IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 001486

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: CHRISTOPHER CLOUGH

Delivered On:	27 November 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	20 August 2013
Findings of:	K.M.W. PARKINSON, CORONER
Place of death/Suspected death:	Railway Tracks, Moore Mews, Pakenham, Victoria, 3810.
PCSU Assisting:	Leading Senior Constable Ross Treverton

I, KIM M. W. PARKINSON, Coroner having investigated the death of CHRISTOPHER CLOUGH

AND having held an inquest in relation to this death on 20 August 2013

at MELBOURNE

find that the identity of the deceased was CHRISTOPHER CLOUGH

born on 17 October 1985

and the death occurred on 26 April 2012

at Railway Tracks, Moore Mews, Pakenham, Victoria 3810.

from:

1A. INJURIES SUSTAINED WHEN STRUCK BY A TRAIN (PEDESTRIAN)

in the following circumstances:

1. A summary inquest was conducted into the death of Mr Christopher Clough on 20 August 2013.

2. A brief of evidence was prepared for the Coroner by Senior Constable Legaie of Victoria Police at Pakenham setting out police investigations. The brief also included comprehensive reports of investigations undertaken by Metro Trains Manager of Investigations, Mr Laurie Lacorcia. I have drawn on all of this material as to the factual matters in this finding. The investigating member gave evidence in the proceeding.

3. Mr Christopher Clough was 26 years old at the time of his death. He resided with his mother, Ms Helen Belton, his stepfather and brothers at Pakenham and had done so since September 2011. He was father to two children by his former partner Ms Melinda Moyle.

4. Christopher was studying to be a personal trainer at the Berwick Chisholm TAFE with a view to establishing a business and was involved in playing and refereeing basketball at the YMCA Fitness Centre in Pakenham. He was committed to his fitness and engaged in weight training and regularly cycled from his home to Cardinia Train Station.

5. His mother stated that Christopher had no previous drug or alcohol abuse history and that he had not exhibited any sign of illicit drug or substance use.

6. Shortly before his death, Christopher had participated in the Tough Mudder Competition on Phillip Island and received a letter informing him that he had finished in the top five per cent of competing athletes. He was reported to have been very pleased with this result as it enabled him to compete in the United States. He was also training to compete in the same competition in Sydney.

7. Christopher had no history of depressive illness and there is no evidence to suggest that he had ever considered or discussed self-harm. His mother reported that to her knowledge he did not see a regular general medical practitioner or counsellor.

8. Whilst Christopher had recent involvement with the criminal justice system and was due to appear at the Magistrates' Court and at the County Court on 18 May and 19 June 2012 respectively, the evidence is that he was making significant progress in his personal life and that he was emotionally prepared for the proceedings. Christopher was also subject to an intervention order and had not seen his children since May 2011. He was however making arrangements for visitation through a mediator.

9. His mother reports that he was positively approaching all aspects of his life and was looking forward to a successful future. In the days prior to his death Christopher is reported to have been engaged in his usual routine of study, attendance at TAFE, fitness training and social activities with family members and his girlfriend.

10. On Thursday 26 April 2012, his mother describes that he was at home with a slight cold, but in good spirits and studying for a forthcoming exam. She last spoke to Christopher at approximately 4.15 p.m. when she went to his room where he was still studying. She was aware that he was due to referee a basketball match at the Casey YMCA stadium in Pakenham that evening.

11. At approximately 6.00 p.m., Christopher said goodbye to his younger brother, Joshua, saying he would see him later and left the house to go to the basketball match. At the time he was wearing black tracksuit pants, black and white referee shirt, and white Nike runners.

THE COLLISION

12. At approximately 6.45 p.m., the leading carriage of the 6:41 p.m. Pakenham to Flinders Street train was travelling generally west when it struck a male person running westbound along the left shoulder of the city bound railway track. The collision occurred approximately 1.2 kilometres east of the Cardinia Road Railway Station. At about the time of the collision an outbound train travelling east was also approaching the site of the collision.

13. The train driver, Mr Muir reports that he observed the headlights of an outbound train departing Cardinia Railway Station. He dipped his headlights to low beam in accordance with published procedure for approaching trains.

14. The trains were almost level, when as he was about to switch back to high beam, he observed a man running in the same direction as the train was travelling. The man was running with his back to the train. The driver observed that the man was not running on the track, but to the left of the left side rail of the train track. The driver observed that the runner was still close enough to be hit by the train because the side of the train protrudes approximately two feet outside the rails on both sides of the track.

15. The train driver had not been able to see the runner until he was approximately 10 - 15 metres away and his ability to see was likely affected by the low beam headlights of the train and by the oncoming train. The train driver applied the emergency brakes as soon as he observed the person on the track. He did not have time to sound the train whistle prior to the collision, due to the speed of the incident. He reports hearing the sound of impact and that the train came to a stop approximately 400 metres from the point of impact.

16. The train TD4064 was a Comeng type comprised of six carriages. The train was fitted with a datalogger device. Also present in the driver's cabin at the time of the incident was a trainee driver, Ms Jacqueline Cox who had been under instruction during the course of the shift. Ms Cox confirmed the matters set out in the statement of the driver Mr Muir. The train driver contacted Metro Train Control. Emergency services and paramedics attended, however Christopher had suffered catastrophic injuries and was deceased at the scene.

17. A post mortem examination was undertaken by Forensic Pathologist Dr Mathew Lynch of the Victorian Institute of Forensic Medicine. Dr Lynch reported that the cause of death was Injuries Sustained when Struck by a Train. A toxicological examination detected diazepam at therapeutic levels and was negative for alcohol and other common drugs and poisons.

THE LOCATION OF THE TRAIN TRACKS

18. Metro Trains Investigations Manager, Mr Lacorcia, reported that the track at the location is raised by a mound of ballast approximately one metre above the surrounding rail reserve.

19. He reported that the tracks are located centrally on the approximately 30 metre wide rail reserve with the city bound track positioned north of that axis. The rail reserve is covered in short grass and fenced on both sides. The rear fences of domestic dwellings line the northern boundary of the rail reserve and the southern boundary is separated from the rail reserve by a wire strand fence approximately 1 metre in height.

20. Mr Lacorcia stated that the train driver's view directly west along the tracks is unobstructed for several hundred metres and that a pedestrian's view east and west to approaching trains is unobstructed.

21. The train was driven by an experienced train driver, who is also an instructor of trainee drivers. The evidence is that the train brakes were functioning normally and the train was operated as required and was travelling within the speed limit of 115kph for that section of track. The train Data-logger recorded that the train was travelling at approximately 86kph when the emergency brakes were applied and brought the train to a stand in approximately 338 metres.

22. Mr Lacorcia stated that:

> "The train came to a stand approximately 352.5m past the point of collision. This indicates the train brakes were applied when the front of the train was approximately 14m past the point of collision. As there is a slight time delay between movement of the brake handle and application of brakes, I consider it likely that the brakes were applied about the point of collision. The Datalogger braking information is consistent with the visibility estimates provided by both the train driver and the trainee driver. The visibility estimates provided by the drivers is fairly consistent

with the illumination provided by the train headlights and the average expected human reaction time of approximately 1 to 1.5 seconds".

23. A preliminary breath test administered at the scene was negative. It is appropriate to comment that there was no action the instructor train driver could have taken which may have avoided the collision.

24. Mr Lacorcia identified a number of factors, which may have been significant in the collision. I agree with the investigator as to these matters. They were:

- That Christopher was on the rail reserve without authority when he ran along the track shoulder inside the danger zone. The evidence is that there are no authorised pedestrian crossing points at the incident location.

- That approximately 25 metres east of the area collision is a drainage culvert that runs underneath both the outbound and city-bound tracks. The rail investigator observed that the culvert is built at right angles to the tracks and effectively divides the otherwise flat grass covered land of the rail reserve. The culvert is sufficiently wide enough to impede pedestrian travel east and west along the rail reserve. He concluded that Christopher may have entered upon the rail track at this point to avoid the culvert. He also reported that the grassy area of the rail reserve was sodden due to recent rains, which may have caused him to choose to run on the more firm and comparatively drier rail track.

- Christopher was wearing dark coloured clothing and was carrying a dark coloured backpack that did not assist the train driver to discern his presence on the otherwise unlit track.

- Christopher had his back to the city-bound train and while likely preoccupied by the train approaching from the west he remained visually and aurally unaware of the train approaching behind from the east.

- The investigator noted that a pair of bud style earphones were connected to an iPhone which was in Christopher's right pocket. The evidence is that one of the earphones was located in Christopher's ear. His mother also reports that his phone indicated that he was listening to music at or around the time of the collision.

- The train drivers adjusted their headlight position in accordance with operating procedures. The investigator reported that the Comeng train's low beam headlamps provided effective illumination over approximately 40-50 metres of track. A train travelling at 86kph travels approximately 23.8 metres per second. This indicates that the headlight illumination would provide approximately 2 seconds visual warning to the train diver of an obstruction ahead.

- The supervising instructor driver and the trainee train driver reported that they became aware of the male person running trackside at about the same moment. The emergency brakes were applied but the train horn was not sounded as there was insufficient time to react. The train brake handle and the horn handle are both operated by the train driver's left hand.

- The glare from the headlights of the outbound train approaching in the opposite direction made it more difficult for Mr Muir to discern the dark figure running west along the track shoulder.

- The investigator observed that the glare from the outbound train would likely have affected Christopher in a similar way by bathing the tracks in light so that he did not notice any increase in ambient light as the city-bound train approached him from behind.

25. Rail authorities were reported to have been undertaking culvert works at the site in recent times. Family members indicated at the inquest that they were concerned to establish whether these works were in response to the circumstances of the collision and related to preventative measures, such as preventing or disabling access to the railway tracks.

26. In response to inquiries made by the Coroner's assistant, the train operator has reported that the works were longstanding scheduled works and resulted from the Cardinia Road Rail Station development and to accommodate infrastructure needs of a shopping complex in the immediate vicinity.[1] They have advised that the works did not occur in response to the collision involving Christopher.

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[1] Statement of Mr Lacorcia dated 8 October 2013 regarding inquiries made in response to request from the Coroner.

27. Christopher may have been utilising the track to avoid the access obstruction to the other section of reserve, caused by the culvert. The area was fenced and he made his way onto the tracks despite the fencing and the culvert.

28. There is no evidence to suggest that Christopher made any attempt to avoid impact and it appears that he was unaware that train approaching from behind.

FINDINGS

29. I find that Christopher Clough died on 26 April 2012 as a result of multiple injuries sustained when as a pedestrian he was struck by a train.

30. Although the timing of the death was proximate to his pending court appearances and he was experiencing some difficulties relating to access to his children, the evidence does not support a finding that these matters were troubling Christopher to such an extent that they may have caused him to deliberately take his own life.

31. I find that Christopher was positioned on the edge of the rail track in such a manner that he was struck by the overhang of the train as the train passed.

32. I am satisfied that Christopher was unaware of the approaching train as a result of the use of bud style earphones which prevented him from receiving any aural warning of the approaching train.

33. It is likely that as a result of running and his positioning on the side of the track, Christopher would not have experienced any underfoot vibration which may have alerted him to the train approaching from behind. A further distraction may have been the oncoming train and attention to its presence rather than awareness of the train approaching from behind.

34. I find that the death was accidental and occurred on a rail track area not designed or designated for pedestrian access.

35. I am satisfied that there was no infrastructure deficiency which may have caused or contributed to the collision.

36. I am satisfied that there were no operational or unusual environmental factors, which caused or contributed to the collision.

37. I find that no other person or organisation caused or contributed to the death.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

1. In this case, Christopher was not running or walking on the rail line itself, but rather on the rail track reserve directly abutting the rail line. It appears that he was not conscious of the risk of being struck by the overhang of a train travelling on the track.

2. It is acknowledged that it is a dangerous practice to cross or walk along rail track reserve not earmarked for pedestrian use. However, experience has shown that for whatever reason people underestimate or ignore the danger of accessing rail track reserve, including train lines. It is therefore necessary for authorities to continue to remind pedestrians of the danger, particularly as access is often relatively easy to obtain.

3. Pedestrians need to remain vigilant and observant when crossing or accessing rail track or rail reserve at any location, and particularly when their capacity to hear approaching train may be impeded by the use of earphones.

RECOMMENDATIONS

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

1. That rail authorities consider the development of a campaign similar to that developed by Tram operators to remind pedestrians about dangers of rail track environs and in particular, the danger to pedestrians of distraction from earphones and other devices which may impede the ability to perceive or identify that a train is approaching.

2. I direct that a copy of these findings and recommendations be provided to:

   The family of Mr Christopher Clough;

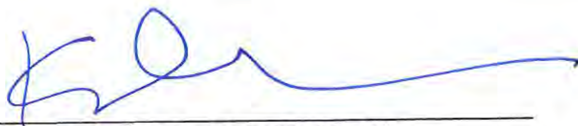
   The Interested Parties;

   The Secretary, Department of Transport (Victoria);

   Mr Laurie Lacoria, Manager Investigations Metro Trains; and

   The Investigating Member of Victoria Police.

Signature:



CORONER K. M.W. PARKINSON
Date: 27 November 2013