CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Matter Title:	**Inquest into the death of Ms TL (a pseudonym)**
Citation:	**[2025] ACTCD 7**
Decision Date:	5 November 2025
Before:	Coroner Archer
Findings:	See [22] - [25]
Catchwords:	**CORONIAL LAW** – manner and cause of death – multiple injuries sustained in a single motor vehicle accident – findings published to place on public records circumstances of the accident
Legislation Cited:	*Coroners Act 1997* (ACT) ss 13(1)(g), 34A, 52, 58 *Road Transport (Safety and Traffic Management) Act 1999* (ACT) s 7(1)(a)
File Number:	CD 156 of 2022

CORONER ARCHER:

Introduction

1. Ms TL died in a motor vehicle accident on Black Mountain Drive that occurred at about 2200 hours on 4 June 2022. Ms TL was 19 years old at the time of her death.

2. The accident occurred as a result of Ms TL losing control of the vehicle she was driving, causing it to collide with a tree that was located near to the road surface. Ms TL suffered significant injuries. She died later that night after being transported to the Canberra Hospital ("TCH").

3. No one else was in Ms TL's car and no one else was injured in the accident.

Jurisdiction

4. Ms TL's death was reported to the ACT Coroner's Court on 5 June 2022, as it fell within the terms of section 13(1)(g) of the *Coroners Act 1997* ("the Act"), being a death that "appears to be directly attributable to an accident".

5. I was required to hold an inquest[1] into the manner and cause of TL's death and make findings that are required by section 52 of the Act. That section of the Act relevantly provides:

> **52 Coroner's findings**
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> (1) A coroner holding an inquest must find, if possible—
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> (a) the identity of the deceased; and
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> (b) when and where the death happened; and
>
> (c) the manner and cause of death; and
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> (d) in the case of the suspected death of a person—that the person has died.
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> (4) The coroner, in the coroner's findings—
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> (a) must—
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> (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
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> (ii) if a matter of public safety is found to arise—comment on the matter.

[1] Under the Act, the meaning given to the term "inquest" varies. In this context it means a process of investigation. There can be a "hearing" for an inquest.

Circumstances Surrounding Ms TL's Death

6. On my behalf, the Australian Federal Police ("AFP") conducted an investigation of the circumstances of Ms TL's death. The accident scene was examined and the road assessed for issues that may have contributed to the accident. Members of Ms TL's family and her boyfriend were spoken to. The car involved in the collision was examined by a mechanic. Dashcam footage from the car was seized and analysed.

7. From those sources of information, it appears that Ms TL had worked overnight on 3 June 2022. She slept all of Saturday morning and remained at home until about 2100 hours on 4 June 2022. She left home at about that time, in a car registered in her name. It was a 1986 Toyota Sedan with ACT registration plates.

8. Ms TL was first issued a learner drivers licence at the age of 15 years and 9 months. She had four years and two months driving experience at the time of the collision. She had held a C-class drivers licence since 28 August 2019, and a R class driver licence since 1 February 2021.

9. The dashcam footage and the associated audio allows Ms TL's movements to be reconstructed. That material provides insight into the potential lethality of a car driven contrary to the rules of the road, not according to weather conditions, and in excess of the capabilities of the car and its driver.

10. At around 2150 hours, Ms TL drove to the summit of Black Mountain and met a person, Mr AK, who was known to her. It is implied from the audio of the dashcam footage that they were both part of a small group who drove around suburban streets and reported their movements and observations to each other over their mobile phones.

11. Shortly after, Ms TL performed a circular burnout in her vehicle in the carpark of Telstra Tower. Ms TL then performed a lap of the carpark and another circular burnout before Ms TL and Mr AK both drove down from the summit of Black Mountain.

12. Ms TL and Mr AK descended from the Black Mountain summit to Clunies Ross Street in Acton. Both vehicles drove north on Clunies Ross Street for a short distance before turning on a roundabout to drive south of Clunies Ross Street. Ms TL's vehicle performed a number of side-to-side weaving patterns on the roadway before turning right, onto Black Mountain Drive, following in the direction of the vehicle driven by Mr AK.

13. Ms TL drove up Black Mountain Drive quickly. The car driven by Mr AK accelerated, opening a gap from the car driven by Ms TL. Ms TL attempted to close the gap along a stretch of Black Mountain Drive that has a number of corners that are challenging to

negotiate at speed. She almost lost control on a number of occasions. Ms TL was driving in excess of the posted speed of 60 km/h.

14. Near a driveway to a small building, approximately 830 metres from Clunies Ross Street, the car driven by Ms TL lost traction with the road surface. The rear of the vehicle slid out towards the right and collided with a mature eucalypt tree beside the roadway. At point of impact, Ms TL's car had rotated to the point where the driver's side was travelling forwards. The impact point of the tree on the car was slightly behind the driver's side B pillar of the vehicle, resulting in the lower structural frame of the vehicle being bent inwards into the vehicle cabin. As the frame bent inwards, the driver seat buckled and folded around the body of the deceased. The speed of her vehicle at the time of impact was estimated by the AFP to have been approximately 80 km/h.

15. As the collision occurred, the car driven by Mr AK continued towards the summit of Black Mountain. Mr AK saw Ms TL's car leave the roadway. He found a suitable location to turn and returned to the site of the collision.

16. He called 000 and requested that ACT Ambulance attend the scene. ACT Ambulance Service ("ACTAS") operations further requested ACT Fire and Rescue ("ACTFR") and ACT Policing ("ACTP") attend the location.

17. Although Ms TL was extricated from the vehicle expeditiously by ACTFR and taken to TCH under lights and sirens, her life could not be saved. No alcohol or drugs (other than caffeine) were found in her blood in the toxicological examination conducted in the post-mortem process.

18. The car driven by Ms TL was examined and found to be roadworthy with no indication that any mechanical or structural failure contributed to the collision.

19. Black Mountain Drive is an undivided road with a single lane in each direction. The roadway was sealed asphalt in reasonable repair. Several cracks and potholes were evident in the vicinity of the collision scene. The roadway at the location of the accident is unlit, and at the time long grass was growing at the edge of the sealed roadway in a number of locations. Metal roadside guard rails are present along several stretches of the roadway where steep off-road gradients are present.

20. I am satisfied that the physical state of the road did not contribute to the accident. I do note that at the time of the collision, weather conditions were cold (about 7 degrees Celsius) and windy. Low cloud was present with intermittent light rain tending to sleet. As a result, the roadway was wet where the accident occurred.

Post-Mortem Examination

21. At my direction, Professor Johan Duflou, forensic pathologist, conducted a post-mortem examination of Ms TL's body on 7 June 2022. The examination consisted of a CT scan, an external examination and toxicological testing. Professor Duflou found that a range of internal injuries and brain swelling caused Ms TL's death.

Prosecution of Mr AK

22. I did not refer Mr AK to the DPP pursuant to section 58 of the Act. Independently of that process, Mr AK was prosecuted for the aggravated offence of furious, reckless, dangerous driving pursuant to section 7(1)(a) of the *Road Transport (Safety and Traffic Management) Act 1999*. He was acquitted at a hearing.

23. I make no findings of fact relevant to Mr AK which are inconsistent with the outcome of those proceedings.

Decision To Dispense with a Hearing

24. Pursuant to section 34A of the Act and having considered the information provided to me by members of the Australian Federal Police and Professor Duflou, I was satisfied that the manner and cause of Ms TL's death were sufficiently disclosed, and, as such, a hearing was unnecessary.

25. I communicated my decision not to conduct a hearing and the reasons therefor to Ms TL's family on 11 September 2025. I provided them with a copy of my provisional findings and invited comment.

Formal Findings as to the Manner and Cause of Death

26. Having considered the evidence available to me and outlined at [6], I find that Ms TL died on 4 June 2022 at about 2310 hours at the Canberra Hospital, Garran ACT from multiple injuries sustained in a motor vehicle collision.

Findings In Respect of Matters of Public Safety

27. Matters of public safety did not arise from my inquest.

28. Notwithstanding the above, I have chosen to publish my findings as it is in the public interest to provide an accessible record of road accident deaths that occur in the ACT.

Condolences

29. I convey my sincere condolences to Ms TL's family. Her death has caused great grief and distress. She was a person of great capacities and her loss was deeply felt by all who knew her. Dying in a car crash is a tragic way for such a young person to die.

30. I apologise to the family for the delay in finalising my inquest.

I certify that the preceding thirty [30] numbered paragraphs are a true copy of the reasons for findings of his Honour Coroner Archer.

Associate: Jacqueline Du

Date: 5 November 2025