



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 006781

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:	LQ
Date of birth:	2012
Date of death:	21 November 2024
Cause of death:	1(a) Traumatic head injury sustained in motor vehicle collision (rider of e-scooter)
Place of death:	Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria
Key words:	E-scooter fatality, child fatality, motor vehicle collision

Aboriginal and Torres Strait Islander readers are respectively advised that this content contains the name of a deceased Aboriginal person.

Readers are warned that there are words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 21 November 2024, LQ was 12 years old when he passed away in hospital from injuries sustained in a motor vehicle collision. At the time of his passing, LQ resided in Victoria with his parents and younger brothers.
2. LQ was a proud Aboriginal boy with connections to the Yorta Yorta people. He is remembered for embracing his culture at a young age.
3. According to the summary provided by Senior Constable Enzo Avangliano-Liuzzi, Coronial Investigator, LQ attended a local Primary School. He enjoyed his BMX club, cooking, gaming, musical theatre, sketch booking, graffiti art, and football. He also joined two local football clubs in 2024.
4. In 2020, LQ's mother purchased a Segway Ninebot KickScooter ES4 (**the e-scooter**) for LQ's father via eBay. The maximum speed of the e-scooter was reportedly 30 kilometres per hour (**kmph**).¹ LQ's father did not use the e-scooter much and so it sat unused in the garage for much of the time.
5. In about September 2024, LQ asked if he could start riding the e-scooter as some of his friends also had e-scooters. His parents consented and cautioned him to follow the same rules as he had for his bicycle – always wear a helmet, not to ride when crossing the road, look both ways before crossing a road, be aware of driveways, and respect other people on the footpath.

THE CORONIAL INVESTIGATION

6. LQ's passing 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.
7. 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.

¹ LQ's parents later told the Court that the maximum speed was 25 kmph.

8. 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.
9. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of LQ's passing. 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.
10. This finding draws on the totality of the coronial investigation into LQ's passing, 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

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

Identity of the deceased

11. On 21 November 2024, LQ, born 2012 was visually identified by his aunt, EM, signed a formal Statement of Identification to this effect.
12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. Senior Forensic Pathologist, Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (VIFM), conducted an inspection on 25 November 2024 and provided a written report of his findings dated 27 November 2024.
14. The post-mortem examination revealed cerebral oedema, intraventricular haemorrhage, parafalcine subdural haemorrhage, skull fractures, fractures left tibia and fibula, and evidence of organ donation.

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.

15. Routine toxicological analysis of ante-mortem samples collected on 20 November 2024 detected rocuronium³ and midazolam.⁴
16. Dr Lynch provided an opinion that the medical cause of death was “*1(a) Traumatic head injury sustained in motor vehicle collision (rider of e-scooter)*”.
17. I accept Dr Lynch’s opinion.

Circumstances in which the passing occurred

18. Senior Constable Enzo Avangliano-Liuzzi reported that on 20 November 2024, both of LQ’s parents went to work. A neighbour kindly drove the children to school.
19. At about 4.15pm, LQ asked his mother for some money as he was going to meet his friend at McDonald’s. She subsequently transferred \$15 into his account.
20. LQ then left home at about 5.00pm on his e-scooter. His mother asked him to call her to let her know he had arrived safely, which he did.
21. At about 6.15pm later that evening, LQ rode his e-scooter north along Betula Avenue in Mill Park with his friend. At this time of day, it was sunny and traffic was light.
22. At the intersection of Childs Road and Betula Avenue, LQ and his friend stopped at the pedestrian crossing. The pedestrian signal was red, and road traffic had right of way due to green lights. At the same time, road traffic waiting to turn right into Childs Road was stationary due to a red arrow.
23. Childs Road runs between High Street in Lalor and Plenty Road in Mill Park. The intersection of Childs Road and Betula Avenue in Mill Park has provisions for two lanes of eastbound traffic and two lanes of westbound traffic, with a third lane for right turns in both directions. The posted speed limit on this section of Childs Road is 70 km per hour.
24. Childs Road is divided by a grassed centre median strip that separates the westbound and eastbound lanes of Childs Road. The intersection is controlled traffic lights which were operational at the time of the collision. A footpath is provided between the westbound and eastbound lanes.

³ Rocuronium is indicated for skeletal muscle relaxation in anaesthesia and intensive care.

⁴ Midazolam is used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.

25. It appears that, seeing that no vehicles were approaching from the right (that is, from the east), LQ rode his e-scooter across the westbound lanes of Child Road and entered the grassed medium strip, leaving his friend behind.
26. Standing at the median strip, LQ saw the stationary vehicles in the right turning lane. He then proceeded to ride his e-scooter across the eastbound lanes of Childs Road, against the red pedestrian signal. It is not clear whether he saw the red pedestrian signal before doing so.
27. LQ rode past the stationary vehicles and as he did so was struck by a 2023 Mazda 6 sedan (**the Mazda**), travelling east in the second lane of Childs Road. The Mazda had right of way as indicated by a green light.
28. At the time of the collision, the Mazda was travelling at approximately 60 kmph, which was below the posted 70 kmph speed limit.
29. Following the collision, LQ landed in the middle of the intersection. His helmet came off due to the impact, and the e-scooter was broken in half. The Mazda driver immediately stopped their vehicle.
30. Witnesses at the scene contacted emergency services and assisted LQ pending arrival of emergency responders. Cardiopulmonary resuscitation (**CPR**) was administered, and a member of the public brought a defibrillator over, which advised no shock when applied.
31. Ambulance Victoria paramedics arrived at the scene at 6.37pm. Following initial treatment and stabilisation at the scene, LQ was loaded into an ambulance and transported to the Royal Children's Hospital (**RCH**) at 7.00pm.
32. Imaging undertaken at the RCH showed that LQ had sustained multiple devastating and unsurvivable injuries. Treating clinicians determined that he was not suitable for neurosurgical intervention. LQ was transferred to the Intensive Care Unit for management while awaiting the arrival of his family and to allow time to evaluate the extent of his brain injury. LQ subsequently passed away at 4.30pm on 21 November 2024 and his family kindly consented to organ donation.
33. Police attending the scene tested the Mazda driver at the scene and they returned negative results for alcohol and illicit drugs.⁵ The driver provided their dashcam footage to police which confirmed the above circumstances. Victoria Police have not charged the driver of the Mazda

⁵ Confirmed by a blood test.

with any offences related to the collision. Police were of the opinion that driver did not have any opportunity to apply their brakes prior to impacting LQ and his e-scooter.

34. Senior Constable Avangliano-Liuzzi identified the following factors as contributing factors to the collision:

- (a) LQ crossed the road against a red man pedestrian signal; and
- (b) LQ was riding an electric scooter on a public road at the age of 12 where the minimum legal age for riding an electric scooter on a public road in Victoria is 16;

35. The following image depicts the relevant intersection and collision and is included for clarity:



FURTHER INVESTIGATION

36. As part of my investigation, I obtained advice from the Coroners Prevention Unit⁶ (CPU) regarding the relevant legislation regulating e-scooter operation at the time of the incident and currently, as well as updated data on e-scooter fatalities.

Legislation

37. The legislation relating to operation of e-scooters (which are referred to in the legislation as electric scooters) in Victoria has undergone several substantial changes over the past five years, however, there have been no changes since LQ's death.
38. An electric scooter is a motor vehicle in the meaning of the *Road Safety Act 1986* (Vic) (**the RSA**). However, under section 3(2)(b) of the Act, the Governor in Council has published an Order in Council⁷ declaring that an electric scooter as defined in the *Road Safety Road Rules 2017* (Vic) (**the Road Rules**)⁸ is not a motor vehicle for the purposes of all the provisions of the RSA.
39. The definition of an electric scooter in the Road Rules is:⁹

electric scooter means a vehicle

- (a) *is designed for use by one person that—*
 - (b) *transports a person while the person is either—*
 - (i) *standing on the vehicle; or*
 - (ii) *sitting on a seat that is structurally part of the vehicle or purposely built for and correctly installed on the vehicle; and*
- (b) *has 2 wheels (one in front of the other); and*

⁶ The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

⁷ The latest such Order in Council was published in Government Gazette S 321 on 18 June 2024.

⁸ Technically, the Order in Council refers to the definition of an electric scooter in the *Road Safety Act 1986* (Vic). However, the definition of an 'electric scooter' in the *Road Safety Act 1986* (Vic) is: "electric scooter has the same meaning as in the Road Rules".

⁹ See the dictionary in the RSA.

- (c) *has a footboard between the front and rear wheels; and*
- (d) *is steered by means of a handlebar; and*
- (e) *has an unladen mass not exceeding 45 kilograms; and*
- (f) *has a maximum speed capability of 25 kilometres per hour when ridden on level ground; and*
- (g) *can be propelled by both of the following—*
 - (i) *one or more electric motors;*
 - (ii) *a person pushing one foot against the ground ...*

40. The Order in Council exempts electric scooters from the motor vehicle registration requirements of the RSA and exempts the rider of an electric scooter from being required to hold a driver's licence or learner permit to drive the electric scooter on a road or road related area. However, it does not exempt the rider of an electric scooter from drink-driving and drug-driving offences when riding the electric scooter on a road or road related area.
41. The Road Rules generally treat electric scooters the same as bicycles; the same Rules generally apply to them for activities such as giving way, keeping to the left on roads, maintaining sufficient distance when passing, wearing helmets, obeying bicycle crossing light signals, and so on.
42. In addition, Part 15 Division 2 of the Road Rules sets out specific Rules for riders of electric scooters. The most relevant such rules include:
 - (a) the rider must not ride the electric scooter on a footpath other than a separated footpath or shared-use footpath (rule 262C);
 - (b) the rider must not ride the electric scooter on a road with a speed limit greater than 60 kmph (rule 262D);
 - (c) a rider must be aged at least 16 years to ride an electric scooter on a road or road-related area (rule 262F); and
 - (d) a rider must not ride an electric scooter on a road or road related area at a speed over 20 kmph (rule 262G).

43. If a vehicle does not meet the definition of an electric scooter in the Road Rules, it is a motor vehicle in the meaning of the RSA. If it cannot be registered as a motor vehicle, it is an unregistered motor vehicle and therefore cannot be operated on a road or road-related area in Victoria. However, it can still be operated on private property.

Current legislation applied to LQ

44. LQ was riding a Segway Ninebot Kickscooter ES4 at the time of the fatal incident, which was reported as having a top speed of 30 kmph. Due to the maximum speed being greater than 25 kmph, LQ was not riding an electric scooter in the meaning of the Road Rules; he was riding an unregistered motor vehicle.
45. However, even if the maximum speed of the Segway Ninebot Kickscooter ES4 was 25 kmph or less and it met the Road Rules definition of an electric scooter, the Road Rules stipulate that he should not have been riding it on a footpath in the lead-up to the fatal incident (rule 262C of the Road Rules).
46. In addition, as LQ was aged 12 years, he should not have been riding it at all on a road or a road related area (rule 262F of the Road Rules requires the rider to be aged at least 16 years to ride an electric scooter on a road or a road related area).¹⁰

Fatal incidents

47. Using the Court's surveillance database, the CPU identified 13 Victorian e-scooter fatalities since 2015. All deceased were riders of the e-scooter and all were male.
48. Where the e-scooter's top speed was known, eight e-scooters had a top speed above the maximum speed capability for an electric scooter set out in the Road Rules and were therefore legally regarded as unregistered motor vehicles rather than electric scooters.
49. Additionally, all five of the deaths that occurred in the period between 15 November 2021 and 5 April 2023 (when the initial Electric Scooter Trial was underway and it was illegal to use private e-scooters) involved private e-scooters rather than hired scooters.
50. From review of the available coronial findings in the closed cases, the CPU identified two cases with coronial recommendations relating to the operation of e-scooters. The findings and recommendations are outlined below.

¹⁰ A road related area includes a footpath under the definitions of the RSA.

51. On 12 December 2024, Coroner Simon McGregor delivered his finding into the death of Martin Lui, a 73-year-old male who died after sustaining injuries in an e-scooter collision on 21 December 2023.¹¹ Mr Lu was riding a Kaabo Sky 8S e-scooter which had a top speed of 40 kmph when he was ejected from the e-scooter after striking a grassed water drainage culvert between the footpath and the road. Mr Lu was not wearing a helmet or any other protective gear. Coroner McGregor recommended:

That the Transport Accident Commission consult with the Department of Transport on how best to improve community education about the conditions and requirements for the safe riding of e-scooters.

52. On 25 February 2025 Jacqui Sampson, Executive General Manager – Community at the Transport Accident Commission (TAC), responded and advised that in October 2024:

[...] the TAC launched a simplified campaign covering the rules around mandatory helmet use, no riding on footpaths and doubling up, no riding while drinking alcohol or speeding or if you are underage.

In December 2024, the TAC launched its follow up campaign “If you think e-scooters are a toy, think again” campaign which focused on the safety of e-scooters in the community and the significant new penalties for riding without a helmet, riding on the footpath, carrying passengers and riding after drinking.

The campaign was backed by research that shows that many Victorians see e-scooters as toys, not realising that failing to use them safely and following the road rules can have serious consequences. Research also found that many people don’t understand the key road safety laws relating to e-scooter use.

53. The campaign was evaluated and anticipated to be reported on in late March 2025. The TAC proposed a re-run of the e-scooter campaign as part of its 2025-2026 Annual Advertising plan submission to government.

¹¹ Finding into death without inquest regarding Martin Kok-Weng Lui, published 12 December 2024.

Coronial investigation into the death of Moustafa Aboueid

54. On 4 August 2025 Coroner Paul Lawrie delivered his finding with inquest into the death of Moustafa Aboueid, a 28-year-old male who died after sustaining injuries in an e-scooter collision on 22 September 2022.¹²
55. Mr Aboueid was riding a Kaabo Mantis 10 Elite which had a top speed of 60 kmph when he was ejected from the e-scooter after he lost control after encountering a speed hump. Mr Aboueid was not wearing a helmet or any other protective gear and suffered significant head injuries.
56. Coroner Lawrie made the following comments:

E-scooters are sold openly throughout Australia on the basis of their power and top speeds. A simple internet search reveals models for sale with advertised top speeds faster than 110 km/h – that is, faster than the highest speed limit in Victoria. The advertising for these models includes enticements such as, ‘... at a speed faster than a lightning bolt on a caffeine high’, and peak power of 5,000 watts. Moreover, the high torque available from a standing start, and the high power to weight ratio of these vehicles corresponds to the capacity for very rapid acceleration.

In a collision or loss of control, the rider’s momentum is carried from their standing position with a real likelihood that they will be propelled head first into whatever is before them. The only thing protecting against a likely catastrophic head injury is a bicycle helmet (if the rider has been sufficiently careful to wear one), which is not designed for the impact forces associated with highway speeds.

It is not only the rider that is exposed to the dangers associated with these high powered devices, pedestrians and other road users are also exposed. The prevalence of use in bicycle lanes, and on shared footways and bicycle paths, serves to highlight these dangers.

A purchaser in Victoria can easily select a high power / high speed model, either online or in store. There is no licencing requirement. There is no training or testing requirement. There is no registration requirement, and no way to readily identify a

¹² Finding into death without inquest regarding Moustafa Aboueid, published 4 August 2025.

particular e-scooter on the road. Finally, and chillingly, there is no rider age restriction.

Any notion that these high speed / high powered e-scooter models are being imported and sold in Australia principally for use by enthusiasts on private land, or for use off road, is fanciful. The failure to properly regulate the importation of these devices leaves Victoria, like other states and territories, to wrestle with the problem once they are on our roads. As small motor and lithium-ion battery technology advances further, it is likely that manufacturers will continue to place an emphasis on greater speed and power to maintain their share of the market for these particular models. The Road Safety Act 1986 properly recognises that e-scooters capable of more than 25 km/h do not belong on Victorian public roads. Outside of established special use cases, there can be no justification for models easily capable of exceeding the speed limit in most residential streets, let alone models capable of travelling at highway speeds.

DITRDCA¹³, by proceeding on the basis that powerful e-scooters are not road vehicles because they are not designed solely or principally for use in transport on public roads, has ignored the reality of their actual use on public roads and the growing problem this presents for state and territory road safety agencies. These devices may lack certain features of road vehicles, and they may be accompanied by assertions that they are not intended for road use above 25 km/h, but the ever more powerful motors and higher top speeds tell a different story.

57. Coroner Lawrie recommended:

With a view to supporting Victorian road safety legislation (and the road safety legislation of other states and territories) which prohibits the use of high power / high speed e-scooters on public roads, the Secretary of the Department of Infrastructure, Transport, Regional Development, Communications and the Arts:

- (a) review the conclusion that e-scooters capable of speeds higher than 25 km/h are not road vehicles for the purposes of the Road Vehicles Standards Act 2018;*

¹³ The Department of Infrastructure, Transport, Regional Development, Communications and the Arts.

- (b) *consider a ban on the importation of high power / high speed e-scooters, save for individual instances on an exemption basis where a proper use case can be established and;*
- (c) *consider a ban on the sale within Australia of high power / high speed e-scooters, save for individual instances on an exemption basis where a proper use case can be established.*

That the Victorian Minister for Transport and Planning seek to introduce amendments to Part 6A of the Road Safety Act 1986 to provide for the forfeiture of high power / high speed e-scooters that do not fall within the exemption to not be a motor vehicle within the meaning of the Road Safety Act 1986, if used on a public road or road related area.

58. On 5 November 2025 Jeroen Weimer, Secretary at the Department of Transport and Planning, responded and advised that the coroner's recommendation is under consideration and further work is ongoing. He further advised:

Victoria Police has advised that identifying non-compliant or modified devices can be difficult, as visual inspection alone is often insufficient to confirm whether a device complies with prescribed technical limits. Accordingly, further work is required with Victoria Police to better understand enforcement and evidentiary challenges, and to explore how any new forfeiture power could operate in practice.

Some steps have already been taken to enhance enforcement capability. The Government recently amended the Road Safety Act 1986 (RSA) to authorise law enforcement officers to use prescribed speed detection devices for e-scooter offences. This enables Victoria Police to better detect and take action against private devices exceeding the legal speed limit. However, a single speed reading may not provide sufficient proof that a device is inherently non-compliant, and factors such as road gradient (slope) or even wind need to be considered as factors outside electric propulsion. As such, speed detection alone may not meet the high evidentiary threshold required to justify forfeiture.

[...]

While the Department supports the intent of the Coroner's recommendation, further consultation with Victoria Police and an examination of existing RSA provisions is

required to determine the most effective and practical approach. The Department anticipates that a more considered position on this recommendation will be available within approximately the next six months and will provide the Court with an update at that time.

59. On 31 October 2025 Melissa Cashman, Assistant Secretary – Vehicle Safety Policy and Partnerships at the Department of Infrastructure, Transport, Regional Development, Communications and the Arts, responded and advised:

On 11 August 2025, the Commonwealth Minister for Infrastructure, Transport, Regional Development and Local Government chaired the Infrastructure and Transport Ministers’ Meeting, where the safety of PMDs was a key agenda item. Ministers agreed to work collaboratively to develop an integrated national regulatory framework aimed at improving safety for both riders and pedestrians.

[...]

While all options to reduce PMD-related risks—including potential bans—are being considered, current discussions recognise that banning the importation or sale of high-powered e-scooters alone is unlikely to be sufficient. The ability for devices to be modified post-importation, assembled from parts, or evade detection at the border presents significant challenges.

To address these issues, the department is working closely with other transport agencies to develop a holistic framework that will include clear and enforceable standards, education and awareness initiatives, and robust compliance and enforcement mechanisms.

Non-fatal injuries

60. The number of Victorian e-scooter fatalities is low in absolute terms, with 13 deaths since 2015. The number of Victorian e-scooter fatalities during this period involving children aged under 16 years (who are not legally permitted at present to ride e-scooters on roads and road-related areas) is even lower, with two deaths including LQ.
61. However, the CPU were concerned that the low absolute number of deaths might be only a small part of the burden of harms to children associated with e-scooter use. Therefore, the CPU contacted the Victorian Injury Surveillance Unit (VISU) at Monash University to find

out how many hospital emergency department presentations have occurred over time in Victoria for non-fatal injuries relating to e-scooters among children aged 0 to 15 years.

62. The VISU maintains the Victorian Emergency Minimum Dataset (**VEMD**), which covers emergency department admissions to all Victorian public hospitals where a 24-hour emergency department is situated.
63. The VISU searched VEMD data covering admissions for the period July 2019 to June 2024,¹⁴ and identified 407 emergency department presentations for injuries relating to e-scooters among children aged 0 to 15 years. Of these, 88 presentations (21.6 percent) resulted in an admission to hospital.
64. Table 1 below shows that, by financial year, the annual number of emergency department presentations increased steadily each year between the 2019/20 financial year and the 2023/24 financial. This confirmed for us that the fatalities are only a very small part of the overall harms that children are experiencing associated with use of e-scooters, and these harms are growing substantially over time.

Table 1. Number of emergency department (ED) presentations for injuries relating to e-scooters among people aged 0 to 15 years by financial year, Victoria, 1 July 2019 to 30 June 2024.		
Financial year	Number of ED presentations	Percent
2019/20	7	1.7
2020/21	21	5.2
2021/22	84	20.6
2022/23	124	30.5
2023/24	171	42.0
Total	407	100.0

65. As shown in Table 2 below, according to the VEMD data, roads and streets and highways were the most frequent location where the e-scooter injuries occurred (182 emergency department presentations, 44.7 percent). Children aged under 16 years are not legally permitted to ride e-scooters of any type on roads and road-related areas, so this data suggests that in nearly half of cases the children were operating e-scooters illegally when injured.

¹⁴ VISU advised the case identification process was as follows. VEMD records were extracted if the 'Description of event' text variable contained any of the terms 'scooter' and 'electric', 'e scooter', or 'e-scooter'" and their variations and derivatives. Cases that mentioned 'mobility' or 'motorised' were excluded as these usually indicate mobility scooters. Cases were manually checked for relevance.

Table 2. Number of ED presentations for injuries relating to e-scooters among people aged 0 to 15 years by location of incident, Victoria, 1 July 2019 to 30 June 2024.

Location of incident	Number of ED presentations	Percentage
Road, street or highway	182	44.7
Home	98	24.1
Place for recreation (e.g. park)	44	10.8
Sport & athletics areas	8	2.0
Other specified place	30	7.4
Unspecified places	45	11.1
Total	407	100.0

Discussion

66. LQ was 12 years old and riding an e-scooter that was actually an unregistered motor vehicle under the Road Rules, when he was fatally struck while crossing a road with a 70 kmph speed limit against a red pedestrian traffic signal at a signal-controlled intersection.
67. LQ is one of two children aged under 16 years who have tragically died in Victorian e-scooter fatalities since 2015; both fatalities occurred on a weekday during school term between the hours of 3pm and 7.30pm. We note that research on fatal e-scooter fatalities involving children from Queensland also found most incidents occurred on a weekday during the school term, with all incidents occurring between 8:00am to 8:30am and 3:00pm to 7:30pm.¹⁵
68. The two deaths since 2015 represent only a fraction of the overall harms associated with children using e-scooters in Victoria. Data from VISU showed that between 2019/20 financial year and the 2023/24 financial year the number of children aged 0 to 15 years who presented to Victorian hospital emergency departments with injuries relating to e-scooters increased from seven to 171. Nearly half of these injuries occurred on roads, streets or highways where children aged under 16 are not permitted to ride e-scooters.

FINDINGS AND CONCLUSION

69. Pursuant to section 67(1) of the Act I make the following findings:
 - (a) the identity of the deceased was LQ, 2012;

¹⁵ Queensland Family & Child Commission, 'Improving safety when young people ride e-scooters and e-bikes', June 2025.

- (b) his passing occurred on 21 November 2024 at Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria;
- (c) the cause of LQ's passing was traumatic head injury sustained in motor vehicle collision (rider of e-scooter); and
- (d) his passing occurred in the circumstances described above.

70. LQ's friends had been riding e-scooters. His father had one that he was not using and so LQ asked if he could use it instead. His parents agreed and set down reasonable safety rules, analogous to rules they would have imposed for bicycle riding but not informed by the legal requirements for e-scooter use in Victoria.
71. On 20 November 2024, LQ rode his e-scooter with a friend. The available evidence suggests that when he came to the pedestrian crossing at Childs Road, he rode against a red pedestrian crossing to the median strip. There, it appears that he misunderstood the traffic environment and likely believed all vehicles had stopped at the lights. In fact, only right-turning vehicles were stopped, but vehicles travelling straight ahead had right of way. It is likely that his view of oncoming traffic was obscured by the stationary vehicles, and that he did not appreciate the full danger of crossing against a red pedestrian signal.
72. LQ's parents told the Court that he was familiar with the relevant intersection as a passenger in a vehicle, but not as a solo e-scooter rider using the pedestrian crossing. They noted that LQ was not a "*silly rider*", he knew the rules and was sensible.
73. The subsequent collision was a tragic accident. The driver of the Mazda was not speeding nor under the influence of alcohol/illicit drugs but was unable to stop in time to avoid the collision. In their statement, they expressed anguish about the incident and subsequent events.
74. I convey my sincere condolences to LQ's family, friends and community for their loss.

COMMENTS

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

75. The CPU has confirmed that e-scooters should not be ridden on footpaths, riders must be at least 16 years old, and the maximum speed capability of the e-scooter should not exceed 25 kmph.

76. My fellow coroners have previously referred to the ease with which e-scooters can be purchased in Victoria, the inherent dangers of e-scooters, previous public safety campaigns, and possible restrictions on sales. I do not need to repeat their concerns.
77. While fatalities linked to e-scooter accidents were low, the CPU identified a large number of non-fatal injuries sustained amongst children under the age of 15 years which required hospital attention.
78. LQ's fatal injuries were sustained in the setting of crossing a road against a pedestrian traffic signal. On one view it was his failure to heed the road rules that caused his death, rather than the fact that he was an underage rider of an e-scooter/unregistered vehicle.
79. In any event, LQ was riding the e-scooter as his parents had permitted him to do. In conversations with Court staff, LQ's parents indicated that they were unaware that children under 16 years of age could not legally ride e-scooters. They also believed that the e-scooter's maximum speed was 25 kmph, and as such legal.
80. Children are dependent on their parents to advocate for them and educate them. It is therefore paramount for parents to understand the following before allowing their children to ride e-scooters:
- (a) which e-scooters are and are not be legal;
 - (b) what age children are allowed to ride e-scooters; and
 - (c) the road rules about where to ride e-scooters and other safety precautions.
81. To be clear, I do not attribute any fault to LQ's parents. It is apparent that they were unaware of the applicable somewhat complicated legislative scheme and thought LQ could ride an e-scooter as they saw other children his age doing.
82. The circumstances of LQ's death highlight the ongoing need to educate the Victorian community more broadly and the parents of young teenagers in particular, about the legislation governing the use of e-scooters on footpaths and public roads.

83. On 19 November 2025, the TAC released a campaign reminding parents that ‘e-scooters are not child’s play’.¹⁶ The campaign is aimed towards parents and guardians to highlight the consequences of reckless e-scooter use and increase awareness of the permanent rules and penalties for underage riding, and riding on a footpath. Having reviewed the campaign, it is unclear whether it also involves directly communicating these messages to parents and students via schools. Doing so would ensure the campaign has enhanced impact in school communities.

RECOMMENDATIONS

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

1. I **recommend** that the **Transport Accident Commission** consult with the Department of Education about what education is currently given to students and their parents about e-scooter legality and safety and determine whether a new or revised communication strategy is required to reach students and parents and explain the legal and safety issues relating to children using e-scooters.
2. At a minimum, any campaign should clearly advise that children under the age of 16 years are not allowed to ride any e-scooter, regardless of its maximum speed on any public roads or footpaths.

¹⁶ Transport Accident Commission, ‘[Campaign reminds e-scooters are not child’s play](https://www.tac.vic.gov.au/about-the-tac/media-room/news-and-events/2025/campaign-reminds-e-scooters-are-not-childs-play)’, <https://www.tac.vic.gov.au/about-the-tac/media-room/news-and-events/2025/campaign-reminds-e-scooters-are-not-childs-play>.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

AQ and SQ, senior next of kin

Royal Children's Hospital

DonateLife Victoria

Commission for Children and Young People

Tracey Slatter, CEO, Transport Accident Commission

Secretary Tony Bates, Department of Education

Senior Constable Enzo Avangliano-Liuzzi, Victoria Police, Coronial Investigator

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 07 October 2026

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.
