



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2025 002555

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

|                 |   |
|-----------------|---|
| Findings of:    | Sarah Gebert, Coroner   |
| Deceased:       | IFL   |
| Date of birth:  | 1999  |
| Date of death:  | 12 May 2025   |
| Cause of death: | 1(a) Head and cervical spine injuries sustained in a<br>motor vehicle incident (driver) |
| Place of death: | Sea Lake-Swan Hill Road, Swan Hill West, Victoria                                       |
| Key words:      | Driver distraction, speed, rumble strips, fatal motor<br>vehicle incident               |

## INTRODUCTION

1. On 12 May 2025, IFL was 26 years old when he sustained fatal injuries in a motor vehicle incident in which he was the driver.
2. At the time of his death, IFL lived in [REDACTED] with his partner and child.

## THE CORONIAL INVESTIGATION

3. IFL'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 Senior Constable (SC) Tobias Gilmour to be the Coroner's Investigator for the investigation of IFL's death. The Coroner's 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. In addition, I asked the Coroners Prevention Unit (CPU)<sup>1</sup> to review the circumstances and contributing factors of IFL's death.
8. This finding draws on the totality of the coronial investigation into IFL's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

---

<sup>1</sup> The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.

refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.<sup>2</sup>

## Background

9. IFL was remembered as a passionate sports enthusiast. During high school he participated in swimming, cross country, badminton, football, and basketball. He was especially passionate about football and played with the under 16s team in 2016. He helped coach the under 17s team and later joined the ██████████ Football Club committee.
10. In 2017, IFL began a relationship with WKJ and, in 2023, they welcomed a child together. WKJ described IFL as a great father who loved spending time with his son.
11. WKJ stated that their relationship was not always good and, following the birth of their son, their relationship continued to be “rocky”. They did however continue to live together to care for their child but commenced an open relationship, and both agreed they could see other people.
12. After completing high school, IFL worked in various labouring jobs. In 2023, he began working in Sea Lake. The location of the worksite meant that IFL would make a 215-kilometre round trip from ██████████ to Sea Lake five to six times per week. His employer described him as a dependable and loyal worker.
13. According to his general practitioner, Dr Ken Mulligan, he last saw IFL on 8 May 2025 with a shoulder injury arising from playing football. At their previous consultation on 9 April 2025, IFL disclosed that he was moody, which was characterised by mild anxiety and depression. He stated that there were no obvious stressors and it was associated with some sleep difficulty. Dr Mulligan prescribed a low dose of sertraline as a mood stabilising agent, but he did not have the opportunity to review IFL’s progress after that prescription. He noted that IFL had not expressed any intent to self-harm.

---

<sup>2</sup> Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

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

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

14. On Saturday 10 May 2025, IFL travelled to Swan Hill to meet up with a woman he had been chatting with via an online dating site. They subsequently spent the weekend together.
15. On Sunday 11 May 2025, WKJ asked IFL to return home to [REDACTED] for Mother's Day. WKJ stated that they ended up having an argument on the phone and somehow the police were called.
16. Acting Sergeant (AS) Michael Hughes of Victoria Police subsequently spoke with WKJ in [REDACTED], whilst First Constable (FC) Mitch Lay of Swan Hill Police spoke with IFL at the Swan Hill Police Station.
17. According to FC Lay, IFL informed him that he had contacted police as WKJ had threatened self-harm. During their conversation, IFL told FC Lay that he was tired, and FC Lay advised him not to drive home to [REDACTED] that evening.
18. AS Hughes stated he initially spoke with WKJ on the phone. She stated that she had no self-harm intentions and the comment was just out of frustration and anger that IFL was away in Swan Hill with friends rather than being home with her and supporting her with the baby. WKJ agreed to meet AS Hughes outside the [REDACTED] High School at which time it became apparent that she was very frustrated with the situation, and the comments were said in the heat of the moment. AS Hughes did not hold any welfare concerns. AS Hughes subsequently completed a Family Violence Report and made referrals as part of the process.
19. WKJ stated that she spoke to IFL on the phone following these interactions with police and he informed her he would stay in Swan Hill because he was tired. They planned to have a more in-depth talk the following day.
20. IFL's female acquaintance noted that he was a bit stressed about the incident and was worried about his son. They later went to sleep around midnight.
21. At about 6.45am the next morning, 12 May 2025, IFL left Swan Hill in his 2007 Mazda BT50 utility to begin driving to work in Sea Lake, where he was due to start his shift at 7.30am. He appears to have been running slightly late.

22. IFL subsequently drove west along the Sea Lake-Swan Hill Road. During his journey, IFL used Snapchat on his mobile phone, taking photographs out of the vehicle's front windscreen, and sent the messages to various friends. It appears that the last message was sent at about 7.04am.
23. At approximately 7.05am, IFL approached a gentle righthand curve in the road, continuing west along the Sea Lake-Swan Hill Road which has two traffic lanes of bitumen road with a 100 kilometre per hour (**km/h**) speed limit. The curve is approximately 16 kilometres west of Swan Hill and overtaking is restricted due to two solid white lines dividing the two lanes. The road was dry and in good condition.
24. As IFL's vehicle approached the curve, the passenger side wheels entered the left (south side) gravel shoulder, where it left tyre imprints for 97 meters before the passenger wheels crossed back onto the bitumen. It appears that at this point IFL realised the vehicle's passenger wheels were in the gravel shoulder and he attempted to steer onto the bitumen.
25. However, IFL oversteered to the right, and the vehicle travelled onto and across the bitumen where subsequent yaw marks (tyre slide imprints) indicated it travelled sideways, with an estimated of speed of about 109 km/h.
26. The vehicle then crossed the incorrect side of the road, across the right (north side) gravel shoulder, and through a moderately dense section of shrubs and mallee trees approximately 20 metres in width. The vehicle impacted some shrubs and trees before it exited through to a clearing in a rural paddock. The vehicle rolled across a barbed wire fence and came to rest on its roof 87 metres from the point where it left the bitumen.
27. A short time later, a road user travelling east along the Sea Lake-Swan Hill Road observed the aftermath of the accident. He stopped his vehicle and approached IFL's vehicle. He subsequently contacted emergency services, informing the call taker that IFL was unresponsive and he could not detect a pulse.
28. Victoria Police members arrived at the scene at about 7.20am. They immediately checked on IFL and were also unable to detect a pulse. Ambulance Victoria paramedics arrived at the scene and verified IFL's death at 7.32am.

*Police investigation*

29. Detective Leading Senior Constable Lindon Walker from the Collision Reconstruction and Mechanical Investigation Unit estimated IFL's vehicle was travelling at 109 km/h as it began to rotate and slide over the bitumen surface.
30. Leading Senior Constable David Giulieri from the Collision Reconstruction and Mechanical Investigation Unit examined IFL's vehicle following the incident. He did not identify any faults with the brakes, steering, or accelerator systems that may have contributed to the incident.
31. SC Gilmour, Coronial Investigator, noted that although the vehicle was travelling nine kilometres above the legal posted limit, he did not consider it to be a determining factor of the collision. The curve in the road is a 100 km/h zone and is not marked with yellow advisory speed signs.
32. SC Gilmour also stated the environmental conditions were not considered to be a causing factor. At the time of the collision, approximately 7.05am, IFL was travelling west in dawn light conditions. The sun was due to rise behind him in the east at 7.11am. The temperature was 13 degrees Celsius with clear skies and light to no wind.
33. Various friends and family stated that IFL was often tired due to parenting obligations, work commitments, and the travelling to and from. IFL's mother KEL believed that he was possibly tired due to stressing about his son and the Family Violence incident which occurred the night before the collision. She stated he was an otherwise safe driver. WKJ stated that IFL would sometimes use his phone whilst driving.
34. SC Gilmour considered it was unlikely that IFL fell asleep, given that he had only commenced his journey a short time earlier, and he had a considerable overnight sleep.
35. With respect to the proximity of the timing the Snapchats were sent and the estimated collision time, SC Gilmour considered it was highly likely that IFL was using Snapchat on his mobile phone, leading to distraction and subsequently he veered onto the left shoulder before losing control around the bend. Analysis of incoming/outgoing calls and text message data from IFL's mobile phone, revealed no activity prior to and around the time of the collision.
36. He highlighted that there were no 'Advanced Audible Warning Systems', commonly known as rumble strips, installed on the road which would warn the driver they are veering towards

the shoulder. He therefore recommended that Advanced Audible Warning Systems (rumble strips) be installed along the outer edges and centre line for the duration of the Sea Lake-Swan Hill Road.

37. SC Gilmour also suggested that consideration and investigation be given to the installation of devices to all motor vehicles which restrict the useability of mobile devices by drivers of those vehicles.

### **Identity of the deceased**

38. On 19 May 2025, IFL, born in 1999, was visually identified by his partner, WKJ.
39. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

40. Forensic Pathology Registrar, Dr Felicity Barnes, from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination on 14 May 2025 and provided a written report of her findings dated 28 May 2025.
41. The post-mortem examination revealed significant head and cervical spine injuries.
42. Toxicological analysis of post-mortem samples identified the presence of paracetamol.
43. Dr Barnes provided an opinion that the medical cause of death was “*1(a) Head and cervical spine injuries sustained in a motor vehicle incident (driver)*”.
44. I accept Dr Barnes’ opinion.

## **FURTHER INVESTIGATION**

### **Coroners Prevention Unit review**

45. Following SC Gilmour’s informed suggestions regarding the installation of rumble strips on the road and devices in all motor vehicles to restrict the useability of mobile devices by drivers of those vehicles, I obtained further advice from the CPU regarding these matters.

## *Advanced Audible Warning Systems*

46. In their road safety materials, VicRoads refers to advanced audible warning systems as ‘Audio Tactile Line Marking’ (ATLM) and advise:<sup>3</sup>

*At a minimum Audio Tactile Line Marking should be considered on high-speed roads (above 80km/hr) and typically on roads with traffic volumes greater than 500 vehicles per day. Audio Tactile Line Marking has been historically used as a counter measure for run-off road crashes but is now considered a default treatment for high-speed rural roads.*

47. The CPU noted that the installation ATLM would be consistent with current road safety priorities. Regional and rural areas provide a challenging environment for road safety, given their low population density, vast road networks, significant socio-economic issues, lack of alternative transport options, and inadequate resources. A goal of the *Victorian Road Safety Strategy 2021-2030* is to “make remote and rural roads safe for all road users”.<sup>4</sup> As of 20 October 2025, there have been 15 percent more road fatalities on Victoria’s rural roads this year than at the same time last year.<sup>5</sup>

48. However, the CPU noted there may be a practical challenge. The VicRoads Research Design Note for ATLM advises that the road needs to have certain characteristics including at a very minimum:

- (a) a total sealed road width at least 6.9 metres;
- (b) a lane width of at least 3.1 metres;
- (c) a minimum 0.3 metre of sealed shoulder beyond the edge of the lane where the ATLM is installed.<sup>6</sup>

49. The road sketch provided shows that the road where the fatal incident occurred did not meet these minimum dimensions. Additionally, it is unclear whether the road has a traffic volume greater than 500 vehicles per day.

---

<sup>3</sup> VicRoads, *Audio Tactile Line Marking (ATLM)*, Research Design Note RDN 03-10, Kew: VicRoads, January 2019, p.2.

<sup>4</sup> Department of Transport, *Victorian Road Safety Strategy 2021-2030*, Melbourne: Department of Transport, 2020, p.9.

<sup>5</sup> Transport Accident Commission, “Lives Lost – Year to Date”, undated, <<https://www.tac.vic.gov.au/road-safety/statistics/lives-lost-year-to-date>>, accessed 21 October 2025.

<sup>6</sup> VicRoads, *Audio Tactile Line Marking (ATLM)*, Research Design Note RDN 03-10, Kew: VicRoads, January 2019, p.2.

50. So, while the CPU agreed in principle that ATLM should be a “*default treatment*” (to borrow the VicRoads wording) along Sea Lake-Swan Hill Road, the CPU was concerned that the road in its present state unfortunately may not have the minimum characteristics required for installation of ATLM.

### ***The area where the fatal collision occurred***

51. As part of the CPU’s review of the circumstances of this fatal incident, they identified that there had been one other fatality on Sea Lake-Swan Hill Road since. This was a head-on collision that occurred approximately five kilometres west of Sea Lake. For comparison, IFL’s death occurred approximately 57 kilometres west of Sea Lake.
52. The CPU also searched Victorian Department of Transport’s road collision data asset to identify non-fatal vehicle injury incidents that occurred on Sea Lake-Swan Hill Road between Dead Horse Lane/Memorial Drive and Waitchie Road in the period from January 2014 to February 2025. The CPU identified seven non-fatal injury incidents: four collisions with a fixed object, two incidents where the vehicle overturned, and one multi-vehicle collision.
53. On the basis of those searches, the CPU did not consider the stretch of road where the fatal incident occurred stands out as a location where a heightened number of fatal collisions and non-fatal injury vehicle incidents / collisions occur.

### ***Restricting mobile phone use while driving***

54. The CPU noted that recent years there is growing acknowledgement that driver distraction is more than just a direct consequence of using mobile phones. Driver distraction occurs because of a complex interaction of interrelated elements within the road traffic system, as well as social and psychological issues beyond the road traffic system.<sup>7</sup>

### ***National initiatives***

55. In 2019 the Queensland Department of Transport and Main Roads led stakeholders in developing a National Roadmap on Driver Distraction,<sup>8</sup> informed by this more sophisticated understanding. Implementing this roadmap is a commitment in Australia’s *National Road*

---

<sup>7</sup> Austroads, “A systems approach to driver distraction: A long-term plan”, undated, <<https://austroads.gov.au/safety-and-design/road-safety/national-roadmap-on-driver-distraction>>, accessed 21 October 2025.

<sup>8</sup> Queensland Government Department of Transport and Main Roads, “National roadmap on driver distraction”, updated 12 December 2023, <<https://www.tmr.qld.gov.au/Safety/Road-safety/Road-safety-strategy-and-action-plans/National-roadmap-on-driver-distraction>>, accessed 21 October 2025.

*Safety Strategy 2021-2030*.<sup>9</sup> In 2023 Austroads assumed responsibility for implementing the roadmap. Its working group prioritised 31 research and development projects based on impact and urgency, four of which have been completed thus far.

56. Vehicle safety systems assisting drivers to stay in their lane, and systems that provide warnings when drivers are drowsy or distracted, are a key priority in Australia's *National Road Safety Strategy 2021-2030*.
57. The Advanced Driver Distraction Warning System is an example of such a system: it is being introduced into vehicles to continuously track a driver's gaze across three key areas (forward view, peripheral areas, and downward areas like the dashboard) and issue real-time alerts to redirect attention to the road when necessary.

#### *Victorian initiatives*

58. In 2023 new driver distraction road rules were introduced in Victoria, which extended existing mobile phone rules to cover modern technology such as:
  - (a) portable devices (tablets, media players, hand-held game consoles, laptops and smart watches not being worn);
  - (b) inbuilt devices (integrated navigation, infotainment, dispatch systems, or heads-up displays);
  - (c) mounted devices (mobile phones or tablets secured according to manufacturer's instructions in a commercially designed and manufactured mount or holder);
  - (d) wearable devices (smart watches, smart glasses, and wearable heads-up displays); and
  - (e) motorcycle helmet devices (heads-up displays, communicators, cameras, and inbuilt or secured mobile phones).
59. Specifically, for the above device types, drivers must not, while driving:
  - (a) enter text, numbers or symbols;
  - (b) scroll (such as on websites, social media, playlists);

---

<sup>9</sup> Infrastructure and Transport Ministers, *National Road Safety Strategy 2021-30*, Canberra: Department of Infrastructure, Transport, Regional Development and Communications, p.19.

- (c) play videos or games or take video calls;
  - (d) display text messages, social media, emails, or photos; and
  - (e) rest a device on any part of the body or pass a device to a passenger.
60. In conjunction with the new laws, the Victorian Government introduced mobile phone and seatbelt cameras (which use artificial intelligence to detect photograph drivers using mobile phones and front-seat passengers not wearing seatbelts), along with related road rules with fines and demerit points.<sup>10</sup> The Victorian Auditor-General's Office is currently evaluating the effectiveness of these developments in improving road safety.

### ***Conclusion***

61. Newer vehicles are safer, at least in part because they generally incorporate newer safety technology. Illustrating this, a 2018 analysis from the Australasian New Car Assessment Program showed vehicles built before 2001 made up 20 percent of the Australian fleet but featured in 36 percent of fatal crashes, whereas newer vehicles built between 2012 and 2017 made up just over 30 percent of the fleet yet were involved in only 13 percent of fatal crashes.<sup>11</sup>
62. There is a concerted national effort at present via the *National Road Safety Strategy 2021-2030* to address driver distraction as a safety issue and introduce new in-vehicle technologies.
63. However, the CPU noted that it also takes some time for new safety technology to spread through the population's vehicle fleet as older vehicles are replaced by newer vehicles and become the norm. In Victoria the average age of a passenger vehicle is currently 11.13 years and that number is increasing year on year.<sup>12</sup> The types of driver distraction technology (such as the Advanced Driver Distraction Warning System) being deployed now will eventually be in most cars, but not for a while.
64. The suggestion that ATLM was a potential intervention is reasonable in the circumstances, however it appears that the Sea Lake-Swan Hill Road in the vicinity of the fatal incident may

---

<sup>10</sup> Victorian Government, "Mobile phone and seatbelt detection cameras", updated 22 August 2025, <<https://www.vic.gov.au/mobile-phone-and-seatbelt-detection-cameras>>, accessed 21 October 2025.

<sup>11</sup> See National Road Safety Strategy, "Fact sheet: Vehicle safety", undated, <<https://www.roadsafety.gov.au/nrss/fact-sheets/vehicle-safety>>, accessed 21 October 2025.

<sup>12</sup> Bureau of Infrastructure and Transport Research Economics, *Road Vehicles, Australia, January 2025*, Canberra: Bureau of Infrastructure and Transport Research Economics, September 2025.

not meet the minimum criteria (in terms of overall sealed road width) for installing ATLM, although it is not clear from the relevant authority that this is the case.

65. In those circumstances, I will make a recommendation that an investigation is undertaken to see whether it is feasible in the circumstances.

## **FINDINGS AND CONCLUSION**

66. Pursuant to section 67(1) of the Act I make the following findings:

- (a) the identity of the deceased was IFL, born in 1999;
- (b) the death occurred on 12 May 2025 at Sea Lake-Swan Hill Road, Swan Hill West, Victoria, from head and cervical spine injuries sustained in a motor vehicle incident (driver); and
- (c) the death occurred in the circumstances described above.

67. The available evidence supports a finding that IFL was likely distracted whilst driving along Sea Lake-Swan Hill Road immediately before the fatal incident. Had ‘rumble strips’ been installed on the road, he may have been warned that he was veering to the road shoulder and been able to take earlier evasive action.

68. IFL’s death is a stark reminder to road users about the dangers of using mobile phones whilst driving, which is reflected in current Victorian road rules.

## **RECOMMENDATIONS**

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

69. I recommend the Department of Transport and Planning investigate whether it is feasible to install Audio Tactile Line Marking along the edge of Sea Lake-Swan Hill Road between Swan Hill and Ultima, Victoria.

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

Pursuant to section 73(1A) of the Act, I order that this finding be published (in redacted form) 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:

WKJ, senior next of kin

Jeroen Weimar, Secretary, Department of Transport and Planning

Senior Constable Tobias Gilmour, Victoria Police, Coronial Investigator

Signature:



---

Coroner Sarah Gebert

Date: 28 April 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.

---