



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 006881

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:	John Frank Stubbs
Date of birth:	23 November 1993
Date of death:	11 December 2023
Cause of death:	1(a) Multiple injuries sustained in a train impact (truck driver)
Place of death:	North Shore Road railway crossing, North Shore, Victoria
Key words:	Truck vs train, truck stuck on level crossing, gradient slope

INTRODUCTION

1. On 11 December 2023, John Frank Stubbs was 30 years old when he sustained fatal injuries after his truck became stuck at a railway level crossing. At the time, Mr Stubbs lived in Frankston South with his family.
2. Mr Stubbs had been in a relationship with Georgie Stokie-Leech since 2020. The couple had two young children together as well as Ms Stokie-Leech's daughter from a previous relationship. They resided with Mr Stubbs' mother and grandfather.
3. Mr Stubbs had been employed as a truck driver at Membreys Transport and Crane (**Membreys**), based in Dandenong South, since August 2022. He held a Heavy Combination Victorian driver's licence with no conditions and was described as very experienced with a wide range of trailers and combinations.
4. Ms Stokie-Leech described her partner as a hard worker who was very fastidious about his truck. He enjoyed working for Membreys as he was able to travel around Victoria and also interstate.

THE CORONIAL INVESTIGATION

5. Mr Stubbs' 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.
6. 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.
7. 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.
8. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Stubbs' 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.

9. This finding draws on the totality of the coronial investigation into Mr Stubbs' 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

10. On 19 December 2023, Coroner Paul Lawrie made a formal determination identifying the deceased as John Frank Stubbs, born 23 November 1993, based on dental record comparison.
11. Identity is not in dispute and requires no further investigation.

Medical cause of death

12. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine (VIFM), conducted an inspection on 13 December 2023 and provided a written report of his findings dated 19 December 2023.
13. The post-mortem examination was consistent with the reported circumstances.
14. Routine toxicological analysis of post-mortem samples detected paracetamol.
15. Dr Young provided an opinion that the medical cause of death was "*1(a) Multiple injuries sustained in a train impact (truck driver)*".
16. I accept Dr Young's opinion.

Circumstances in which the death occurred

17. On 10 December 2023, Mr Stubbs and Ms Stokie-Leech attended the Membreys Christmas party. Mr Stubbs had about six stubbies throughout the afternoon. They left the party at about

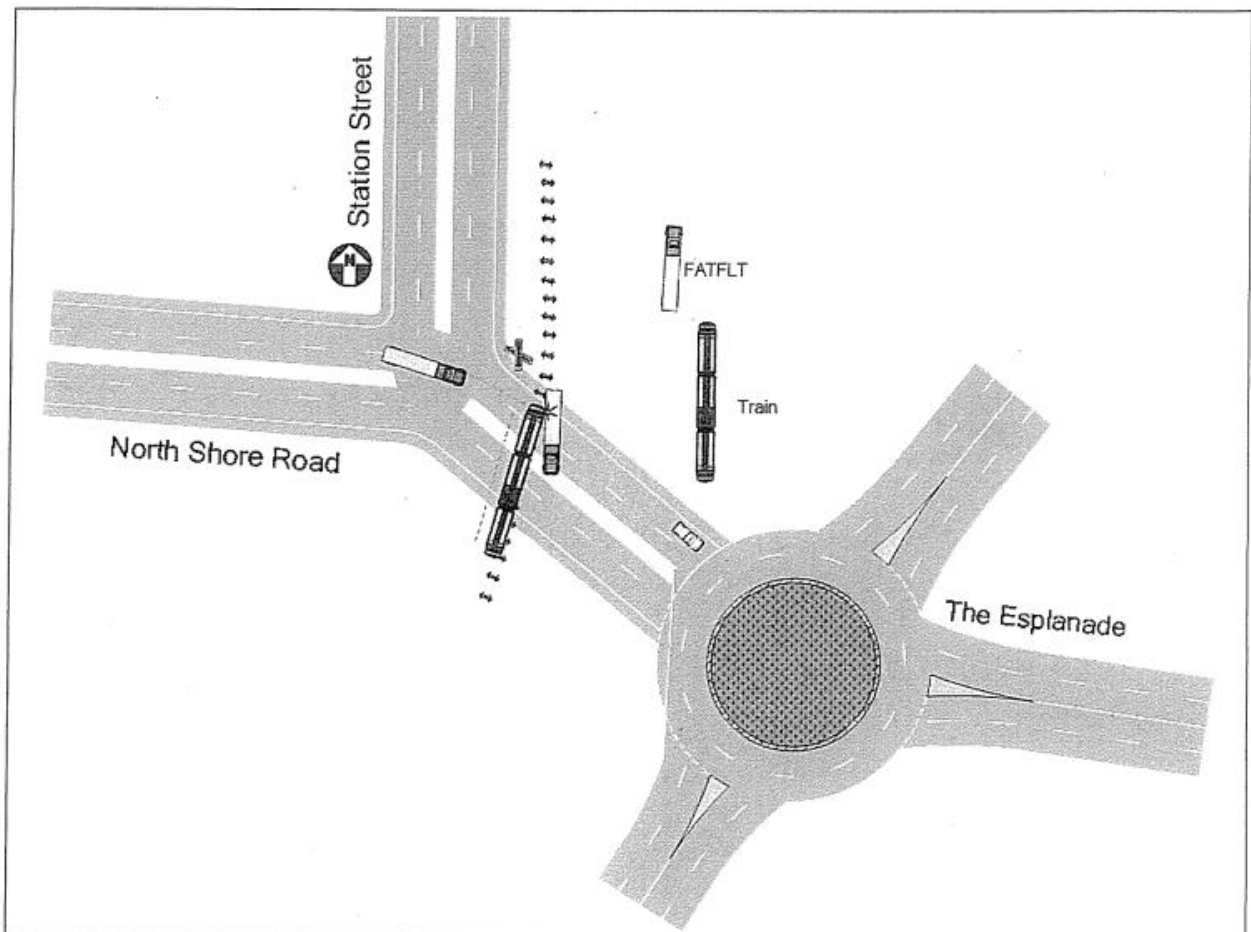
¹ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters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

4.30pm with Ms Stokie-Leech driving home. That evening, they retired to bed at about 8.30pm.

18. Mr Stubbs awoke about 5.00am the next morning, 11 December 2023 and left for work at about 6.00am.
19. At about 6.30am, Mr Stubbs arrived at Membreys. He was due to transport a re-entry hub bracing frame from Qube Energy in Lara to Corio.
20. Mr Stubbs arrived at Qube Energy at about 10.00am, and the frame was loaded onto the low loader trailer of the Membreys Kenworth prime mover (**the truck**). The maximum gross weight of the load was about 16,000 kilograms. Mr Stubbs adjusted the height of the trailer by adjusting the hydraulics.
21. At about 11.45am, Mr Stubbs left the Qube Energy yard led by his pilot driver, George Manolopoulos, who was also employed by Membreys. Daniel Dixon, an employee of Oceaneering Oil and Gas, was a passenger in the pilot vehicle. Aaron Thomas and Steve Drives, employees of Cooper Energy, followed behind the truck in another vehicle.
22. The vehicles travelled along their pre-determined route² along Heales Road before turning left onto Bacchus Marsh Road and onto the Princes Highway. They then turned left onto North Shore Road.
23. At approximately 12.05pm, a V/Line train (**the train**) departed South Geelong railway station and began to make its way to Southern Cross railway station.
24. At about 12.15pm, the pilot vehicle crossed the level crossing at North Shore Road and waited at the roundabout intersection of Sea Breeze Parade. As Mr Stubbs began to cross the tracks, the truck became stuck, and he radioed Mr Manolopoulos who subsequently exited the pilot vehicle and walked over to see if he could assist.
25. In his statement, Mr Manolopoulos stated, *“I could see that the trailer was bottomed out on the railway lines and I began to panic. I couldn’t see John but assumed that he was trying to raise the hydraulics in an effort to raise the trailer which would have allowed him to drive the truck and trailer from the tracks”*. Mr Dixon also exited the vehicle and stated Mr Stubbs *“began using the trailer controls to try and jack the trailer up”*.

² The route had been planned by Paul Kaye, external transport coordinator at Membreys.

26. Moments later, the level crossing lights began flashing, the sirens began sounding and the boom gates lowered.
27. At 12.12pm, the train departed North Geelong railway station toward Southern Cross railway station. It reached a maximum speed of about 87 kilometres per hour (**km/h**) before the driver then powered down to coast toward the 80 km/h speed curve. The driver blew the whistle at about 520 metres prior to the North Shore level crossing.
28. As the train came out of the 80 km/h speed curve, the driver saw two men waving their arms toward him. The driver immediately applied the emergency brakes (at a location about 222 metres from the subsequent point of impact) and left the cabin, running toward the rear of the carriage and away from the imminent impact zone.
29. As the train neared, Mr Stubbs attempted to enter the driver side cabin. The train subsequently struck the rear of the low rider trailer at a speed of about 32 km/h. The collision caused the truck and trailer to rotate clockwise causing Mr Stubbs to be thrown from the truck and under the train.
30. The train stopped about 25 metres from the point of impact, derailing to the left. Neither the driver, nor the passengers were injured. However, Mr Stubbs sustained fatal injuries and died at the scene. Ambulance Victoria paramedics formally verified his death at 12.15pm.
31. In accordance with routine practice, the train driver was tested for alcohol and illicit drugs and returned negative results for both.
32. According to Leading Senior Constable Robert Nuske, Coronial Investigator, the North Shore Road level crossing has a 7.5 percent gradient (about 200 millimetres) over a nine-metre width of road bitumen. He noted that the level crossing is part of the Regional Rail Revival Project. As at the date of the collision, improvements of the level crossing had been proposed in the near future. Leading Senior Constable Nuske also noted that there had been multiple incidents at the level crossing since 2017, which mainly involved vehicles, including heavy vehicles, colliding with the railway infrastructure.
33. He concluded his investigation but noting that Mr Stubbs had enough time to get out of the way of the oncoming train but unfortunately chose to re-enter the truck as the train approached, likely making a last-ditch effort to try to remove the truck from the tracks and avert a collision.



Picture 1: Depiction of the level crossing and adjacent intersections

FURTHER INVESTIGATION

34. Leading Senior Constable Nuske provided a list of 37 incidents³ occurring at the level crossing between November 2017 and March 2024. He also noted:

The level crossing at North Shore where the fatal collision occurred carries a huge volume of train commuters to and from Melbourne as well as freight line trains. The crossing also allows for direct passage of log trucks and semi-trailers to access the Ports and Spirit of Tasmania. ... there is a gradient slope across the crossing in excess of 200mm. Most vehicles and semi-trailers that cross the intersection would clear this gradient easily. Low loader semi-trailers would need to make the necessary adjustments. If you are unfamiliar with this crossing, then it would be too late to turn around due to the sheer size of you truck and trailer.

³ V/Line noted that there had been 52 incidents since 2017, which included incidents such as signalling issues, trespass (both on track and on the adjacent rail reserve), vehicle obstructions, and vandalism up until June 2025.

35. He therefore suggested I make the following recommendations:
- (a) placing signage on the side of the road leading up to the crossing to make drivers aware of the gradient ahead so they can make the necessary adjustments before entering the crossing. If the truck driver or the pilot vehicle driver were aware of the gradient upon approach and made the necessary adjustments prior to the crossing, this fatality could have been avoided;
 - (b) that the VicRoads website regarding truck routes used by trucking companies when planning their routes highlight this level crossing in 'YELLOW' with a drop-down box showing a photo of the gradient with the measurements and alternatives prior to the crossing;
 - (c) installation of a warning system to the train drivers approaching a blind corner that something is impeding the crossing allowing them sufficient time to slow down and avoiding a collision (however, V/Line stated this may not be possible as it would affect the train time timetable if trains had to slow down all the time); and
 - (d) low loader trucks be prohibited from using the level crossing during particular times (this would have to have consultation with V/Line).
36. He noted that due to the complexity of the crossing, a complete removal of the crossing is not an option nor is a 'fly over'.
37. As part of my investigation, I made enquiries with the Australian Rail Track Corporation (ARTC), V/Line, and the Department of Transport and Planning about maintenance, recent upgrades, and planned modifications of the level crossing.

Australian Rail Track Corporation

38. Peter Haskard, Manager Engineering, provided a statement dated 22 July 2025.
39. ARTC operates and maintains a level railway crossing at the 67.212 kilometre mark on North Shore Road, Norlane, at which Mr Stubbs was involved in a fatal incident on 11 December 2023. ARTC shares responsibility for the level crossing as follows:
- (a) ARTC responsible for the signalling discipline of the level crossing including associated infrastructure such as the booms, lights, bells, signage, function testing / switch operation;

- (b) ARTC is responsible for the civil infrastructure associated with the single standard gauge rail line through the level crossing; and
 - (c) V/Line is responsible for the civil infrastructure associated with the three broad gauge rail lines through the level crossing including broad gauge track circuitry for the level crossing which ARTC receives as an input into the componentry that activates the level crossing.
40. The level crossing is one of approximately 30 level crossings that ARTC and V/Line share responsibility for in a similar manner.
41. The level crossing is subject to the following regular maintenance schedule in accordance with the relevant Civil Technical Maintenance Plan:
- (a) a weekly active Level Crossing Test by a Track Examiner and Certifier, with a latitude of +/- 20 percent;
 - (b) a General Inspection conducted every 365 days by a Track Examiner and Certifier, with a latitude of +/- 10 percent; and
 - (c) a Detailed Inspections conducted every 3650 days by a Level Crossing Specialist or Engineer, with a latitude of +/- 10 percent/
42. And it is also subject to maintenance in accordance with the relevant Signalling Technical Maintenance Plan as follows:
- (a) general inspections (Level Crossing 01) conducted every 30 days by a Signal Technician with a latitude of +/- six days;
 - (b) detailed inspections (Level Crossing 02) conducted every six months by a Signal Technician with a latitude of +/- 27 days; and
 - (c) more comprehensive Level Crossing Engineer Inspection conducted every year by a Signal Engineer with a latitude of +/- 54 days.
43. If ARTC identifies an issue with a level crossing or other equipment during the course of routine maintenance, track inspections or some other method such as reporting from train drivers, the issue is recorded as a defect to be actioned.

44. There have been no upgrades to the level crossing since the fatal incident. However, VicRoads and the City of Greater Geelong closed one lane to force heavy vehicles to take a wider approach on the crossing. ARTC was not involved in this decision.

V/Line Corporation

45. Warwick Horsley, Acting Chief Executive Officer, provided a statement dated 25 July 2025.
46. Mr Horsley confirmed the level crossing infrastructure is shared between V/Line and the ARTC. V/Line is responsible for:
- (a) the maintenance of the broad-gauge tracks;
 - (b) the pedestrian crossing and the associated equipment, which intersect onto the Corio Independent Goods Line (east side and a V/Line managed freight line);
 - (c) the road and pedestrian pavement above the V/Line assets; and
 - (d) the track circuits that are on V/Line's tracks that integrate with the ARTC level crossing equipment.
47. Inspections are undertaken as follows:
- (a) signalling system, or track circuits, which integrate with the ARTC level crossing equipment, are inspected weekly;
 - (b) inspection of the rail head is required to be carried out every seven days to ensure the rail head is clear of contamination that may impair train detection and prevent the safe operation of the level crossing infrastructure;
 - (c) the pedestrian gates and equipment are inspected every eight weeks.
 - (d) general inspections of level crossings are carried out yearly; and
 - (e) the buried rail through the level crossing is inspected every five years (the overlaying bitumen is disturbed to inspect the rail and sleeper condition underneath).
48. A number of safety reviews regarding the level crossing have been undertaken since 2017. Mr Horsley indicated that V/Line conducted a review of track geometry and identified that this level crossing was not compliant with V/Line's then current standard for the vertical geometry of roadways over a level crossing. Following the Incident, V/Line commissioned an

internal track geometry assessment of over 1,000 public level crossings on active railway lines across regional Victoria, on the V/Line network. However, no further information was provided in terms of specific findings or proposed action, if any.

49. V/Line has not undertaken any works to change/improve or modify the level crossing since 2023.
50. Following the incident, the level crossing was updated on the National Heavy Vehicle Regulators Route Planner and Network Map to notify users that the level crossing was not suitable for vehicles over 20 metres due to the risk of short stacking.⁴
51. V/Line reported that improvements or alterations were made by VicRoads to the road approaching the level crossing prior to the incident.

Department of Transport and Planning

52. Nelson Dzadey, Director Network Safety, provided a statement dated 24 April 2025.
53. Mr Dzadey noted that the Department conducts surveys of level crossing through the Australian Level Crossing Assessment Model (ALCAM).⁵ The most recent ALCAM survey for North Shore Road was completed in May 2022. Based on this survey, the crossing is currently ranked #17 out of 1,642 public road level crossings in Victoria (where #1 is the highest risk rank). However, he noted:

It is important to note that ALCAM is an assessment tool used to identify key potential risks at level crossings and to assist in the prioritisation of crossings for upgrades. The tool should not be applied in isolation and does not preclude the need for sound engineering judgement and consultation with all stakeholders associated with a particular level crossing to determine any recommended treatments.

54. The Victorian Rail Crossing Safety Steering Committee (VRCSSC) also funded a human factors study of the crossing to understand human behaviour at the crossing, identify potential

⁴ Short stacking is the term used when the distance between the closest rail of the level crossing and a downstream intersection is not long enough to accommodate a vehicle stopped at the intersection without the rear of the vehicle overhanging on the tracks.

⁵ Mr Horsley also referred to this report and noted, “A range of ALCAM safety observations have been raised and recorded in the ALCAM online portal and assigned to the ARTC as the primary Rail Infrastructure Manager and to the road manager and the Greater Geelong City Council for this level crossing”.

influencing factors, and provide recommendations to inform future safety improvement strategies.⁶

55. The human factors study was completed in August 2024. The key issues identified included vehicles proceeding through flashing lights, vehicles queuing on the crossing while the crossing was not active, pedestrians using the road to traverse the crossing, and other non-compliant behaviours associated with road users turning right from North Shore Road onto the crossing. None related to the gradient slope. The recommendations from the assessment included changes to the infrastructure design (grade separation, closing or modifying the intersection), education in the community of the risks associated with the crossing, and consideration of automated cameras for enforcement of non-compliant behaviour.
56. Mr Dzadey also noted that mid-2023, upgrades were completed to the roundabout on the eastern side of the level crossing, including resurfacing and line-marking.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

57. It is evident from the materials that the railway tracks and relevant infrastructure undergo regular inspection and maintenance.
58. In addition, a number of incidents have occurred at the North Shore Road level crossing – generally related to damage to or faults with infrastructure. A human factors study also revealed road users had a poor understanding of the intersection and there were multiple incidents of road users failing to comply with the safety features of the level crossing.
59. Since Mr Stubbs' death, there have been no upgrades to the level crossing despite it being ranked 17 out of all public road level crossings in Victoria.
60. However, other improvements have been implemented, such as closing one lane to force heavy vehicles to take a wider approach on the crossing.
61. It is unclear whether the maintenance, inspections, assessments, or lane closure would have prevented Mr Stubbs' death. The cause of his truck becoming stuck on the level crossing was not due to a fault or lack of maintenance of the track, nor was it due to his careless driving or failure to respect road rules or safety features of the level crossing. It appears that the incident

⁶ Mr Horsley additionally referred to this assessment and provided a copy of the report, dated August 2024.

was due to Mr Stubbs being unaware of the gradient slope of the level and how it would impact his journey.

62. Leading Senior Constable Nuske made thoughtful submissions about improvements that could be made to prevent similar incidents. One appears to have been implemented already – the National Heavy Vehicle Regulators Route Planner and Network Map now notifies users that the level crossing is not suitable for vehicles over 20 metres. However, this warning is due to the risk of short stacking rather than in reference to the gradient.
63. Installation of a warning system for train drivers and prohibiting trucks from using the rail crossing during certain times would require significant planning and stakeholder consultation and are unlikely to be implemented in the near future, if at all.
64. However, Leading Senior Constable Nuske’s suggestion that additional signage along the road leading up to the level crossing to alert drivers to the gradient ahead appears achievable in the short term and would not require significant redesign of the current infrastructure nor extensive stakeholder consultation. Adequate warning would allow truck drivers to pull over to adjust their hydraulics or seek an alternative route. This would appear to be a relatively simple strategy to help prevent similar incidents resulting in deaths or significant injury.

FINDINGS AND CONCLUSION

65. Pursuant to section 67(1) of the Act I make the following findings:
 - (a) the identity of the deceased was John Frank Stubbs, born 23 November 1993;
 - (b) the death occurred on 11 December 2023 at North Shore Road railway crossing, North Shore, Victoria;
 - (c) the cause of Mr Stubbs’ death was multiple injuries sustained in a train impact (truck driver); and
 - (d) the death occurred in the circumstances described above.
66. I wish to convey my sincere condolences to the family of Mr Stubbs for their loss.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation on a matter connected with the death of Mr Stubbs:

1. That as a matter of urgency, the City of Greater Geelong and/or the Department of Transport and Planning collaboratively plan for and install additional road signage on all approaches to the North Shore Road level crossing forewarning drivers of the problematic gradient ahead and allowing them to adjust their hydraulics or seek an alternative route.

PUBLICATION

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.

DISTRIBUTION

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

Georgina Stokie-Leech, senior next of kin

Raelene Stubbs

Ali Wastie, Chief Executive Officer, City of Greater Geelong

Jeroen Weimar, Secretary, Department of Transport and Planning

Leading Senior Constable Robert Nuske, Victoria Police, Coronial Investigator

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 17 October 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.
