



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 2173

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Paul Lawrie
Deceased:	JNL (Jeremy) ¹
Date of birth:	2010
Date of death:	22 April 2025
Cause of death:	RETROPERITONEAL HAEMORRHAGE SECONDARY TO ABDOMINAL INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (E-SCOOTER RIDER VERSUS CAR)
Place of death:	Royal Children's Hospital 50 Flemington Road, Parkville, Victoria
Keywords:	E-scooter, electric scooter, underage rider

¹ A pseudonym applied to facilitate publication of the finding pursuant to section 73(1A) of the Act where the identity of the deceased is excluded from the direction for publication. JNL's family members are identified throughout by reference to their relationship to JNL rather than by name.

INTRODUCTION

1. On 22 April 2025, JNL (**Jeremy**) was 14 years old when he died shortly after the e-scooter he was riding collided with a utility at the intersection of Grey Street and Lyons Street, Terang. He was gravely injured after the collision and transported by air ambulance to the Royal Children's Hospital but was pronounced deceased upon arrival at the hospital. At the time of his death, Jeremy lived in Terang, Victoria with his immediate family.

THE CORONIAL INVESTIGATION

2. Jeremy'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.
3. 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.
4. 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.
5. Senior Constable Lewis Martin of Victoria Police acted as the Coronal Investigator for the investigation of Jeremy's death. SC Martin conducted inquiries on my behalf and compiled a coronial brief of evidence. The coronial brief includes statements from eyewitnesses, police members, Ambulance Victoria paramedics, and a collision reconstruction report.
6. This finding draws on the totality of the coronial investigation into Jeremy's death including the 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

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.

BACKGROUND

7. Jeremy was born in 2010 and grew up in Terang, Victoria. He lived at home in Terang with his parents and siblings. In 2025 he was a student in Year 9. Jeremy enjoyed school and excelled academically.
8. In about May 2025, Jeremy started a part-time job, working for one hour every evening after school. He saved enough money to buy an e-scooter from a friend. His mother recalled that he had always wanted an e-scooter, and that he particularly wanted to be able to ride to and from home and his part-time job. He bought the e-scooter for \$150 from his friend approximately one month before the critical events, and he had ridden it before that time.

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

The e-scooter

9. Acting Sergeant Pearce of the Collision Reconstruction and Mechanical Investigation Unit examined the e-scooter and prepared a report which included the following observations and opinions:
 - (a) The e-scooter was a “Wouoda” brand, fitted with a rear hub mounted motor controlled by a twist grip throttle on the right handlebar. Power was supplied by a 48 V / 13 Ah battery.
 - (b) The power output of the motor could not be readily ascertained but, based on the size of the hub motor and the battery specifications, the motor was likely 900 W with three “gears” or speed limiter settings. The e-scooter was likely capable of 40 to 50 km/h, depending on the weight of the rider and the terrain.
 - (c) The e-scooter had front and rear cable operated disc brakes with single piston callipers. Both brake rotors were dry and smooth, and the brake pads had sufficient friction material. The front brake assembly had been damaged in the collision, but the hand lever still actuated the front calliper so that it would function as intended. The rear brakes were found to operate properly.

- (d) It was fitted with 9.5” wheels front and rear³, with pneumatic tyres. The front tyre had sufficient tread but had deflated due to damage to the rim in the collision. The rear tyre had no tread at the centre of the pattern, but this was not thought to be a contributory factor given that the road surface was dry. Neither tyre showed signs of malfunction or failure prior to the collision. The front and rear suspension components were undamaged and functioned as intended.
- (e) It was also fitted with a white LED front light and a red LED rear light.
- (f) There were no faults, conditions or failures that could have caused or contributed to the collision.
10. I accept the opinions provided by Acting Sergeant Pearce. I also note that the particular brand of e-scooter includes a 900 W model advertised as being capable of 40 km/h.

Location of the collision

11. The collision occurred at the intersection of Lyons Street and Grey Street, Terang (**the intersection**). Grey Street is approximately 8 metres wide and runs east-west. Lyons Street is approximately 9.5 metres wide and runs north-south. A 50 km/h speed limit applies to both streets.
12. Both streets are flat and straight and meet as a simple cross intersection where traffic from both directions on Lyons Street is subject to a Give Way sign. The road surfaces are bitumen and were in good condition. The only painted markings are the longitudinal approach lines⁴ in Lyons Street leading to the broken lines at the north and south boundaries of the intersection associated with the Give Way signs. For north bound traffic there is a single Give Way sign on the left (west) side of the road set back approximately 13 metres from the intersection.
13. The intersection lies in a residential area of the town 260 metres north of the Princes Highway. The adjacent properties on all sides are set well back and there are wide grassy nature strips with concrete curbs. There is a streetlight mounted on a power pole in the nature strip at the south-west corner.

³ Wheel rim diameter – 6.5” / tyre outer diameter – 9.5”

⁴ The longitudinal approach line for traffic approaching the intersection from the south is approximately 21.5 metres long. For traffic approaching the intersection from the north, the line is approximately 11 metres long.

14. There is nothing about the physical aspects of the intersection, the approaches, or the immediate area that appears adverse. There appear to be good sight lines for all traffic near the intersection in all directions.

Prelude to the collision

15. At approximately 6.00pm on 22 April 2025, Jeremy was at home when he asked his mother for permission to go out to meet up with some friends. He often caught up with his friends at the Apex Park playground, just south of the Princes Highway. He left the house shortly after speaking with his mother.
16. Sunset was at 5.51pm. The weather was fine with good visibility, and the roads were dry.
17. Shortly before 6.40pm, Lucy Stinchcomb was driving west on the Princes Highway when she saw Jeremy riding west, also on Princes Highway, in the vicinity of the roundabout at Estcourt Street. She noticed that he was wearing a black top and dark pants and was difficult to see. He was wearing a helmet, but the straps were undone. Ms Stinchcomb was travelling at 50 km/h as she slowly went past Jeremy. She estimated his speed to be 35 to 40 km/h.
18. A short time later, Aimee Bennett saw Jeremy at the intersection of Baynes Street and Lyons Street, approximately 130 metres south of the site of the collision. Ms Bennett was the front passenger in a vehicle travelling east through the roundabout at this intersection. She saw Jeremy pass behind her vehicle heading north along Lyons Street. She noticed that he was hard to see and there appeared to be no light at the front of the e-scooter, and just the red glow on the ground from a light at the rear. Ms Bennett described Jeremy appearing “from nowhere under the orange streetlight”, and further stated:

It was concerning because it seemed to me that the male coasted through the roundabout quicker than a car would, and he just maintained his speed between 15-20 km/h and just rode the outside of the roundabout.

19. A CCTV camera at a house approximately 40 metres south of the intersection recorded Jeremy as he rode past on Lyons Street.⁵ The recording is of indifferent quality, and it was not possible to accurately determine his speed from this source, save to say that he can be seen to be moving quickly. Notably, the e-scooter’s front LED light is on.

⁵ Although a time is shown in the recording, it is apparent that it has not been set correctly.

20. Having regard to all the evidence, I conclude that it is likely that Jeremy was travelling at 30 to 40 km/h as he entered the intersection.

The collision

21. At approximately 6.40pm, Christopher Forrest was driving west along Grey Street in a 2004 Ford Courier crew cab utility, fitted with a flatbed cargo tray (**the Ford**). He was alone in the vehicle.
22. Mr Forrest is very familiar with the area and estimated that he was travelling at 40 km/h at the critical time. There is nothing in the physical evidence to suggest that this speed is understated.
23. Mr Forrest recalled that as he reached the intersection, he glanced a “tiny little red light” to his left and turned his head to see Jeremy just before he hit the passenger side of the Ford. Mr Forrest instinctively swerved to his right, but this manoeuvre could do nothing to materially alter the effect of the impact.
24. Jeremy collided with the passenger door of the Ford with sufficient force to leave a large dent just below the door handle. He and the e-scooter hit the barrier frame at the front of the cargo tray, and the side frame of the cargo tray as the Ford continued forward.
25. Mr Forrest stopped immediately, just west of the intersection. As he got out of the Ford, he saw Jeremy trying to stand and told him to “wait there”. Mr Forrest then reversed the Ford so he could direct its headlights onto Jeremy and see better to help.
26. There is nothing to suggest that a lack of attention or any other element of poor driving by Mr Forrest contributed to the collision. I am also satisfied that there were no means available to him to avoid the outcome.

The aftermath

27. Jeremy got up and walked a very short distance before collapsing. Mr Forrest rang his wife (a nurse) and 000 Emergency. Within minutes Mr Forrest’s wife was at the scene with other members of the public, all trying to help Jeremy who was now unresponsive.
28. The first police unit arrived at 6.45pm and the first Ambulance Victoria paramedics at 6.47pm. Over the next hour and a half multiple ambulance crews worked to save Jeremy. He went into cardiac arrest at 7.04pm and required repeated cycles of CPR and defibrillation. Bilateral chest

decompression was performed and whole blood was brought to the scene from Camperdown Hospital. There was a return of spontaneous circulation shortly after 7.27pm.

29. Efforts to stabilise Jeremy continued and he was transported from the scene by ambulance at 8.15pm to meet with the Ambulance Victoria HEMS⁶ helicopter. At 8.36pm the helicopter took off with Jeremy, but he suffered further cardiac arrests whilst on board. By this time Jeremy was beyond help and the HEMS crew, after consultation with an emergency physician at the Royal Children's Hospital, ceased treatment at 9.05pm. Jeremy was declared deceased upon arrival at the hospital.
30. Mr Forrest accompanied police to the Terang Hospital where he underwent a blood test which was negative for both drugs and alcohol.

Identity of the deceased

31. On 23 April 2025, Jeremy was visually identified by his father who provided a statement of identification.
32. Identity is not in dispute and requires no further investigation.

Medical cause of death

33. Forensic Pathologist Dr Felicity Barnes from the Victorian Institute of Forensic Medicine conducted an autopsy on 29 April 2025 and provided a written report of her findings dated 18 November 2025.
34. The post-mortem examination revealed multiple abrasions to the face, right arm and hand, upper and lower right flank, and both legs. Further examination revealed the most significant internal injury which was a laceration of the inferior vena cava leading to extensive bleeding into the soft tissues of the abdominal cavity.
35. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.
36. Dr Barnes provided an opinion that the medical cause of death was RETROPERITONEAL HAEMORRHAGE SECONDARY TO ABDOMINAL INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (E-SCOOTER DRIVER VERSUS CAR).

⁶ Helicopter Emergency Medical Services

37. I accept Dr Barnes' opinion save for the use of the word "driver" instead of "rider".

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was JNL, born 2010;⁷
- b) the death occurred on 22 April 2025 at The Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria 3052, from RETROPERITONEAL HAEMORRHAGE SECONDARY TO ABDOMINAL INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (E-SCOOTER RIDER VERSUS CAR).
- c) the death occurred in the circumstances described above.

COMMENTS

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

39. In the inquest into the death of Moustafa Aboueid⁸ I examined the inherent dangers of high power electric scooters, particularly when ridden on public roads.
40. In Victoria, the default position is that e-scooters are motor vehicles within the meaning of section 3(1) of the *Road Safety Act 1986*, unless the vehicle falls within the definition of an 'electric scooter' in the *Road Safety Road Rules 2017*⁹ which is then declared by the Governor in Council to not be a motor vehicle for the purposes of the *Road Safety Act* (**an exempt e-scooter**).
41. An exempt e-scooter may be driven by one or more electric motors but must not have a maximum speed capability of more than 25 km/h¹⁰ when ridden on level ground.¹¹ Accordingly, an e-scooter that is capable of more than 25 km/h is considered to be a motor

⁷ The identity of the deceased is fully detailed in Schedule 1 to this finding. Schedule 1 is excluded from the direction for publication.

⁸ COR 2022 5630

⁹ As the derivative source of the definition of 'electric scooter' from s.3(1) of the *Road Safety Act 1986*.

¹⁰ The increase in the maximum speed capability from 20 km/h to 25 km/h came into effect on 5 April 2023.

¹¹ *Road Safety Road Rules 2017* – Dictionary (Schedule 5)

vehicle under the *Road Safety Act 1986* with all the consequential requirements for compliance with Australian Design Rules, registration, and licencing of the rider/driver.

42. In addition to the requirements for the vehicle to be an exempt e-scooter if it is to be ridden on a road or road related area, the *Road Safety Road Rules 2017* impose further requirements upon the riders of e-scooters. These include:
- (a) a minimum age of 16 years;¹²
 - (b) a speed limit of 20 km/h;¹³
 - (c) no riding along roads where the speed limit is greater than 60 km/h;¹⁴ and
 - (d) wearing an approved bicycle helmet unless exempt.¹⁵
43. Accordingly, the e-scooter Jeremy was riding may be considered to be a motor vehicle, but one which was not registered and not capable of being registered in Victoria.
44. Between 17 November 2025 and 30 January 2026, the Victorian Government and the Transport Accident Commission conducted a safety awareness campaign titled “E-Scooters are not child’s play”. The campaign consisted of a series of 15 second videos depicting crashes in various contexts such as: underage riding; no helmet; intoxicated rider; and riding on footpaths. Whilst this campaign is commendable, it is apparently no longer running.
45. The circumstances of this case make it clear that more needs to be done to raise awareness of the safety issues for young riders. Teenagers, particularly young teenagers, possess only nascent road safety awareness. Nonetheless, these devices are readily available to anyone, regardless of age. They include high power / high speed models which may not be ridden legally on public roads. It is easy to understand that parents may be misled into thinking that there could be nothing “illegal” about an e-scooter that is for sale at a major retailer or available for purchase through an on-line Australian retailer. While a ban on the importation and sale of high power / high speed e-scooters may carry enforcement challenges, these should not represent a bar to this approach.
46. The imposition of a ban (moderated by a scheme for exemption in special use cases) would help to create a clearer landscape for the public to understand what is legal and what is not – what is safe and what is not. It would also provide a clear sign for parents who are endeavouring to make well informed decisions about matters that bear upon the safety of their children.

¹² *Road Safety Road Rules 2017* – r.262F

¹³ *Road Safety Road Rules 2017* – r.262G

¹⁴ *Road Safety Road Rules 2017* – r.262D

¹⁵ *Road Safety Road Rules 2017* – r.256

47. In the event of a collision, the difference between 20 to 25 km/h and 40 km/h is substantial. The kinetic energy of an e-scooter rider does not increase with speed in a linear fashion, but with the square of their velocity. The kinetic energy of a rider travelling at 40 km/h will be almost quadruple the energy of the same rider at 20 km/h.¹⁶ In a collision with a solid object, as was the case in this instance, the energy at impact is critical to the outcome for the rider.
48. Following the inquest into the death of Moustafa Aboueid, I made recommendations including to the Commonwealth Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts (**DITRDCSA**). Those recommendations included considering a ban on the importation and sale within Australia of high power / high speed e-scooters which cannot be ridden lawfully on public roads.
49. On 31 October 2025, DITRDCSA responded to the recommendations, stating (in part):

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 PMDs¹⁷ 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.

This work is being led by Western Australia, with support from the National Transport Commission (NTC), the department, and other jurisdictions.

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.

50. The observation that “banning the importation or sale of high-powered e-scooters alone is unlikely to be sufficient” is almost certainly correct. However, this should not disqualify the strategy from being a part of a multifaceted solution.
51. The work towards an integrated national regulatory framework is of vital importance as each passing year is likely to bring more varied and powerful devices onto our public roads, bicycle paths and footpaths.

¹⁶ $E = \frac{1}{2} mV^2$. For a 50 kg rider: 20 km/h (5.6 m/s) = 780 J; 40 km/h (11.1 m/s) = 3,080 J

¹⁷ Personal Mobility Devices

RECOMMENDATIONS

52. Pursuant to section 72(2) of the Act, I make the following recommendation:

That the Victorian Department of Transport and Planning and the Transport Accident Commission conduct further safety awareness campaigns with aims to include increasing public awareness of the particular dangers and illegalities associated with high power / high speed e-scooters.

ACKNOWLEDGEMENTS

I convey my sincere condolences to Jeremy's family and friends for their loss.

I thank the Coronial Investigator and those assisting for their work in this investigation.

ORDERS AND DIRECTIONS

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

NOTE: In order to facilitate publication of this finding without the identity of the deceased, the pseudonym "JNL" or "Jeremy" has been applied, and the date of birth has been withheld, save for the year of birth. The full details of the finding concerning the identity of the deceased pursuant to section 67(1)(a) of the Act are contained in Schedule 1.

2. Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following "1(a) RETROPERITONEAL HAEMORRHAGE SECONDARY TO ABDOMINAL INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (E-SCOOTER RIDER VERSUS CAR)".

3. I direct that a copy of this finding (excluding Schedule 1) be provided to:
- (a) Department of Transport and Planning
 - (b) Transport Accident Commission
 - (c) Kidsafe Victoria
 - (d) National Transport Commission
 - (e) The Royal Children's Hospital
4. I direct that a copy of this finding (including Schedule 1) be provided to:
- (a) Senior Next of Kin
 - (b) Senior Constable Lewis Martin, Coronial Investigator

Signature:



Coroner Paul Lawrie

Date: 25 March 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.
