

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 0307

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

I, PETER WHITE, Coroner having investigated the death of JAMES EMMET WILKINSON without holding an inquest:

find that the identity of the deceased was JAMES EMMET WILKINSON

born on 5 April 1993

and the death occurred on 24 January 2012

at Caulfield Railway Station, Caulfield, Victoria

from:

1 (a) ELECTROCUTION IN A TRAIN SURFING INCIDENT

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

1. James Emmet Wilkinson (herein referred to as James), was an 18 year old man who lived with his parents and two siblings. In 2011, he began working towards a carpentry apprenticeship. He was known by his friends as the life of the party.
2. On 24 January 2012, James went to a friend's 18th birthday party in Carnegie. James and a group of friends were drinking alcohol and James was described as being intoxicated. At approximately 10pm, James and his friends left the party and walked down to Carnegie train station. They waited for the next city bound train.
3. At approximately 10.48pm the train arrived at the station. As the train pulled in to the station, James decided to jump on to the metal platform between carriages three and four that link the carriages. His friend also jumped onto the metal platform. James then said that he was going to climb on to the train's roof. As the train departed the station, he climbed onto the roof and told his friend to join him. James then continued on along the roof.
4. As the train approached Caulfield station, James came into contact with the pantograph on top of the train. The pantograph connects to the overhead powerlines and was live with electricity. On approach to the platform, a Metro staff member signalled to the driver to

stop. The train driver lowered the train's pantographs immediately. One of James' friends climbed onto the top of the train to assist, as did another passenger. Emergency services attended promptly however James had passed away.

5. Senior Pathologist Dr Michael Burke of the Victorian Institute of Forensic Medicine performed a post mortem medical inspection. Dr Burke noted that external examination showed severe electrical burns consistent with the circumstances reported to him by the police. Toxicology analysis showed an alcohol concentration of 0.20g/100mL. Dr Burke concluded that the cause of James' death was 1(a) electrocution in a train surfing incident. I adopt Dr Burke's findings in relation to the cause of death.

Coronial investigation

6. As part of my mandate as coroner that I am able to explore whether any lessons can be learnt that might prevent similar deaths in the future.
7. This prevention role is one of two parallel functions of the modern coronial system. The first involves the findings that I must make under the *Coroners Act 2008* (Vic), which requires, if possible, that I find the:
 - identity of the person who has died
 - cause of death (and for our purposes this usually refers to the medical cause of the death) and
 - circumstances surrounding the death.
8. James' identity and cause of death are not in issue. It is the investigation I am permitted to conduct surrounding the circumstances of a death that gives rise to my ability to consider broader issues of public health and safety. These considerations form the second parallel purpose of a coronial investigation into a death. This purpose has been enshrined in the Preamble of the *Coroners Act 2008* (Vic), which sets out that the role of the coroner should be:
 - a. to contribute to the reduction of the number of preventable deaths and
 - b. promote public health and safety and the administration of justice.
9. I therefore requested that the Coroners Prevention Unit conduct an investigation into adolescent risk taking behaviour. As part of that investigation I requested a report from Dr Bridie Scott-Parker, Research Fellow at the University of the Sunshine Coast Accident Research Centre who has expertise in the area of youth risk taking behaviours. Dr Scott-Parker provided the Court with a summary of factors involved with youth risk taking behaviours. I attach a copy of that report as Annexure A.
10. As Dr Scott-Parker identified, adolescent risk-taking behaviour is a part of growing up, but the degree of risk taking can be along the spectrum of low to extreme and the types of risk vary, for example from drink driving, train surfing, unsafe sex, cigarette smoking and drug use. Adolescents see many of the behaviours as not being associated with risks, which complicates the situation.
11. The development of evidence-based and effective programs aimed at adolescents and their parents specific to risk-taking behaviours that does not medicalise but educate and mentor safe behaviours, is still in the stages of development and evaluation.

Finding

12. I find that James Emmet Wilkinson died as a result of electrocution while train surfing in the above circumstances.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that this finding be published on the internet.

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

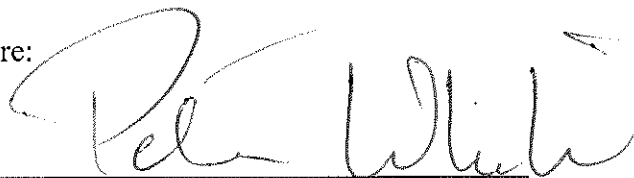
Mr Timothy Wilkinson, senior next of kin

Mr Laurie Lacorcchia, Metro Trains

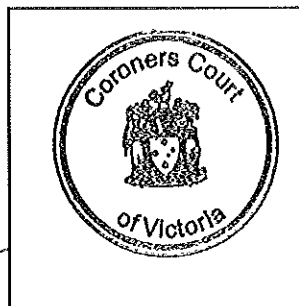
Mr Peter Coats, Minter Ellison on behalf of the Department of Transport

Senior Constable David Ingram, investigating member

Signature:



PETER WHITE
CORONER
Date: 25 August 2014



Adolescent risk taking – who, what and why?

Adolescence and risk-taking behaviour often go hand-to-hand. Risk-taking behaviour can include smoking, drinking alcohol and using illicit drugs; unprotected sex; risky driving and passenger behaviour; tattoos and piercings; truancy, delinquency and vandalism; and train-surfing. Risk-taking behaviours are of concern because of the considerable potential for the adolescent to incur injury – both in the short- and the long-term, temporarily and permanently, and of minor or major severity including death.

There are a number of reasons why adolescents engage in risk-taking behaviour.

Firstly, while adolescents may *look* like an adult, and indeed they may *think* they are adults, they *do not* have an 'adult brain'. Two brain networks are important to consider in adolescent risk-taking. The socio-emotional network is highly attuned to stimuli that are social (eg., friends) and emotional (eg., rewards that feel good), and this network develops in early adolescence in response to pubertal hormone changes. The cognitive-control network looks after planning, self-regulation and self-control, and develops gradually into young adulthood. These two networks have important implications for adolescent risk-taking, particularly as the areas of the brain that process and respond to sensation seeking and rewards are fully developed before the areas of the brain that regulate behaviour¹⁻⁴.

Secondly, the adolescent is carving out their *identity* – who they are, and by extension, who they are not, away from parents. Adolescents report tattoos express their self-identity, whilst adults view these tattoos as deviant⁵. Moreover, 'fitting in' to the friendship group is very important for the adolescent, and *peers* can be models of, and inspirations for a variety of risk-taking behaviours and attitudes⁶ such as permanent body ink. Risk-taking behaviour may not be seen as risky; rather it may be seen as just a normal element of the peer group who provide a social meaning to the risk taking⁸. Simply having peers around increases the salience of the rewards associated with risk-taking behaviours¹⁻⁴, and having a strong attachment to peers has been found to encourage risk-taking⁷.

Thirdly, parents are important. The *family structure* has been found to influence adolescent risk-taking, such that two-parent families, well-educated parents, and, relatedly, higher socioeconomic status, can be protective⁶⁻⁷. In contrast, single-parent families have been found to be associated with more spending money for the adolescent, which increases the risks of earlier sexual experiences for adolescents of both genders, and more sexual partners for boys in particular⁹. The *family processes*, that is, parenting behaviour, can also be protective. Parents model acceptable behaviours¹⁰, and adolescents who report that (a) their parents monitor their behaviours^{6,11}, (b) they have a good parent-adolescent relationship⁷, and (c) they have good parent-adolescent communication⁶, report less risk-taking¹¹.

Fourthly, the *school* environment is also important. Positive attitudes towards school are associated with less risk-taking. Interestingly, in cases of low parental attachment, school attachment can actually reduce risk-taking. Perhaps unsurprisingly, low parent attachment and low school attachment has been found to be associated with increased risk-taking⁷.

Fifthly the *individual themselves* is important. Some adolescents simply have a personality that is geared towards risk-taking, whilst other adolescents are attuned to avoiding risks; for example, adolescents with Conduct Disorder have been found to engage in a variety of risk-taking behaviours¹². Adolescents with higher levels of religiosity are less likely to engage in risk-taking behaviour, whilst adolescents with higher levels of psychological distress (such as depression, anxiety, and suicidal ideation) and lower levels of self-esteem are more likely to engage in risk-taking behaviour⁶. Importantly, engaging in one risk-taking behaviour can lead to engagement in other risk-taking behaviours. For example, risky sexual behaviours has been found to be associated with delinquency⁶ and drinking alcohol or using illicit drugs^{6,10}. In addition, adolescents with tattoos and/or body piercings also have been found to engage in other risk-taking behaviours like illicit drug use and risky sexual behaviour¹³.

References

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