IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 002344

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Frank Cecil Baker
Date of birth:	20 November 1945
Date of death:	3 May 2023
Cause of death:	1(a) Injuries sustained in a motor vehicle collision (driver)
Place of death:	Bellarine Highway, Wallington, Victoria
Key words:	Bellarine Highway, motor vehicle collision, loss of control, poor road condition, poor road surface, wet weather

INTRODUCTION

1. On 3 May 2023, Frank Cecil Baker was 77 years old when he sustained fatal injuries in a motor vehicle collision. At the time, Mr Baker lived in Belmont.

2. Mr Baker's medical history reportedly included hypercholesterolaemia, prostatic adenocarcinoma, smoking, hypertension, osteoporosis, rheumatoid arthritis, and chronic obstructive pulmonary disease.

3. He held a full and current Victorian driver's licence at the time of the incident and worked as a handyman.

THE CORONIAL INVESTIGATION

4. Mr Baker's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Baker's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into Mr Baker's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

9. On 15 March 2023, Coroner Sarah Gebert made a formal determination identifying the deceased as Frank Cecil Baker, born 20 November 1945, based on expert
10. evidence of DNA comparison analysis.

11. Identity is not in dispute and requires no further investigation.

Medical cause of death

12. Forensic Pathologist, Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 5 May 2023 and provided a written report of her findings dated 2 June 2023.

13. The post-mortem examination revealed multiple significant injuries.

14. Routine toxicological analysis of post-mortem samples did not detect any alcohol or any commonly encountered drugs or poisons.

15. Dr Francis provided an opinion that the medical cause of death was *"1(a) Injuries sustained in a motor vehicle collision (driver)"*.

16. I accept Dr Francis's opinion.

Circumstances in which the death occurred

17. At about 10.20am on the morning of 3 May 2023, Mr Baker drove his 2013 Toyota Hiace van (**the van**) east along Bellarine Highway in Wallington. It was a rainy and windy morning, and the roads were wet.

18. At about this time, a 2010 Mitsubishi Freighter MR Truck (**the truck**) travelled west along the Bellarine Highway. The sole occupant of the truck was the driver (**the truck driver**) who

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

held a current full Victorian driver's licence (car and heavy rigid). At the time of the incident, he was working for a transport company. The truck was fitted with a dashboard camera that was recording at the time of the incident and captured movements of the truck prior to and following the subsequent collision.

19. Bellarine Highway in Wallington was a two-way, four lane, divided road with provision for two lanes of traffic in each direction. The road ran generally west to east. The opposing carriageways were divided by a wide grassed median and the adjacent lanes were divided by single broken white lines. The westbound carriageway was bordered by white painted fog lines. The northern fog line was on the edge of the bitumen and there was a narrow bitumen shoulder to the south. The westbound carriage way was essentially straight with a slight uphill gradient. The posted speed limit of the west bound carriageway was 80 kilometres per hour (**km/h**) and was sign posted to change to 100 km/h shortly after the collision scene.

20. According to Detective Senior Constable Melanie Macfarlane, Coronial Investigator, the westbound carriageway was in poor condition at the time due to a 'flushed' surface. She explained that a flushed surface appears 'glossy' or 'shiny' with a reduced surface texture that can lead to reduced wet weather skid resistance.

21. The eastbound carriageway had a similar layout to the westbound carriageway, with a white painted fog line on the edge of bitumen abutting the grass centre median (south side) and a narrow bitumen shoulder to the north. A solid 'W' barrier was present on the northern side of the road. A wire rope barrier on the southern side of the road, abutting the centre median, stopped a short distance from the collision scene. The posted speed limit of the east bound carriageway at the collision scene was 80km/h.

22. In the lead up to the collision, the truck was travelling in the left lane at approximately 75km/h through a green light at the intersection of Wallington-Ocean Grove Road. The truck changed lanes after the intersection and accelerated up the hill to approximately 85km/h.

23. As the truck was travelling at approximately 87km/h, it lost control and began travelling across the centre median, colliding with a number of trees and Mr Baker's van at approximately 77km/h.

24. Mr Baker's van was struck as it travelled in the left lane of the eastbound carriageway, with the truck impacting the front driver side quarter panel by the truck. The van was push into the 'W' barrier on the northern side of the road. The truck rotated and came to a stop a short distance from impact. Both vehicles sustained significant damage in the collision.

25. Other road users stopped to assist and contacted emergency services.

26. The truck driver did not sustain any injuries in the collision. Sadly, Mr Baker sustained fatal injuries and passed away at the scene.

27. When Victoria Police members arrived at the scene, the truck driver stated he had lost traction while driving up the hill and despite taking his foot off the accelerator, the truck continued to rotate and slide.

28. The truck driver subsequently returned negative results for alcohol and illicit drugs. There was no evidence that the truck driver had been using any of his mobile phone's functionality at the time of the collision. According to the coronial investigator, the truck driver has not been charged with any offences relating to the collision.

Victoria Police investigation

29. Senior Constable Daniel Pearce, Mechanical Investigator with the Victoria Police Collision Reconstruction and Mechanical Investigation Unit, inspected the truck and did not find any faults, failures, or conditions with the vehicle which would have caused or contributed to the collision.

30. Detective Sergeant Jenelle Hardiman examined the collision scene. In her analysis, she described the westbound lanes in the area as being in *"poor condition with low levels of exposed aggregate"*. The right of the two westbound lanes was in even poorer condition with the wheel paths being described as *"slippery"* to walk on.

31. Detective Sergeant Hardiman conducted a series of skid tests to assess the skid resistance of the west bound carriageway. As a result of these tests, she concluded that the friction results were *"well below what would typically be expected for a major highway".*

32. She concluded that the truck was likely travelling between 80 and 90 km/h when it lost control. At impact, the truck was travelling at about 40 km/h. She was unable to determine the speed of the van at impact but there was no evidence that it was travelling above the speed limit.

33. Detective Sergeant Hardiman was unable to determine why the truck appeared to lose control on a straight section of road but could not exclude the possibility that condition of the road contributed to the initial loss of control. She noted that poor road conditions are more likely to affect vehicle stability in wet conditions and at higher travelling speeds.

Similar incidents in the same area

34. Detective Senior Constable Macfarlane noted her enquiries revealed that there had been multiple collisions in the vicinity since 2016 due to 'loss of control' due to road or environmental collisions or inconclusive causation.

35. One of these included a collision that occurred on the morning of 18 March 2022 in very similar circumstances as the collision which led to Mr Baker's death. That collision involved an unladen 2018 Hino truck travelling west on the Bellarine Highway in the righthand lane when it lost control on a wet road, crossed the grassed median, and collided head on with an oncoming vehicle. On that occasion, the driver of the oncoming vehicle survived but sustained a serious injury.

36. Detective Sergeant Hardiman also referred to this incident in her report, noting that the loss of control essentially occurred at the same location. Both vehicles had rotated clockwise and travelled essentially the same path, crossing the median before impacting another vehicle in the eastbound lanes.

Investigation regarding road surface

37. Detective Senior Constable Macfarlane contacted to Mark Tonkin, Manager of Movement and Safety at the Department of Transport and Planning (**the Department**), about the section of the road where the incident occurred. She stated that during their correspondence, it was identified that the Department of Transport's records were unclear about when that section of road had been resurfaced. Although, in appeared initially that the westbound carriageway was resurfaced in 2020, closer inspection of the relevant records indicated that this occurred in 2010.

38. Mr Tonkin provided a copy of the Road Asset System (**RAS**) report dated 8 May 2023 which noted, *"Surface conditions are rated as poor, due to the degree of flushing observed".*

39. Mr Tonkin subsequently provided a statement which revealed:

    (a) safety barriers had been installed in the 100 km/h section of Bellarine Highway in 2019;

    (b) the pavement condition report completed after Mr Baker's death rated the road surface as 'bad', but the site had not been registered in the Pavement in Poor condition database. The site has now been registered as a Pavement in Poor condition;

(c) following Mr Baker's death, 'slippery when wet' signage was installed in May 2023, including additional 80 km/h speed limit signage; and

(d) safety barriers were also installed at the location (along the median) in May 2023.

40. The road surface was unable to be repaired at the time due to the winter period. However, a resurfacing treatment was scoped at the time. It was deemed a high priority for the Department's resurfacing program for the 2023 to 2024 financial year.

41. As a result of her enquiries and investigation, Detective Senior Constable Macfarlane concluded that the poor road condition and adverse weather conditions were contributing factors in Mr Baker's death. I accept and agree with her conclusion.

42. As part of my investigation, I obtained an update from the Department of Transport and Planning regarding the planned works for the relevant section of the road. Laura-Jo Mellan, Director Regional Operations – Planning, provided a statement dated 29 July 2024 which indicated the following:

(a) the relevant section of the roadway has not been party to any resurfacing program for many years; and

(b) the relevant section of the roadway is on a program for resurfacing, but Ms Mellan could not confirm an exact timing of this process.

FINDINGS AND CONCLUSION

43. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Frank Cecil Baker, born 20 November 1945;

(b) the death occurred on 3 May 2023 at Bellarine Highway, Wallington, Victoria;

(c) the cause of Mr Baker's death was injuries sustained in a motor vehicle collision (driver); and

(d) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. In the interest of public safety, to prevent further death and injuries, I recommend that the **Secretary Department of Transport and Planning** immediately prioritise the resurfacing of the westbound lanes of Bellarine Highway in Wallington (between Curlewis Road and Fenwick Street), Victoria.

2. If not already undertaken, the resurfacing of this section of the Bellarine Highway should be completed before the rains of winter 2025, to avoid another prolonged period of hazardous road conditions along this section of the road, in particular in the wet.

I convey my sincere condolences to Mr Baker's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Annie Peng, senior next of kin
Jeroen Weimar, Secretary Department of Transport and Planning
Detective Senior Constable Melanie Macfarlane, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 20 February 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.