IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 002512

FINDING INTO DEATH WITHOUT INQUEST

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

I, ROSEMARY CARLIN, Coroner having investigated the death of DEAN WATT
without holding an inquest:
find that the identity of the deceased was DEAN WATT
born on 18 December 1993
and the death occurred on 28 June 2012
at Railway tracks between Carrum and Seaford Railway Stations, Victoria

from:

1a. MULTIPLE INJURIES SUSTAINED IN COLLISION WITH TRAIN (PEDESTRIAN)

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

1. Mr Dean Watt was born on 18 December 1993 and he was 18 years old at the time of his death. Dean lived in Carrum Downs with his family. He is survived by his parents and brother. At the time of his death, Dean undertook part-time work hand-sanding floors.

2. A brief prepared by Victoria Police for the Coroner includes statements obtained from Dean's father, his treating clinician and from investigating officers. The brief also includes a report upon the results of extensive investigations undertaken by Safety Investigator, Mr Paul Downes, of the rail operator Metro Trains. I have drawn on all of this material as to the factual matters in this finding.

BACKGROUND AND CIRCUMSTANCES

3. Dean was born in Scotland and attended school there until he located to Australia with his family in June 2003. Dean completed his primary schooling in Australia and commenced secondary education, before leaving to commence further studies and work.

4. Dean had a history of substance abuse including magic mushrooms and cannabis. His treating clinician, Psychiatrist Dr Ranee Richards reported that Dean suffered from drug induced psychosis. Dean had spent time at mental health care facilities within hospitals where he received treatment. He also received treatment from mental health care teams following his discharge from hospital.

5. Dean was prescribed the anti-psychotic, Risperidone. Dean's father reported that Dean's mental health had improved in the period preceding his death and that his treating clinician had discussed lowering his medication as he had been doing well.

6. On Thursday 28 June 2012, Dean had cooked dinner for his family. He did not work that day and also had the following day off. Following dinner, Dean's family sat in the living room and watched TV. It is reported that Dean entered the living room and remarked that he was bored, before sitting down with his family for a while. Dean then proceeded to his brother's room where they talked and watched a movie together.

7. Following the movie, Dean proceeded to his own room to sleep. It is reported that his mother went to his room and discussed dinner plans for the following night. She left Dean some grocery money, as he was intending on preparing dinner for the family. Dean's parents then proceeded to their bedroom to sleep.

8. At approximately 11.45 p.m., Dean was seen walking south on the railway tracks between Carrum and Seaford station. He was walking in the middle of the track with his hooded jumper covering his head. Dean was walking with his back against the southbound trains, when he was struck by a train and died as a result of multiple injuries.

9. Police located Dean's mobile phone and earphones near the track, indicating that he may have been listening to music at the time of the collision and consequently unable to hear the approaching train.

THE COLLISION

10. The rail investigator Mr Paul Downes reported that at approximately 11.45 p.m. on Thursday 28 June 2012, the leading carriage of the Flinders Street to Frankston train, TD4519, was travelling generally south, between Carrum and Seaford railway stations, when it struck a person approximately 70 metres south of the Armstrongs Road level crossing between Carrum and Seaford railway stations.

11. The train driver, Mr Christopher Vaz, was appropriately qualified and medically fit to operate an electric train and he has stated that the train brakes and whistles were operating normally. He reported that as he drew closer to the level crossing he observed a blue object on the track approximately 140-200m distant, but was unable to discern what the object was. He travelled a short distance and realised that it was a person wearing dark clothing walking along the outbound rail track with his back to the approaching train.

12. Mr Vaz applied the emergency train brakes and sounded the train whistle continuously. The train continued under emergency braking for approximately 400 metres before coming to a stand. Despite efforts of the train driver to stop the train, impact was made and Dean died instantly, having suffered catastrophic injuries.

13. Mr Downes reported that according to GPS calculated speed data, the train was operated at a speed of approximately 92 kph immediately prior to the application of the emergency brakes. The general maximum line speed for trains travelling between Carrum and Seaford is 95 kph.

FINDING

14. An inspection and report was undertaken by Dr Jacqueline Lee, Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Lee reported the cause of death as Multiple Injuries Sustained in Collision with Train (Pedestrian).

15. Toxicological analysis of post-mortem samples was negative for alcohol. The anti-psychotic medication, Risperidone was detected in blood at 13ng/mL.

16. It is appropriate to comment that the train driver took all steps reasonably possible to avoid the collision and that there was nothing that he could have done to prevent the collision. The speed of the train was within the prevailing track speed of 95 kph. The emergency brakes were applied appropriately and performed as designed. All equipment including the train brakes and whistles were in proper working order. There were no other environmental factors which may have caused or contributed to the collision.

17. Although Dean struggled with a history of psychosis, the evidence does not support a finding that he was suicidal. Dean's father reported that Dean was working and made future plans including attempts to secure full time employment and discussing plans for his birthday. He was in good spirits, spending time with his family and contributing to household duties. I am satisfied that the death was accidental.

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

19. I find that Mr Dean Watt died on 28 June 2012 and that his death was caused by multiple injuries sustained in collision with train (pedestrian).

COMMENTS

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

1. It is acknowledged that it is a dangerous practice to cross or walk along rail track reserves not earmarked for pedestrian use. However, experience has shown that for whatever reason people underestimate or ignore the danger of accessing rail track reserves, 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.

2. Pedestrians need to remain vigilant and observant when crossing or accessing rail tracks or rail reserves 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.

This is the same recommendation that was made in a finding delivered on 27 November 2013 in respect of another investigation into a similar death.

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

The family of Mr Dean Watt;
Interested Parties;
The Secretary, Department of Transport, Planning and Local Infrastructure (Victoria);
Mr Laurie Lacorcia, Manager Investigations Metro Trains; and
Investigating Member, Victoria Police.

Signature:

ROSEMARY CARLIN
CORONER
Date: 22 January 2014