



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Leigh Mackey, Coroner, having investigated the death of Graham John McKay

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

- a) The identity of the deceased is Graham John McKay (date of birth 19 April 1941).
- b) Mr McKay was 82 years old at the time of his death. He lived in Clarendon Vale with his wife of nearly 50 years, Maureen McKay. Together they had three children, Jason, Deborah and Tracey. Mr McKay enjoyed fishing and shooting and worked as a removalist, security guard and cleaner.

Mr McKay had a significant medical history, including longstanding “childhood arthritis” primarily affecting his hip, which contributed to him retiring in 1987. He had hypercholesterolaemia, atrial fibrillation, hypertension, chronic obstructive pulmonary disease (COPD), congestive cardiac failure, and chronic kidney disease. His mobility was significantly reduced, and he required the use of a walker to mobilise when outside the home.

Mr McKay received medical management of his health conditions, including cardiovascular, respiratory and supportive therapies and pharmacotherapy. In the months prior to the collision, Mr McKay’s health became further compromised from sepsis due to methicillin-resistant *Staphylococcus aureus* (MRSA), iron deficiency anaemia, acute renal impairment, deep venous thrombosis and aspiration pneumonia. He received treatment including intravenous antibiotics but experienced complications including acute kidney injury associated with vancomycin therapy.

On 15 July 2023, Mr McKay was travelling as a front seat passenger in a Ford Territory SUV driven by his wife, Maureen south along Flagstaff Gully Link Road heading toward the Mornington Roundabout. At the same time

Rodney Horne, was driving his Jeep Cherokee station wagon north along Flagstaff Gully Link Road intending to turn right, across the north bound lane to enter the access ramp to the east bound lanes of the Tasman Highway. To do so he was required to give way to any vehicles using that lane. Mr Horne turned right and entered the southbound lane and in doing so failed to give way to the Ford Territory

It is estimated that the collision occurred at 10.48am, based on the timing of the first call to emergency services regarding the accident being received at 10.50am.

At the time of the collision, Maureen was travelling lawfully within her lane and within the designated speed limit for the roadway of 60 km/h. Mr Horne was travelling at a low speed while undertaking the turn. There was no evidence of braking prior to impact, suggesting Maureen had insufficient time to react to the incursion of the Jeep onto her lane of travel.

The section of Flagstaff Gully Link Road where the collision occurred was in good condition, of bitumen construction, two lanes wide, one headed north and the other south. The lanes were separated by double white lines broken at the entrance of the access ramp to enable north bound vehicles to enter and access the ramp leading to the east bound lanes on Tasman Highway.

Mr Horne states he did not see the Ford Territory before executing his turn and entering the southbound lane. No environmental, mechanical or personal factors have been revealed by the evidence that explained Mr Horne's failure to see the oncoming vehicle. Both drivers submitted to testing after the accident. Neither alcohol nor drugs were detected. Interrogation of Mr Horne's mobile phone records show an incoming call with a duration of nil seconds was received at 10:48:28 on 15 July 2023. The evidence does not permit a finding as to whether Mr Horne was aware of the incoming call, reacted to it or was distracted by it or indeed if the call was incoming prior to, at the time of or, after the collision occurred.

Mr McKay, Maureen and Mr Horne were wearing seatbelts. Air bags were triggered in the Ford Territory from the momentum of the collision. The damage to both vehicles and their final resting positions indicated an offset head on collision with the Jeep turning slightly to the east toward the

access ramp.¹ There was no significant intrusion into the passenger compartment of either vehicle. Mr Horne was uninjured, and Maureen sustained minor injuries not requiring hospital admission.

Mr McKay was extricated from the vehicle and transported by ambulance to the Royal Hobart Hospital (RHH). He was assessed as having a neck of femur, rib and sternum fractures. On admission his respiratory function worsened, he aspirated and developed pneumonia. Mr McKay required intubation and mechanical ventilation and was monitored in the Intensive Care Unit of the RHH. Surgical repair of the femur fracture was anticipated but not proceeded with due to his condition. Despite intensive medical management, Mr McKay continued to decline and following discussion between treating clinicians and family members, active treatment was withdrawn and care directed toward his comfort commenced. He died on 20 July 2023. The decision to withdraw active treatment measures was reasonable in the circumstances.

- c) Mr McKay's cause of death was respiratory failure.
- d) Mr McKay died on 20 July 2023 at Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr McKay's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Tasmanian Government Death Report to Coroner;
- Affidavit as to identity;
- Opinions of the forensic pathologist;
- Toxicology report;
- Affidavit of Maureen McKay, sworn on 24 August 2023;
- Police Investigation and corresponding affidavits;
- Healthology Medical Centre, Tasmanian Health Service and Ambulance Tasmania Records;
- Phone records; and
- Crash investigation reports.

¹ Southern District Crash Investigation Services report 15 July 2023 p6.

Comments and Recommendations

The cause of the collision was Mr Horne's lapse of concentration resulting in a failure to observe the approaching southbound Ford Territory. Whilst he had, mere moments before the collision, demonstrated an understanding of the need to give way to southbound traffic on Flagstaff Gully Link Road before attempting to turn onto the access ramp, he failed to give way to the Ford Territory driven by Maureen and occupied by Mr McKay.

The evidence produced by this investigation into Mr McKay's death have not identified any reason for this lapse. Mr Horne's driving record is lengthy and reflects him to be a usually safe and reliable driver. There is no suggestion on the evidence of any matters that impeded his view of the Ford Territory as it approached the point of collision and he was unaffected by alcohol or drugs.

Mr Horne pleaded guilty to charges of causing the death of another person by negligent driving and was sentenced to three months imprisonment wholly suspended on condition that he not commit another offence punishable by imprisonment for the next two years, fined \$98.50 and his licence disqualified for 15 months.

There was nothing in the manner in which Maureen was driving that caused or contributed to the accident. This accident serves as a reminder of how mere momentary inattention whilst driving on our road network can result in devastation and loss of life.

I extend my appreciation to investigating officer Douglas McKinlay for his investigation and report.

The circumstances of Mr McKay'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 Mr McKay.

Dated: 26 June 2026 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner