



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2025 007049**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner David Ryan
Deceased:	Gino Frederick Galea
Date of birth:	30 December 1986
Date of death:	3 October 2025
Cause of death:	Chest injuries and traumatic compression asphyxia of the chest
Place of death:	Bacchus Marsh Road Balliang Victoria
Keywords:	Motor vehicle accident – seatbelt - distraction- road condition

## **INTRODUCTION**

1. On 3 October 2025, Gino Frederick Galea was 38 years old when he died from injuries sustained in a motor vehicle accident. At the time of his death, Gino lived in Lara with his wife, Giuseppina Galea. He is warmly remembered by family and friends as a kind and generous man.

## **BACKGROUND**

2. Gino had no recent or relevant medical history. He was employed as a plumber and drove a 2015 Mercedes Benz Tipper truck. He had a valid Victorian driver licence and was authorised to drive the truck. The vehicle was well maintained. His employer stated that Gino was a valued member of the team and was a *“highly capable and safety-conscious truck driver”* who *“demonstrated professionalism and attention to detail”*.

## **THE CORONIAL INVESTIGATION**

3. Gino’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 an officer to be the Coronial Investigator for the investigation of Gino’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. The brief also contains Dash Cam footage from Gino’s vehicle.

7. This finding draws on the totality of the coronial investigation into Gino's death of including evidence contained in the coronial brief. While 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.<sup>1</sup>

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

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

8. On 3 October 2025 at around 11.33am, Gino was driving his truck northbound on Bacchus Marsh Road in Balliang when he was involved in a collision. The site is between Matfins and Sharkey Roads. Gino had not been wearing a seatbelt and the driver side window was wound down. Approaching from the south, the relevant section of road consists of a single lane of traffic in either direction divided by a metal barrier. The speed limit is 100 kilometres per hour and there are signs warning motorists of the "rough surface". The Coronial Investigator has advised that nine serious injury collisions and two fatal collisions have occurred along this section of road since 2017.
9. Just before the collision site, the road northbound extends to create two lanes with a rumble strip and an Armco barrier running along the left side. As Gino entered this area in his truck, he drove over an area of rough surface on the road and the truck suddenly veered to the left, colliding with the Armco barrier. It then rolled onto the driver side and Gino was partially ejected through the driver side window as the vehicle came to rest.
10. A motorist who had been driving behind Gino's truck witnessed the collision and he contacted emergency services and stopped to render assistance. He noted that Gino was unresponsive and without a pulse. Ambulance Victoria and Victoria Police attended shortly afterwards and Gino was pronounced deceased at the scene by paramedics. Police observed that Gino was carrying a vape in his right hand.
11. Victoria Police obtained the Dash Cam footage from Gino's truck and also retrieved his mobile phone which was found in the cabin. They assessed that the phone had been placed in a holder mounted on the windscreen at the time of the collision.

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<sup>1</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.

12. Victoria Police downloaded the data from Gino's phone which disclosed that it had been connected to Bluetooth and he had been accessing Apple Maps at the time of the collision. The letters "P PPP" had been typed into the search bar.

### **Identity of the deceased**

13. On 6 October 2025, Gino Frederick Galea, born 30 December 1986, was visually identified by his wife, Giuseppina Galea.
14. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

15. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an examination on 7 October 2025 and provided a written report of his findings dated 12 December 2025. A post-mortem computed tomography (CT) scan revealed multiple rib fractures. It is clear that death would have been instant.
16. Toxicological analysis of post-mortem samples identified the presence of diazepam (and its metabolite) and cocaine metabolites.
17. Dr Beer provided an opinion that the medical cause of death was *1(a) Chest injuries and traumatic compression asphyxia of the chest.*
18. I accept Dr Beer's opinion.

### **FINDINGS AND CONCLUSION**

19. Pursuant to section 67(1) of the Act, I make the following findings:
  - a) the identity of the deceased was Gino Frederick Galea, born 30 December 1986;
  - b) the death occurred on 3 October 2025 on Bacchus Marsh Road, Balliang, Victoria, from chest injuries and traumatic compression asphyxia of the chest ;  
and
  - c) the death occurred in the circumstances described above.
20. Having considered all of the evidence, I am satisfied that Gino died from injuries sustained after losing control of his vehicle while not wearing his seatbelt. His attention was likely

distracted at the time by the use of his mobile telephone and his response may have been further affected by carrying a vape in his hand. Further, I am satisfied that that his vehicle veered to the left after driving over a section of rough surface on the road.

## RECOMMENDATIONS

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

1. The Department of Transport and Planning review the condition of the road surface on Bacchus Marsh Road in Balliang and carry out any rehabilitation works that are assessed to be required to ensure the safety of road users.

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

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

Giuseppina Galea, Senior Next of Kin

Department of Transport and Planning

Senior Samuel Constable, Coronial Investigator

Signature:



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Coroner David Ryan

Date: 24 March 2026

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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.

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