



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 000868**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	Bruce David Manintveld
Date of birth:	12 December 1973
Date of death:	13 February 2024
Cause of death:	1a : UPPER CERVICAL SPINE INJURY
Place of death:	670 Boolarra-Mirboo North Road Darlimurla Victoria 3871
Keywords:	Natural disaster; Motor vehicle accident

## INTRODUCTION

1. On 13 February 2024, Bruce David Manintveld was 50 years old when he died in a motor vehicle accident. At the time of his death, Bruce lived with his wife of twenty years, Fiona Baker, on their farm at 670 Boolarra-Mirboo North Road, Darlimurla, Victoria, 3871.
2. Bruce and Fiona purchased the farm in 2013. Bruce worked it full time, with Fiona helping out part time.<sup>1</sup> Fiona described him as being “born to be a farmer”.<sup>2</sup>
3. A typical day on the farm began at approximately 4:45 AM milking the cows and whilst other chores were attended to during the day, the cows needed to be milked again late in the afternoon before the day's work was complete.<sup>3</sup>

## THE CORONIAL INVESTIGATION

4. Bruce’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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Bruce’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.

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<sup>1</sup> Statement of Fiona Baker, Coronial Brief.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

8. This finding draws on the totality of the coronial investigation into the death of Bruce David Manintveld 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.<sup>4</sup>
9. In considering the issues associated with this finding, I have been mindful of Bruce's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

### **Circumstances in which the death occurred**

10. On 13 February 2024, at about 4.45 pm, a severe storm heralded a change in the weather pattern in the South Gippsland area. Contemporaneous wind gusts at weather sites near Bruce's farm recorded gusts between 55 and 85km/h. This equates to 7-9 on the Beaufort Wind Scale, which signals the potential for structural damage and dislodged roofing risks.<sup>5</sup> Indeed, there are several photos on the brief of other proximate damage caused by the extreme wind that one could speculate were in excess of those officially recorded that day.<sup>6</sup> The extreme weather event and associated damage was widely reported in the media.<sup>7</sup>
11. Fiona had returned to the farm from her other external work early because of this extreme weather. At about 4.30pm, the couple saw the storm coming on the weather radar, and Bruce formed the view that if he started his end of day farm routine, bringing the cows in for their afternoon milking, immediately, he ought to be able to get the cows safely into the milking shed, and set off to do that riding his quadbike as usual.<sup>8</sup>
12. After the storm had passed, Fiona went out to give Bruce a hand at the milking shed but was surprised that he was not there. She walked up the laneway looking for him and initially

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<sup>4</sup> 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.

<sup>5</sup> Attachment 1, Coronal Brief.

<sup>6</sup> Exhibit 1, Coronal Brief.

<sup>7</sup> Exhibit 2 & Attachment 2, Coronal Brief.

<sup>8</sup> Statement of Fiona Baker, Coronal Brief.

noticed some apparently dead cattle, and the farm quad bike stationary. She then noticed that Bruce had been thrown clear of the bike onto the ground, Fiona called 000 and followed the 000 call taker's instructions, commencing resuscitation until paramedics and police arrived in about 25 minutes later.<sup>9</sup>

13. WorkSafe senior investigator Gregory Rogers also attended the scene.<sup>10</sup>
14. A retractable roof was dislodged from the top of its shed by the extreme wind and blown about 150-200 metres away into an adjacent paddock. From retracing the path of the debris whilst looking at the pattern of visible injuries, it appears the roof was blown directly into his path, striking Bruce and also killing several nearby cows.<sup>11</sup>
15. The quadbike had no 'roll-cage' or similar protective feature, and Bruce was not wearing a helmet. WorkSafe Victoria completed an investigation and did not identify any *Occupational Health and Safety Act* breaches, so I will not duplicate their work.<sup>12</sup>

### **Identity of the deceased**

16. On 13 February 2024, Bruce David Manintveld, born 12 December 1973, was visually identified by his wife, Fiona Baker. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

17. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 14 February 2024 and provided a written report of his findings dated 19 February 2024.
18. The examination revealed evidence of substantial blunt force injuries to the head, neck and right side of the body.
19. Toxicological analysis of post-mortem samples identified the presence of a therapeutic dose of the anti-coagulant<sup>13</sup> medication Warfarin, consistent with the medical history. No alcohol or other common drugs or poisons were identified.

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<sup>9</sup> Ibid.

<sup>10</sup> Statement of Gergory Rodgers, Coronial Brief.

<sup>11</sup> Ibid.

<sup>12</sup> See Section 7 of the Act.

<sup>13</sup> Blood thinning.

20. Dr de Boer provided an opinion that the medical cause of death was 1(a) UPPER CERVICAL SPINE INJURY, and I accept that opinion.

## FINDINGS AND CONCLUSION

21. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.<sup>14</sup> Adverse findings or comments against individuals in their occupational capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.
22. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Bruce David Manintveld, born 12 December 1973;
  - b) the death occurred on 13 February 2024 at 670 Boolarra-Mirboo North Road, Darlimurla, Victoria, 3871, from 1(a) UPPER CERVICAL SPINE INJURY; and
  - c) the death occurred in the circumstances described above.
23. Having considered all of the circumstances, I am satisfied that Bruce's death was the unintended consequence of the deliberate decision to attempt to continue the proper management of his farm during an extreme weather event, and I make no adverse finding about his conduct.

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

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<sup>14</sup> *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'.

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

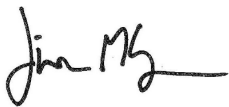
I direct that a copy of this finding be provided to the following:

Fiona Baker, Senior Next of Kin

Glen Rodgers, Worksafe

Senior Constable Varli Blake, Coronial Investigator

Signature:



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Coroner Simon McGregor

Date: 24 July 2025

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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.

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