IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005003

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

*Amended on 5 December 2025 pursuant to section 76 of the **Coroners Act 2008***[1]

Findings of:	Coroner Simon McGregor
Deceased:	Jennifer Lee Hombsch
Date of birth:	8 July 1956
Date of death:	24 August 2024
Cause of death:	1a : MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (PEDESTRIAN)
Place of death:	Intersection of the Peninsula Link and Frankston-Flinders Road, Baxter, Victoria, 3911
Keywords:	Motor Vehicle Incident; Pedestrian; Mornington Peninsula Highway; VicRoads

[1] Paragraph 15 of the finding was amended to amend a typographical error.

INTRODUCTION

1. On 24 August 2024, Jennifer Lee Hombsch was 68 years old when she died in a motor vehicle accident. At the time of her death, Jennifer lived at 646 Frankston-Flinders Road, Baxter, Victoria, 3911 with her husband, Stephen (Steve) Hombsch.

2. Jennifer was known to walk her dog regularly across the intersection of Frankston-Flinders Road. Jennifer walked with the assistance of an elbow crutch as she had a past history of congenital dislocated left hip causing mobility issues.

THE CORONIAL INVESTIGATION

3. Jennifer'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.

4. 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.

5. 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.

6. Victoria Police assigned Leading Senior Constable Suzanne Howes to be the Coronial Investigator for the investigation of Jennifer'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.

7. This finding draws on the totality of the coronial investigation into the death of Jennifer Lee Hombsch 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.[2]

8. In considering the issues associated with this finding, I have been mindful of Jennifer'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

9. On 24 August 2024, Ms Sofia Manolios, was driving her Audi car home from the Southland Shopping Centre in Cheltenham. At around 2:50 pm, Ms Manolios was observed by witnesses to be driving along the off-ramp from the Mornington-Peninsula Link Highway (M11) towards the intersection with Frankston-Flinders Road.[3]

10. Ms Manolios was observed to be in the left lane close to the marked pedestrian crossing attempting to turn left onto Frankston-Flinders Road.[4] At the same time, Jennifer was walking her dog and crossing over the marked pedestrian crossing and was impacted by Ms Manolios's vehicle as the vehicle was turning left. Witnesses noted that Ms Manolios vehicle appeared to be stationary when Jennifer started crossing the marked pedestrian crossing.[5]

11. Ms Manolios stopped the vehicle when she realised that she had hit a pedestrian who was now trapped under the front driver's side of the car.[6] Several witnesses attempted to assist Jennifer before paramedics arrived at the scene.[7]

12. Ambulance paramedics arrived around 3:12 pm but despite their best efforts, they were unable to resuscitate Jennifer. Jennifer was pronounced deceased at the scene.[8]

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[2] 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.
[3] *Coronial Brief*, Statements of Morgan McCall and Hayley Eastland.
[4] Ibid.
[5] *Coronial Brief*, Statement of Hayley Eastland
[6] *Coronial Brief*, Exhibit 6 – Transcript Record of interview – Sofia Manolios.
[7] *Coronial Brief*, Statement of Gina Morris.
[8] *Coronial Brief*, Statement of Constable Corey Brander.

13. Police arrived on scene at the same time as Ambulance paramedics and started processing the scene. A Victoria Police collision reconstruction specialist reviewed the available evidence and noted that:[9]

    a) Ms Manolios was licensed, and her Audi vehicle was registered at the time of the fatal collision.

    b) The Audi vehicle owned and operated by Ms Manolios was examined and did not reveal any faults, failures or conditions that could have caused or contributed to the collision.

    c) Ms Manolios's mobile phone was seized but was not found to have been in use at the relevant time of the fatal collision.

    d) Ms Manolios was drug and alcohol tested and both tests were negative.

    e) The road conditions at the time of the fatal incident were dry, weather was fine and visibility was good.

14. Ms Manolios was charged with careless driving and failure to give way to a pedestrian at a pedestrian crossing. Ms Manolios was found guilty and convicted of careless driving, she received a $2000 fine and her drivers license was suspended for six months.

Identity of the deceased

15. On 24 August 2024, Jennifer Lee Hombsch, born 8 July 1956, was visually identified by her son, Daniel Hombsch.[10]

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

Medical cause of death

17. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 3 September 2024 and provided a written report of his findings dated 10 September 2024.

18. The post-mortem examination revealed evidence of significant injuries to the abdomen and chest. In the abdomen, the liver was ruptured and associated with 1 litre of bleeding into the

[9] *Coronial Brief,* Statement of Detective Sergeant Jenelle Hardiman.
[10] Amended on 5 December 2025 pursuant to section 76 of the *Coroners Act 2008* to amend a typographical error.

abdominal cavity. In the chest, there were there were multiple right-sided posterior rib fractures, and multiple bilateral anterolateral rib fractures, associated with haemo pneumothoraces. Whilst some of the anterolateral rib fractures may have been due to cardiopulmonary resuscitation (**CPR**), the posterior rib fractures are much more likely to be due to the motor vehicle incident.

19. Dr Young noted that there were also other injures attributable to the motor vehicle incident including subarachnoid haemorrhage on the left side of the brain, and fracture of the left scapula.

20. Toxicological analysis of post-mortem samples identified the presence of ketamine and ondansetron (~0.04 mg/L). These substances were likely administered during resuscitation attempts by paramedics.

21. Dr Young provided an opinion that the medical cause of death was 1(a) Multiple injuries sustained in a motor vehicle incident (Pedestrian) and I accept his opinion.

FAMILY CONCERNS

22. In their email to the Court dated 21 July 2025, Jennifer's husband, Steve Hombsch, expressed significant concern about the following:

    a) The whole length of Frankston-Flinders Road and the roundabout along Baxter-Tooradin Road and Baxter Sages Road needs a reduction in speed limit from 80km/h to 50 km/h to reduce risk to pedestrians;

    b) The adequacy of signage in the surrounding area of the intersection of Frankston-Flinders Road and the Mornington Peninsula Link (M11) highway; and

    c) The need for additional pedestrian crossing lights and painted pedestrian crossings in the adjacent and nearby junctions to the intersection of Frankston-Flinders Road and the Mornington Peninsula Link (M11) highway.

23. I have considered the concerns listed above and support the suggested changes to signage and traffic management noted above. I have made a recommendation in this finding to support VicRoads and the Mornington Peninsula Shire to consider the suggested changes to improve safety of pedestrians at the relevant traffic junction where the fatal incident occurred.

FINDINGS AND CONCLUSION

24. 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.[11] Adverse findings or comments against individuals 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.

25. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Jennifer Lee Hombsch, born 8 July 1956;

    b) the death occurred on 24 August 2024 at intersection of the Peninsula Link and Frankston-Flinders Road, Baxter, Victoria, 3911, from 1(a) Multiple injuries sustained in a motor vehicle incident (Pedestrian); and

    c) the death occurred in the circumstances described above.

26. Having considered all of the circumstances, I am satisfied that Jennifer's death was the unintended consequence of Ms Manolios' failure to exercise proper caution when driving through a pedestrian crossing.

RECOMMENDATIONS

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

A. That VicRoads and the Mornington Peninsula Shire consider improvements to pedestrian safety at the intersection of Frankston-Flinders Road and the Mornington Peninsula Link (M11) highway including the suggestions outlined in Steve Hombsch's petition available online at: https://chng.it/tXVXqnTr8G.

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

[11] *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(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:

Stephen (Steve) Hombsch, Senior Next of Kin

Jeroen Weimar, Secretary of the Department of Transport and Planning (Victoria)

Courtney Finlay, Peninsula Private Hospital

Jonathan Chiu, Ramsay Health

Chief Executive Officer, Mornington Peninsula Shire

Leading Senior Constable Suzanne Howes, Coronial Investigator

Signature:

Date: 5 December 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.