IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 3858

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, CAITLIN ENGLISH, Coroner having investigated the death of Andrew Ngo

without holding an inquest:
find that the identity of the deceased was Andrew Ngo
born on 4 April 1992
and the death occurred on 13 September 2012
at the northbound railway pedestrian crossing between St Albans and Ginifer Railway Stations
from:

1 (a) BLUNT FORCE TRAUMA TO THE HEAD (TRAIN IMPACT)

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Andrew Ngo was 20 years of age at the time of his death. Mr Ngo resided at 4 Palace Court, Kingspark with his family, namely his parents and siblings, Linda and Alex. Mr Ngo was completing a hairdresser's course at the time of his death.[1]
2. A police investigation was conducted into the circumstances of his death.
3. A brief prepared by Victoria Police for the coroner includes statements from Mr Ngo's mother and girlfriend, the train driver and investigating officers. The brief also contains a report of an investigation conducted by Metro Trains Melbourne. I have drawn on all this material as to the factual matters in this finding.

[1] Coronial Brief, Page 7.

Background and circumstances

4. Mr Ngo's mother, Ms Binh Truong, stated Mr Ngo was completing a hairdresser's course but he was ultimately hoping to utilise his personal training certificate. She described him as *'happy with life.'*[2] Aside from asthma, Mr Ngo's mother stated he did not have any other medical issues. His mother stated:

'Andrew took good care of himself and his health. He went to a few gymnasiums to keep fit. He won awards for athletics [,] he loved sport and that is why he did his personal training certificate.'

5. Mr Ngo's girlfriend, Jenny Do, also described him as *'happy.'*[3]

6. The last time Mr Ngo's mother saw her son alive was on 12 September 2012 when she drove him to St Albans railway station, as he was going to a dentist's appointment. She last spoke to him at 3.05pm on the 13 September 2012. She stated that it was a normal conversation and that Mr Ngo had said he would be home around 6pm after going to his girlfriend's house.

7. On Thursday 13 September 2012 at approximately 4.00pm, Ms Do called Mr Ngo and invited him to her house and he replied that he would come over.

8. At approximately 5.02pm, Mr Ngo was crossing at a designated pedestrian crossing between Ginifer and St Albans Railway Stations.

9. Mr Ngo started to cross the northbound train tracks, but appears to not have seen or heard the southbound train and as a result was struck by the train causing major trauma to the back of his head.

10. Train driver David Massie stated that *'[a]s I was in the vicinity of the crossing I noticed a male person of Asian appearance on the Down track on my right. The person crossed with their head down and I did not see the male look up or react. I then yelled and heard a very loud thump as the front left side of the train struck the male. It all*

[2] Ibid, Page 8.

[3] Coronial Brief, Page 10.

happened so quickly that I did not have time to sound the whistle and I believe I applied the emergency brake at the time of the collision.'[4]

11. In accordance with practice in such circumstances, Mr Massie underwent a preliminary breath test and the result was negative for alcohol.

12. Mr Ngo's mobile phone was located near his feet. Police obtained the phone records of Mr Ngo, which showed the last use of his phone to be a text message, which was read around the same time that Mr Ngo was hit by the train.

13. Toxicology results indicated the presence of approximately 14 ng/mL of Delta-9-tetrahydrocannabinol in Mr Ngo's blood.

14. Mr Ngo's family and girlfriend were unaware of his cannabis use.

Post Mortem Examination

15. A post mortem examination was conducted by Forensic Pathologist Dr Malcolm Dodd at the Victorian Institute of Forensic Medicine on 14 September 2012. Dr Dodd formulated the cause of death, blunt force trauma to the head (train impact). I accept his opinion.

Metro Train Melbourne investigation

16. An incident investigation was conducted into the accident by investigator Alan Scott of the Office of Health Safety Environment, & Quality at Metro Trains Melbourne.

17. His report describes the crossing as follows:

'The pedestrian crossing crosses the tracks south-west to north-east and leads from Willis street on the south-west to St Albans Road to the north-east...

The crossing is a passive type with a 'U' (mazed) shaped entry/exit point. The construction of the crossing fence attempts to encourage pedestrians [to] look north-west and south-east along the track prior to entering the track area. Railway signage posted at the crossing advises that there are two tracks and to look both ways and for cyclists to dismount...

The pathways leading to the pedestrian crossing are paved in asphalt and the words 'WAIT HERE' are stencilled in yellow on the pavement of the crib crossing immediately prior to

[4] Coronial Brief, Page 6.

the tracks. The fence posts at the same location are also painted yellow. The view along the tracks in both directions from the crossing is not obscured...

...Trees line the fence outside the rail reserve and run along the length of this fence and do not restrict the view of pedestrians. "[5]

18. A 'passive' pedestrian crossing is the opposite of 'active'. An active pedestrian crossing has pedestrian gates and audible tones that operate for the passage of trains. Mr Scott in his report has recommended the crossing be made active through the implementation of such measures. Mr Scott has advised the Coroners Court of Victoria that as at 28 August 2014, the crossing has not been upgraded.

FINDING

Victoria Police reported no suspicious circumstances. I am satisfied having considered all of the evidence before me that no further investigation is required.

I find Mr Ngo died when he was struck by a train whilst attempting to cross at a pedestrian crossing in circumstances where he failed to notice the train and he was distracted by his mobile phone.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. I recommend that consideration be given to making the Willis Street, St Albans pedestrian crossing active through the provision of pedestrian gates and audible tones that operate to warn pedestrians of the passage of trains.
2. I commend rail authorities for their current education programs, and recommend they continue to remind pedestrians of the dangers of the rail track environment and in particular the danger to pedestrians of distraction from electronic devices which may impede the ability to perceive or identify that a train is approaching.

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

Ms Binh Thuc Truong
The Secretary, Department of Transport, Planning and Local Infrastructure (Victoria)

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[5] Metro Trains Melbourne Investigation Report, Page 5.

Mr Laurie Lacorcia, Manager Investigations Metro Trains Melbourne

Sergeant Laura Dess

Signature:

CAITLIN ENGLISH
CORONER
Date: 28 August 2014