IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007080

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Martin Kok-Weng Lui
Date of birth:	31 May 1950
Date of death:	21 December 2023
Cause of death:	1a: Head injury sustained in an e-scooter accident
Place of death:	Royal Melbourne Hospital 300 Grattan Street Parkville Victoria 3052
Keywords:	Electric scooter, head injury

INTRODUCTION

1. On 21 December 2023, Martin Kok-Weng Lui was 73 years old when he died at the Royal Melbourne Hospital from injuries sustained in an electric scooter (**e-scooter**) accident. At the time of his death, Martin lived by himself at 2/27 Ruffey Street, Templestowe Lower, Victoria.

2. Martin was born in Malaysia and came to Australia in around 1970. He finished high school in Australia and studied accounting at RMIT, then worked in that field until he retired, spending 30 years with the agricultural machinery manufacturer Massey Ferguson.[1]

3. Martin and his former wife raised their two daughters in Templestowe, and Martin chose to remain in the area when he and his wife divorced in 2020 in part because there were so many trails suitable for riding the various bicycles, e-bikes and e-scooters he had in his collection. His daughter Nicole described him as a 'very experienced', early adopter of electric scooters and bikes, who was 'very safety conscious and would pretty much always wear a helmet'. Martin would often ride all the way into the city or to Port Melbourne to go fishing and meet up with friends.[2]

4. Martin had purchased the Kaabo Sky 8S e-scooter he was riding at the time of the accident in around September 2021.[3]

5. Martin suffered a stroke in 2002, and although he fully recovered, he chose to retire two years later when his office was moving to a less convenient location. His other relevant medical conditions included high cholesterol, hypertension, Type 2 Diabetes and low-grade prostate cancer which required no treatment. In 2022, he burned his hands with cooking oil which required plastic surgery, but he made a full recovery and was able to use his hands normally.[4]

THE CORONIAL INVESTIGATION

6. Martin'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.

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

[1] Statement of Nicole Lui, Coronial Brief.
[2] Statement of Nicole Lui, Coronial Brief.
[3] Appendix 1 - Kaabo Sky 8S Electric Scooter Specifications; Statement of Nicole Lui, Coronial Brief.
[4] Statement of Nicole Lui, Coronial Brief.

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.

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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Martin's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as witnesses, family, the forensic pathologist, treating clinicians, an accident reconstruction expert and my investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Martin Kok-Weng Lui 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.[5]

11. In considering the issues associated with this finding, I have been mindful of Martin's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

12. At the time of the collision, Martin's friend Ann Wong was staying with him on holiday from Malaysia. On Thursday 21 December 2023, they woke up early and shared a pot of tea with Martin's neighbour, before going shopping together.[6]

[5] 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.

[6] Statement of Nicole Lui, Coronial Brief.

13. Martin was a keen gardener and had some time earlier noticed some discarded PVC piping at a hard rubbish collection site not far from his home. At around 4:00 pm, Martin told Ann he was going to collect the piping.

14. At 4:21 pm, front and rear dashcam footage provided by witness Rudiberto Canales shows Martin travelling north on the eastern side of Ruffey Street, Templestowe Lower, not far from his home. As Mr Canales' car approaches Martin, who can be seen riding on the adjacent footpath, both are initially travelling at around 20 km/h. As Mr Canales sped up to around 35 km/h, he overtook Martin.[7] The street has a gentle downward incline at this location. [8]

15. The maximum lawful speed for any e-scooter is 20 km/h and e-scooter riders are only permitted to ride them on roads or shared bike paths, where they must always wear a helmet.[9]

16. Whilst his speed was towards the upper lawful limit, the footage clearly shows that Martin is not wearing a helmet nor any other protective gear, and is only wearing sandal-style open-toed footwear. As Martin rides down Ruffey Street's non-shared footpath, he can be seen somewhat awkwardly using his left hand to try to hold several pieces of PVC piping and two wooden batons perpendicularly up against the handlebars of his scooter and wobbling a little in the process. His right hand is unimpeded.

17. The Ruffey Street footpath on which Martin was travelling ends 2-3 metres before Ruffey Street's intersection with James Street, with a grassy, downward sloping nature strip which extends to the bitumen surface of James Street. The footpath then resumes directly from the bitumen surface on the northern side of James Street. Ruffey Street is a suburban side street with no speed signs posted, so the default speed limit is 50 km/h on the road.[10] Whilst there is no prescribed speed limit on a footpath, e-scooter riders are not permitted to ride on the footpath at all.[11]

18. The moment that Martin leaves the footpath and enters the intersection is precisely the time that he passes from the front dash camera footage to the rear camera footage from Mr Canales' vehicle, so the immediate precipitant of the collision cannot be directly observed, but it is apparent from the rear camera footage that Martin has not continued straight onto the footpath on the northern side of the James Street intersection, as perhaps would be expected, but has

[7] Statement of Rudiberto Canales, and Exhibit 3 Dashcam Footage, Coronial Brief.
[8] Exhibit 6 - GoPro Footage of Collision Scene, Coronial Brief.
[9] See VicRoads website (E-scooters).
[10] Exhibit 6 - GoPro Footage of Collision Scene, Coronial Brief.
[11] See https://transport.vic.gov.au/road-rules-and-safety/bicycles/places-to-ride.

veered to his left and ended up with his front tyre in a grassed water drainage culvert between the footpath and the road, and has then been ejected from the e-scooter, landing head-first on the bitumen road surface.

19. It is also possible that Martin had chosen this moment to attempt to steer his e-scooter left toward the other side of Ruffey Street where his house was located, but regardless of what his intention was, it is evident that he lost control of his e-scooter at this point.

20. Mr Canales stopped to render assistance. Ambulance Victoria paramedics attended 10 minutes later. Martin was still unconscious and had significant bleeding from his left ear, so was promptly transported to the Royal Melbourne Hospital, arriving at 5:25 pm.[12] Despite intensive resuscitation efforts, Martin was unable to be revived, and he was pronounced deceased at 7:04 pm.[13]

21. The Kaabo Sky 8S e-scooter was subsequently inspected and found to be free of any relevant mechanical fault.[14] The vehicle's product specifications do not list it as having any cargo carrying capacity at all, just a gross maximum weight, which Martin would not have exceeded.[15]

22. My investigators attended the scene within about 20 minutes of the accident and described the road conditions as dry and the weather as being clear that day.[16]

Identity of the deceased

23. On 21 December 2023, Martin Kok-Weng Lui, born 31 May 1950, was visually identified by his daughter, Natalie Kim Lui.

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

Medical cause of death

25. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an external examination on 26 December 2023 and provided a written report of her findings dated 4 March 2024.

[12] Statement of Vanessa Macaulay and Exhibit 4 - Ambulance Victoria Patient Care Record, Coronial Brief.
[13] Statement of Dr Lisa Walker, Coronial Brief. E-Medical Deposition of Dr Lisa Walker, 21 December 2023.
[14] Statement of SC Max Edwards, Coronial Brief.
[15] Appendix 1 - Kaaboo Sky 8S electric scooter vehicle specification, Coronial Brief.
[16] Statement of SC Max Edwards, Coronial Brief. See also Exhibit 3 - Dashcam Footage, Coronial Brief.

26. A postmortem CT scan showed global subarachnoid haemorrhage, bilateral temporoparietal skull fractures, an occipital skull fracture, diastasis of the sagittal and lambdoid sutures with extension into the left frontal bone, and a small left pneumothorax with intercostal catheter inserted during the emergency medical procedures. Some mild coronary artery calcifications were also observed.

27. The external physical examination did not reveal any inconsistent clinical information nor any other independent cause of death.

28. Toxicological analysis of post-mortem samples did not identify the presence of alcohol or any other common drugs or poisons.

29. Dr Baber provided an opinion that the medical cause of death was 1(a) head injury sustained in an e-scooter accident, and I accept her opinion.

FINDINGS AND CONCLUSION

30. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[17] The effect of the authorities is that adverse comments or findings should not be made unless the evidence provides a comfortable level of satisfaction that an individual (or institution) caused or contributed to the death, and in the case of individuals acting in a professional capacity, that they departed materially from the standards of their profession.

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

    a) the identity of the deceased was Martin Kok-Weng Lui, born 31 May 1950;

    b) the death occurred on 21 December 2023 at Royal Melbourne Hospital, 300 Grattan Street Parkville Victoria 3052, from 1(a) head injury sustained in an e-scooter accident; and

    c) the death occurred in the circumstances described above.

[17] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

32. Having considered all of the evidence, I am satisfied that Martin suffered unsurvivable head injuries after losing control of, and being thrown from, the e-scooter he was riding, in circumstances where he was:

    a) riding on a non-shared footpath;

    b) not wearing a helmet or any other protective clothing or footwear; and

    c) using his left hand to attempt to carry unwieldy and unsecured cargo, rather than using it to assist with the safe control of the vehicle.

COMMENTS

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

33. Anecdotally, I have observed many e-scooter riders in our community not complying with the prescribed conditions for their safe use, and this undermines an otherwise efficient way to better utilise our existing road and shared path networks.

RECOMMENDATION

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

(i) 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.

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

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

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

Natalie Lui, Senior Next of Kin

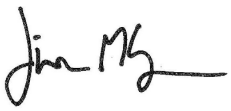
Danielle Middleton, Transport Accident Commission

Andrew Mariadason, Royal Melbourne Health

Kellie Gumm, Royal Melbourne Hospital

Senior Constable Max Edwards, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 12 December 2024

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.