

CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title: Inquest into the death of KT

Citation: [2026] ACTCD 9

Decision Date: 19 June 2026

Before: Coroner K J Archer

Findings: See [29 -32]

Catchwords: **CORONIAL LAW** – MANNER AND CAUSE OF DEATH – Road accident – single vehicle – multiple injuries – detachment of utility tray from vehicle – findings as to manner and cause of death – decision not to conduct a hearing – publication of findings to establish a record of road related deaths

Legislation Cited: *Coroners Act 1997* (ACT) ss 13, 34A, 52 and 58

File Number: CD 311 of 2022

CORONER ARCHER:

Introduction

1. On 22 October 2022, at approximately 22:00 hours, a driver in the ACT, referred to throughout these findings as KT, died in a single motor vehicle accident on Maribyrnong Avenue, Kaleen in the Australian Capital Territory (“ACT”). There were no passengers in the vehicle. At the time of his death, KT was 24 years old.
2. The deceased died at the scene from multiple serious injuries sustained in the accident.
3. The vehicle he was driving was a 2009 Nissan Navara cab chassis with a tray.
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.
5. I have referred my report to the Commonwealth Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts, as the relevant federal agency responsible for administration of road vehicle safety legislation.

Jurisdiction

6. KT’s death was reported to the ACT Coroner’s Court on 23 October 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”.
7. I was required to hold an inquest¹ into the manner and cause of the death and make findings that are required by section 52 of the Act. That section of the Act relevantly provides:

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.

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

Evidence

8. On my behalf, the Australian Federal Police (“AFP”) conducted an investigation of the circumstances of this death. The accident scene was examined, and the road was assessed for issues that may have contributed to the accident. A mechanical inspection of the vehicle was conducted and a report produced by a qualified technician. CCTV footage was obtained from residential security cameras with coverage of the accident site. Police spoke with the deceased’s family and with several witnesses to the accident.

Circumstances surrounding KT’s death

Context

9. The deceased was born in Canberra, as one of four children. At the time of the crash, the vehicle was registered in the ACT, and the deceased held a current ACT driver’s license.
10. On the evening of 22 October 2022, the deceased went to a friend’s house in Lawson, ACT. There were a number of people there and the deceased consumed some alcohol. During the evening, it is likely that he also consumed cocaine. Some members of the group decided they would go out and meet at an entertainment venue in the inner north of Canberra. The deceased was seen to quickly consume a number of vodka-based drinks immediately before he departed in his car.
11. The chosen route took him in the northeast direction along Maribyrnong Avenue in Kaleen. The crash occurred at approximately 21:58 hours. The location of the crash was just southwest of the roundabout where Maribyrnong Avenue intersects with Ellenborough Street. At the point of the collision, the road gently bends towards the left.

The Collision

12. The AFP obtained CCTV footage from a nearby house that faced onto the street. That footage showed the car immediately before the crash, albeit slightly obstructed by the trees lining the street.
13. Based on an analysis of the footage and a measurement of the area, the estimated speed of the car before it left the road surface was approximately 109 km/h. Following the crash, the speedometer was inspected and displayed a reading of 105 km/h.
14. The car was most probably under acceleration immediately before it failed to steer around the slight bend in the road. At this point it is likely that the deceased lost control of his vehicle. The car travelled approximately 15 metres across the southwest-bound lane and nature strip, crashing into a tree on the opposite side of the road. The impact was on the driver’s side of the car.

15. During the collision, the tray of the utility separated from the vehicle at its fixed points and struck KT. He was thrown from the car.
16. KT suffered very severe injuries. Nearby residents who had heard the crash and pedestrians who were passing by rushed to the scene and were at his side within seconds. Despite their interventions, including attempted cardiopulmonary resuscitation ("CPR") by a passerby who happened to be a nurse, he died at the scene.
17. The car sustained severe damage. The driver's side door and the roof were torn from the vehicle. The driver's side seatbelt had sheared away from the car but was still inserted into the buckle, indicating it had been worn at time of the crash. The airbags were deployed.
18. Emergency services were contacted by members of the public who encountered the collision scene immediately after it occurred. ACT Ambulance Service, ACT Fire and Rescue, and the AFP all attended at about 22:06 hours.
19. A number of opened and unopened cans of vodka mixed drinks were found near the vehicle. His mobile phone was also found nearby. An analysis of the phone suggested that KT had been using it while driving and that it had been in call mode at, or very close to, the time of the accident.
20. At about 00:50 hours on 23 October 2022, a Forensic Medical Officer attended the scene, conducted an examination of the deceased and pronounced life to be extinct.

Post-mortem

21. At my direction, forensic pathologist Dr Sanjiv Jain conducted a post-mortem examination of the deceased on 26 October 2022. The post-mortem examination included an external examination and blood samples taken for toxicological analysis.
22. Toxicological analysis of post-mortem blood detected concentrations of 0.1mg/L of methylenedioxymethamphetamine ("MDMA"), 0.1mg/L of cocaine, and 0.179g/100mL of ethyl alcohol in KT's system. Caffeine and nicotine were also detected.
23. The direct cause of death given by the forensic pathologist was multiple serious injuries due to the motor vehicle accident.

Mechanical inspection

24. Mechanical Inspector Robert Nicholas, employed by the AFP, conducted a mechanical examination of the vehicle. Given the severity of injury caused to the deceased by the utility tray, I directed that consideration be specifically given to the detachment of the tray from the vehicle

25. Mr Nicholas' report states:

The aluminium tray was determined to have separated from the vehicle as a direct consequence of the dynamic forces generated by the vehicle's speed at the time of the incident. Inspection of the mounting points and fastenings showed no sign of fatigue, corrosion, or pre-existing mechanical defects that could have contributed to failure. The mode of detachment is consistent with impact and velocity-induced loading, where inertial forces exceeded the structural capacity of the tray's attachment system, resulting in a rapid shear and tensile overload of the connection points. ...

The damage profile, including tearing of the tray supports and deformation patterns, aligns with the failure under sudden kinetic energy transfer rather than progressive mechanical degradation. Based on these observations, the separation is attributed to speed related loading conditions, and not to an underlying mechanical issue or material deficiency in the tray assembly.

26. There were no other indications that the vehicle otherwise suffered any mechanical or structural failure that may have contributed to the collision.

Road conditions at the time of the accident

27. Maribyrnong Avenue is a road comprising of two traffic lanes, with a kerb and gutter on each side. The road consists of a resealed surface with the retro-reflective pavement markers, signage and centre line marking. The traffic lanes are approximately 4.8 metres wide, with total carriageway width of approximately 9.6 metres. The posted speed limit is 60 km/h.

28. The weather at the time was lightly raining. At the time of the accident, the road was wet with surface water but in good repair. Streetlights were operational at the time and location of the accident.

Findings pursuant to Section 52

29. Pursuant to section 52 of the Act I find that KT died on 22 October 2022 of multiple injuries sustained in a motor vehicle accident that occurred on Maribyrnong Avenue, Kaleen in the Australian Capital Territory.

30. I do not find a matter of public safety arises from the deaths. However, I refer my findings to the Commonwealth Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts for consideration of the relevance of any safety issues that they may consider arising from the detachment of the tray from the utility vehicle.

Postscript

31. I express my condolences to the family of the deceased. KT's death was an unspeakable tragedy.
32. I apologise to the family for the delay in finalising my inquest.

I certify that the preceding thirty-two [32] numbered paragraphs are a true copy of the Decision of His Honour Coroner Archer

Associate: Ella Mansfield

Date: 19 June 2026