLOGIST	Neil McLACHLAN-TROUP
C6	PATHOLOGIST	Dr. Andrew Scott REID
C6A	AFFIDAVIT – SWORN 5 JUNE 2025	Dr. Andrew Scott REID
C7	MEDICAL RECORDS – TSCHERKASKYJ (Disc)	Healthology Medical & THS
C8	PATIENT CARE REPORT (TSCHERKASKYJ)	Ambulance Tasmania
C9	PATIENT CARE REPORT (McCAULEY)	Ambulance Tasmania
C10	PATIENT CARE REPORT (WRIGLEY)	Ambulance Tasmania
C11	AFFIDAVIT & SCREEN SHOT OF PHONE ALERT	Kellie-Ann JAY (SNOK)
C12	AFFIDAVIT	Patrick Bruce LONERGAN
C13	STATUTORY DECLARATION & 000 Recordings	Emily Maree WRIGLEY
C14	STATUTORY DECLARATION	Lachlan James HALL
C14A	AFFIDAVIT – SWORN 21 MAY 2025	Lachlan James HALL
C15	STATUTORY DECLARATION	Haylee Maree MADDEN
C16	AFFIDAVIT & BWC (DISC)	Cst James HATTON
C17	AFFIDAVIT & BWC (DISC)	Cst Ellie DAVIDSON
C18	AFFIDAVIT & POLICE PHOTOGRAPHS	Cst Dean WALKER
C19	AFFIDAVIT - CIS	Cst Jared GOWEN
C20	AFFIDAVIT & DRONE FOOTAGE (DISC)	Sgt Adam ARCHER
C21	AFFIDAVIT (VEHICLE INSPECTION)	Transport Inspector Paul WELLS
C22	AFFIDAVIT & PAPER RUN ROUTE	William PERRY

LIST OF EXHIBITS

Record of investigation into the death of John Charles TSCHERKASKYJ

C23	STATUTORY DECLARATION (SURVEILLANCE) & CCTV – BUSHY PARK ROAD HOUSE (DISC)	Phillip CURRY
C24	SCENE NOTES	Csts Jared GOWEN / Adam HALL
C25	RECONSTRUCTION DRIVETHROUGHS (DISC)	Csts Jared GOWEN / Adam HALL
C26	COLLISION ANALYSIS REPORT	Cst Jared GOWEN
C27	SCENE SURVEY	Cst Jared GOWEN
C28	BLOOD ANALYSIS RESULTS - McCAULEY	FSST / Tasmania Police
C29	DRIVER LICENCE HISTORY (TSCHERKASKYJ)	Department of State Growth
C30	REGISTRATION HISTORY (J19EE)	Department of State Growth
C31	DRIVER LICENCE HISTORY (McCAULEY)	Department of State Growth
C32	REGISTRATION HISTORY (E50ZI)	Department of State Growth
C33	TRAFFIC CRASH REPORT (21005105)	Tasmania Police
C34	ESCAD (000038-08082021)	Tasmania Police
C35	CRASH HISTORY (GORDON RIVER ROAD)	Department of State Growth
C36	WEATHER OBSERVATIONS (BUSHY PARK)	BOM
C37	CALL CHARGE RECORD & MOBILE PHONE DOWNLOAD – McCAULEY (DISC)	Cst Oliver MUNDY-CASTLE
C38	WORKSAFE FILE (1) INVESTIGATION REPORT (2) INSTRUMENT OF APPOINTMENT (3) S155 NOTICE TO B TRANZ PTY LTD (4) B TRANZ RESPONSE TO S155 (5) EMPLOYMENT RECORDS- MR JOHN TSCHERKASKYJ (6) DELIVERY DRIVER JOB DESCRIPTION (7) B TRANZ FATIGUE MANAGEMENT POLICY (8) B TRANX ALCOHOL AND DRUGS POLICY (9) B TRANZ REMOTE AND ISOLATED WORK PROCEDURES (10) B TRANZ VEHICLE USE CHECKLIST (11) B TRANZ SAFE WORK METHOD (12) COMPETENCY DECLARATION FOR MR JOHN TSCHERKASKYJ	

LIST OF EXHIBITS

Record of investigation into the death of John Charles TSCHERKASKYJ

	(13) DRIVERS LICENCE (14) MR JOHN TSCHERKASKYJ TIME SHEETS (15) B TRANZ INVESTIGATION (16) B TRANZ WHS STANDARDS (17) B TRANZ HAZARD NOTIFICATION FORM (18) B TRANZ INDUCTION PRESENTATION (19) B TRANZ RISK MANAGEMENT POLICY (20) B TRANZ WHS POLICY (21) B TRANZ RISK MANAGEMENT REGISTER (22) B TRANZ WHS MANAGEMENT AND PROCESS MANUAL (23) DYNAMIC COMPANY REPORT	
C39	FACTS, SENTENCING	DPP
C40	DRAWN DIAGRAM FROM WHITE BOARD DURING QUESTIONING	CONSTABLE JARED GOWEN
C41	STATUTORY DECLARATION – DECLARED 26 AUGUST 2024	Edward LARNER
C41A	STATEMENT – DATED 12 JANUARY 2025	Edward LARNER
C42	AFFIDAVIT – SWORN 4 JUNE 2025	Robert Frederick Douglas SHOOBRIDGE
C43	AFFIDAVIT – SWORN 13 JUNE 2025	Snr Cst Adam HALL
C44	AFFIDAVIT – SWORN 4 JUNE 2025	Nathan RANSLEY