CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Matter Title:	**Inquest into the death of Laura Alice Kelly**
Citation:	**[2026] ACTCD 13**
Decision Date:	7 August 2026
Before:	Coroner Archer
Findings:	See [34-35]
Catchwords:	**CORONIAL LAW** – MANNER AND CAUSE OF DEATH – multiple injuries arising from an accident – E-Scooter rider struck by motor vehicle – driving through a red pedestrian light – absence of helmet – illicit substances detected – regulation of E-Scooters in the ACT – adequacy of regulatory scheme not considered
Legislation Cited:	*Coroners Act 1997* (ACT) ss 13, 34A, 52 *Road Transport (Road Rules) Regulation 2017 (*ACT*)* *Road Transport (Alcohol and Drugs) Act 1977 (*ACT*)*
File Number:	CD 278 of 2022

CORONER ARCHER:

INTRODUCTION

1. On 26 September 2022, Ms Laura Alice Kelly died at the Canberra Hospital ("TCH") after sustaining multiple injuries in an E-Scooter accident the day before on Drakeford Drive, Kambah, in the Australian Capital Territory ("ACT"). I will, with respect, refer to her as Laura in these findings. At the time of her death, Laura was 19 years old.

JURISDICTION

2. As Laura's death appeared to be, for the purposes of section 13(1)(g) of the *Coroners Act 1997* (ACT) ("the Act"), "directly attributable to an accident", it was reported to the ACT Coroner's Court on 26 September 2022.

3. Pursuant to section 13 of the Act, I am required to conduct an inquest into the manner and cause of Laura's death. Section 52 of the Act outlines the findings I am required to make:

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

4. I have chosen to publish my findings in this inquest as it is in the public interest to provide an accessible record of road accident deaths that occur in the ACT, so as to better facilitate consideration of road safety issues. Laura's death was the first road accident death in the ACT associated with the use of an E-Scooter.

BIOGRAPHICAL MATERIAL

5. Laura was described by her family as a dedicated family member, and a loyal and gentle friend. Her family spoke of her as a natural leader with an ability to positively influence those she encountered in life. She had recently obtained employment and moved into

new accommodation. I was told Laura loved riding her E-Scooter, which was one of her favourite things to do, along with listening to music.

EVIDENCE

6. In making the findings that follow, I have considered the following materials:

   (a) Police coronial report, dated 28 September 2022;

   (b) Post-mortem report, dated 4 October 2022, prepared by forensic pathologist, Professor Johan Duflou;

   (c) Mechanical Inspection report, dated 11 April 2023, prepared by the Australian Federal Police ("AFP") Vehicle Inspection Team; and

   (d) Collision Analysis, dated 16 April 2023, prepared by the Major Collision Team, ACT Policing.

CIRCUMSTANCES SURROUNDING LAURA'S DEATH

7. Just after 1500 hours on 26 September 2022, Laura was riding her E-Scooter along Jenke Circuit and O'Halloran Circuit in Kambah. She had visited Hungry Jacks and purchased food. She may have been riding home at the time of the accident, but this cannot be known.

8. Laura's movements were captured on a CCTV camera at a nearby service station from approximately 1506 hours. She was wearing all black and riding without a helmet. A large bag was hanging from the handlebars of the E-Scooter, and it was wound around the brake actuating mechanism. She may also have been using her left hand to control the bag. As a consequence, her ability to use the braking mechanism on the E-Scooter may have been compromised to an unknown extent.

9. At 1507 hours, Laura went outside the coverage of the CCTV camera, as she travelled east towards the crash scene.

The Collision

10. The following narrative of events arises from eyewitness accounts and the analysis of the collision undertaken by AFP investigators acting on my behalf.

11. At 1507 hours on 25 September 2022 Laura approached the intersection from the area of Namadgi School and proceeded to cross Drakeford Drive. At the time, the pedestrian signal facing Laura was red. The northbound traffic faced a green traffic light. Witnesses told investigators that at the time Laura rode onto Drakeford Drive there was a large

group of cars passing through the intersection north bound then a gap in the line of traffic followed by two cars including a silver Ford Falcon station wagon ("the Ford") driving in the lane nearest the point at which Laura entered onto Drakeford Drive. Her reasons for entering the line of traffic are unknown. Clearly, she did not see the Ford. She collided with the Ford near the headlight on the driver's side. The Ford did not slow after Laura came onto the carriageway, indicating the driver did not see her prior to the collision.

12. Eyewitness testimony was that the Ford was being driven at the posted speed limit of 80 kmh. The driver indicated to police that it was her usual practice to slow as she entered intersections to check for traffic.

13. Following the collision, the driver of the vehicle immediately stopped and ran to provide first aid to Laura.

14. An off-duty police officer in his private vehicle was stopped at the traffic lights at the intersections of Summerland Circuit and Drakeford Drive at the time of the collision. Arriving at the scene, he and other people began administering first aid to Laura and emergency services were promptly contacted. While waiting for the arrival of emergency services, a member of the public identified themselves as a doctor and further assisted in providing first aid to Laura.

15. At 1514 hours, ACT Ambulance paramedics arrive at the scene, followed by ACT Fire and Rescue. The paramedics reported Laura to be unresponsive and in a critical condition. At 1524 hours, she was transported to TCH.

16. She arrived at TCH at 1533 hours. CT imaging showed an unsurvivable head injury as well as other serious internal injuries. Her condition deteriorated overnight and despite treatment Laura died at 0940 hours on 26 September 2022

POLICE INVESTIGATION

17. Laura was riding a Ninebot E2 KickScooter, fitted with a 0.3kW electric motor. It has a speed limit of 25kmh in its factory state. No evidence of post-purchase modification was found during the mechanical inspection. The E-Scooter sustained contact damage to the lower rear frame, bending longitudinally towards the right. Inspection of the E-Scooter indicated that it was likely in good repair prior to the collision.

18. Eyewitness accounts indicate the Ford was travelling at approximately the posted speed limit of 80kmh when it entered the intersection.

19. The Ford sustained contact damage on its bonnet and side mirror on the driver's side. An inspection of the Ford revealed it to be in a roadworthy condition.

20. The weather on the afternoon of the collision was fine; no rain had fallen that day. There was scattered high altitude cloud cover. To that extent, and subject to what follows, there were no environmental factors that might explain the accident.

Drakeford Drive

21. Drakeford Drive is orientated primarily north-south in the vicinity of the collision scene. The roadway is a level, multi-lane divided arterial road comprising of three lanes northbound and three lanes southbound. The opposing lanes of traffic are divided by a large grass median strip.

22. The intersection at which the collision occurred is controlled by traffic lights fitted to each corner and the centre median traffic island. The traffic lights were observed to be functional by AFP officers on the afternoon of the collision. Additionally, the off-duty police officer present at the time of the collision confirmed that the traffic lights were functioning correctly.

23. Signage was installed close to the roadway for a COVID-19 testing facility on Jenke Circuit. It was hypothesised that the proximity of the sign to the roadway may have affected driver visibility on approach to the intersection. However, after a drive through inspection, with recreation of the conditions on 25 September 2022, the AFP analysis concluded it is unlikely that the sign in question obscured the drivers view of Laura approaching the roadway.

24. No tyre marks were observed in lane one where the Ford had driven, and it is highly likely that braking had not occurred prior to the collision.

25. The collision analysis conducted by an AFP expert calculated the speed of the Ford as being no less than 44 kmh and no more than 80 kmh at the time of the accident. Laura's dark clothing when taken with the environmental factors affecting her conspicuity (shadows, signage, light poles) may have affected the ability of the driver of the Ford to recognise Laura's presence as she approached the road. The opinion of the collision analyst was that the driver of the Ford could not have avoided colliding with Laura. I find no blame attaches to the driver of the Ford for the collision that occurred.

POST-MORTEM EXAMINATION

26. A post-mortem examination was conducted by Professor Duflou, on 4 October 2022. Professor Duflou identified that Laura's "injuries can be reasonably expected to be the result of a medium to high velocity motor vehicle collision". He formulated the cause of Laura's death as multiple injuries as sustained in the accident. Professor Duflou is of the

opinion that the presence of a helmet is unlikely to have mitigated Laura's head injuries to the degree required to give her a chance of surviving the impact with the Ford.

27. Laura's ante-mortem blood was sampled for toxicological testing. Results revealed the presence of methamphetamine (0.56 mg/L) and amphetamine (0.12 mg/L) (a breakdown product of methamphetamine), as well as the presence of cannabis (43 ng/ml). At the measured levels, these substances are likely to have had an intoxicating effect (and perhaps a very profound intoxicating effect) impairing her ability to control the E-Scooter and may have also affected her capacity to accurately discern breaks in traffic flow and to appropriately assess risks associated with crossing Drakeford Drive.

PUBLIC SAFETY ISSUES - E-SCOOTERS

28. This was the first instance of an E-Scooter-related death in the ACT.

29. In the circumstances of this case, a consideration of the adequacy of the regulatory regime applying to E-Scooters does not arise. There was nothing about the inherent characteristics of the E-Scooter Laura was riding that contributed to the accident.

30. In the ACT, E-Scooters are regulated under the *Road Transport (Road Rules) Regulation 2017 (*ACT*)* and the *Road Transport (Alcohol and Drugs) Act 1977 (*ACT*)*. These laws classify E-Scooters as personal mobility devices and set out rules for their safe use. Riders must stay off roads where footpaths or shared paths are available, keep left, give way to pedestrians, and avoid riding against traffic. Speed limits apply as follows: 25 kmh on shared paths, 15 kmh on footpaths, and 10 kmh at crossings. Riders must wear an approved helmet, cannot carry passengers, and must not use mobile phones while riding. E-Scooters must have a bell or warning device, and lights and reflectors when riding at night. Riders must maintain control, exercise care, and comply with age restrictions for children under 12. It is also an offence to ride while impaired by alcohol or drugs. E-Scooter riders, like all people who have control of a vehicle such as a motorcycle, motorcar or pushbike, have a responsibility to comply with any applicable road rule and exercise due care and attention.

31. Here, Laura's manner of riding, the absence of a helmet and her level of intoxication obviously involved breaches of some of these limitations and prohibitions

DECISION TO DISPENSE WITH A HEARING

32. Having considered the evidence gathered during the inquest, I was satisfied that the manner and cause of death were sufficiently disclosed, and, as such, a hearing was unnecessary. That preliminary view was discussed with Laura's mother and then communicated to her in writing. A copy of my provisional findings was sent with that

correspondence with an invitation to comment on them. In light of the family's response, a detailed traffic accident report relevant to Laura's death was sent to Laura's mother to assist in her understanding of what had happened.

33. The findings I have made have been settled in light of the family's response to the Court's correspondence. Laura's family indicated to me that they did not consider that the circumstances of Laura's death needed to be the subject of a public hearing.

FORMAL FINDINGS

34. For the purposes of section 52(1) of the Act, I find:

> That, Laura Alice Kelly died at the Canberra Hospital on 26 September 2022 as a result of multiple injuries sustained in a motor vehicle collision whilst riding her E-Scooter on Drakeford Drive, in the Australian Capital Territory.

35. I do not find any matter of public safety to arise in connection with the inquest into death in respect of which comments should be made.

POSTSCRIPT AND CONDOLENCES

36. I extend my sincere condolences to Laura's family. Her death has caused great grief and distress. Laura was a person of great capacities, and her loss was deeply felt by all who knew her.

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

I certify that the preceding thirty-seven [37] numbered paragraphs are a true copy of the Findings of his Honour Coroner Archer.

Associate: Ella Mansfield

Date: 7 August 2026