IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 4274

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the ***Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of MICHAEL SEAN DALY

without holding an inquest:

find that the identity of the deceased was MICHAEL SEAN DALY

born 6 November 1993

and the death occurred on 22 August 2015

on the railway line, approximately 1013m northwest of Berwick Railway Station, Berwick Victoria 3806

from:

1 (a) INJURIES SUSTAINED WHEN STRUCK BY TRAIN

Pursuant to section 67(1) of the **Coroners Act 2008,** I make findings with respect to **the following circumstances**:

1. Michael Sean Daly was 21 years of age at the time of his death. He lived in Rosebud with his father and worked at a McDonald's restaurant. Mr Daly was in good health and had not been known to attend a doctor or fill prescriptions for medication in several years.

2. At approximately 3.59pm on Saturday 22 August 2015, the driver of the 3.05pm Flinders Street to Pakenham train TD4047 observed a male walking east, seven metres from the track on her left, between Narre Warren and Berwick Railway Stations. The male was only wearing a white top, with no pants or shoes on; his face was expressionless and quite blank. The driver

slowed the train and contacted the Metrol[1] radio controller, providing a location of about 200-300m on the upside (west) of Berwick Railway Station. At 4.01pm, the Metrol radio controller informed all drivers on the Pakenham railway line of the sighting of a trespasser, providing the location given by the reporting train driver.

3. The driver of the 3.53pm Pakenham to Flinders Street train TD4652 heard the Metrol radio controller's line call announcement while parked at Pakenham Railway Station, but the sound was distorted and unclear. He understood the message that there was a trespasser in the vicinity of Berwick Station and subsequently approached that station at a reduced speed.

4. At 4.10pm, the TD4652 train departed Berwick Railway Station, heading west towards Narre Warren Railway Station. The conditions were dry and there was good visibility. The driver accelerated to a speed of approximately 40kph, keeping an eye out for the trespasser. As the driver reached the Clyde Road level crossing and received a proceed aspect, meaning he could go to line speed, he considered he had passed the area of danger. After the crossing, there was a left curve with a 90kph speed limit and the driver accelerated to approximately 85kph. The driver was unable to see any trespassers as the train travelled around the curve. He checked the rear of the train using mirrors. When the driver looked ahead, at 4.11pm he saw a male come running from the left hand side of the tracks to stand in front of the train, 10 feet ahead. The male appeared to be dancing, and had both hands raised in the air. The driver hit the emergency brakes and sounded the train's whistle but was unable to avoid a collision, and struck the male approximately 1013m northwest of Berwick Railway Station. The driver radioed Metrol at 4.13pm. Metrol contacted emergency services.

5. Victoria Police, Metro Trains Melbourne, State Emergency Services, Country Fire Authority and Ambulance Victoria staff attended the scene of the collision. It was apparent that Mr Daly was deceased. The train driver was subject to a preliminary breath test and returned a negative reading for the presence of alcohol.

INVESTIGATIONS

6. By way of Form 8 pursuant to section 24 of the *Coroners Act 2008*, dated 26 August 2015, circumstantial evidence and deoxyribonucleic acid (DNA) comparison were used to determine the identity of the deceased was Michael Sean Daly.

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[1] Metrol oversees the operation of the Melbourne electrified metropolitan rail network.

Forensic pathology investigation

7. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Mr Daly, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury. Toxicological analysis of post mortem blood detected lysergic acid diethylamide.[2] On the evidence available to him, Dr Lynch ascribed the cause of Mr Daly's death to injuries sustained when struck by a train.

Police investigation

8. Upon attending the site of the collision, Victoria Police did not identify any signs of third party involvement or locate any 'suicide note'. No wallet or any other form of identification were located. Narre Warren police received information from Mr Daly's friend, James Brown at 11.00pm on 22 August 2015. Mr Brown told police that Mr Daly had last been seen at a residence on Sweeney Drive, Narre Warren shortly before 2.00pm that day. Police conducted checks on the Law Enforcement Assistance Program (LEAP) database, which helped them to subsequently contact Mr Daly's father, Ross Daly.

9. First Constable (F/C) Claire Macaulay, the nominated coroner's investigator,[3] conducted an investigation of the circumstances surrounding Mr Daly's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mr Daly's father Ross Daly, friends and acquaintances James Brown, Sean Webb, Mitchell Tucker, Cale Tucker, a witness, and both train drivers.

10. In the course of their investigation, police learned that Mr Daly had no known history of suicidal ideation or mental health issues requiring medical intervention. Police obtained Medicare and Pharmaceutical Benefit Scheme information, which suggested Mr Daly had not consulted a registered medical practitioner or been prescribed medication between 1 December 2010 and his death. Ross Daly reported that his son was happy and in good health; he went to

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[2] Lysergic acid diethylamide (LSD) is an indole derivative. The d-isomer is one of the most potent hallucinogenic agents known.

[3] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

the gym every night and ate healthily. The last time he remembered Mr Daly seeing a doctor was at the age of eight. Ross Daly stated that Mr Daly did not suffer from depression, but experienced anxiety at normal levels. He described his son as motivated and as someone who maintained friendships and strived to improve himself. Mr Daly's friend and colleague, James Brown reported that he was never afraid to pitch in and help at work, and would come in to help on his days off and stay around hours after he finished work. Another friend Sean Webb reported that Mr Daly openly admitted to him that he had anxiety.

11. According to his father, Mr Daly drank alcohol occasionally and binged every couple of weeks but it did not agree with him. Ross Daly also reported that he used 'cream chargers' (nitrous oxide) in the past, but not recently. Mr Brown reported that Mr Daly did not often consume alcohol; they drank together socially quite a few times, but he cut back considerably in the last few months because he was on a strict diet. The only drug Mr Brown had known Mr Daly to take was LSD from time to time. He did not use it as a 'party drug' but more as a way to explore different theories in the world. Mr Daly had disclosed past cannabis use to Mr Webb.

12. When Mr Daly was three years of age, his mother took her own life. Ross Daly reported that he first spoke openly with his son about his mother's death when he was about ten years old. Mr Daly had not appeared to need formal counselling. In 2009, Mr Daly's school friend took his own life, and the school suggested he undergo counselling. Ross Daly had not held concerns in relation to his son at this time.

13. Mr Brown reported that when he discussed the issue of suicide, Mr Daly expressed the opinion that suicide was horrible, something nobody should ever do. He liked the idea of 'RU OK Day' and believed suicide only led to suffering for the people left behind. Mr Brown stated that he firmly believed Mr Daly did not intend to take his own life. Mr Webb agreed that Mr Daly was opposed to suicide and believed self-harm was stupid. Mr Webb also believed that Mr Daly did not intentionally take his own life.

14. Ross Daly last saw Mr Daly on Thursday 20 August 2015. He observed that his son was sort of himself, but a bit anxious. Mr Daly had four days off work and told his father that he was going to a house warming in Langwarrin or Narre Warren, and not to worry. He said he would be home by Tuesday 25 August 2015 at the latest, because he had work on Wednesday.

15. On 21 August 2015, Mr Daly went to the Pancake Parlour at Fountain Gate Shopping Centre with a number of friends. Sean Webb reported that Mr Daly seemed happy and his usual self.

They left the Pancake Parlour and returned to Mr Webb's home in Sweeney Drive, Narre Warren, and Mr Daly stayed there overnight.

16. Mr Webb reported that on the morning of 22 August 2015, Mr Daly and a number of friends returned to Fountain Gate Shopping Centre to purchase alcohol and food. Mr Webb had organised a housewarming party and they returned to his house at about 12.00pm. The group started drinking alcohol and Mr Webb observed that Mr Daly consumed some of the UDL Vodka cans with them. Mr Webb observed that Mr Daly was a little withdrawn from the group of people present and was not talking very much. However, Mr Webb believed this was due to the fact he did not really know the other people and he was usually a little withdrawn in large groups. At the housewarming party, Mr Daly was wearing a white singlet and black running shorts.

17. According to Mr Webb, at approximately 12.30pm, Mr Daly told the group that he was in possession of five LSD drug tabs. He said he bought them off the 'Silk Road' website and received them in the mail. Mr Webb took one and did not see Mr Daly take one, but was told he took it by putting it on his tongue. After they took the LSD, Mr Daly was lying on his swag, looking at the wall and the ceiling. Mr Webb asked if he was okay and Mr Daly replied 'yes'. They continued drinking the UDL and Mr Webb estimated that Mr Daly drank three cans.

18. Between 2.00pm and 2.30pm, Mr Daly left the house, leaving behind his phone and wallet. Mr Webb reported that when they noticed Mr Daly was missing, the group searched the street for him but could not locate him. More people arrived for the party. Mr Webb contacted their friend James Brown who was in Rosebud, and was informed he had not seen Mr Daly, but was going to come and look for him. At 7.00pm, Mr Brown told Mr Webb he planned to report Mr Daly missing to police.

19. Between 3.30pm and 4.10pm, a witness who was a passenger in a car travelling along the Monash Freeway saw a person walking east along the middle of the up track of the Pakenham railway line, between Narre Warren and Berwick Railway Stations. The witness and two family members drove over to the railway line to investigate. They saw a train cross the Clyde Road level crossing, travelling towards Narre Warren Railway Station, before coming to a stop.

20. Closed-circuit television (CCTV) footage captured from the rear of the nearby Insight Education Centre indicated that Mr Daly was aware of and facing the oncoming train, but did not make any attempt to move out of its path prior to the collision.

21. Mr Webb reported that he located Mr Daly's wallet following his death. It contained one more LSD tab, and three Circadin 2mg[4] prolonged release tablets in a blister pack.

Metro Trains Melbourne investigation

22. Alan Scott, an Investigator at Metro Trains Melbourne (MTM), provided an incident investigation report to F/C Macaulay by letter dated 13 January 2016.

23. The report noted that following the Metrol radio controller's line call to drivers on the Pakenham line at 4.01pm, the radio controller called the line controller at 4.02pm to inform him of the trespasser and the line call. This call ended at 4.03pm. The line controller provided information to the effect that he would usually call the first train due through the area if the radio controller did not. However, in these circumstances there was a situation unfolding on the Craigieburn Line involving a possibly unconscious person, and as the line call had been made, he decided to deal with that issue first. He did not call the TD4652 driver before the collision occurred. The line controller stated that he also did not have an opportunity to inform the senior controller of the trespasser. The senior controller reported that he was not aware of a trespasser in the area at any time.

24. The report referred to the document L2-SWS-PRO-009, 'Dealing with an Incident or Condition Affecting the Safety of the Network', a governance document issued by MTM's Safety Environment and Risk department. *Inter alia*, the document stipulates that in the event of an incident, such as a trespasser on or near the line, if a worker becomes aware of the incident which will or may potentially affect the safe operation of the Metro Network, the matter must immediately be reported to the train controller at Metrol. In turn, the document requires that upon becoming aware of the incident, the train controller must take all reasonable steps to ensure all drivers approaching or travelling through the area are advised of the incident or condition. If necessary, this entails arranging to prevent rail traffic from approaching the affected portion of the line and if the incident involves rock throwers or trespassers, informing Victoria Police and Metro Authorised Officers.

[4] Circadin is a prescription only medication - it contains melatonin and is used to treat insomnia.

25. The report indicated that non-documented Metrol work practices provide that upon the report of a trespasser, Metrol will warn the train drivers to proceed through the section of track under extreme caution and then report back to Metrol with their observations. Dependent upon what is reported by train drivers, further action is taken.[5]

26. Investigator Scott opined that the train driver involved in the collision reasonably determined that he passed the area of danger based upon the information provided by Metrol and his understanding of that information. His actions in checking the rear of the train via the mirror as he traversed the curve were in line with driver audit requirements.

27. Investigator Scott was satisfied that the train driver that reported a trespasser on the line satisfied her requirements under L2-TSD-PRO-025 by informing Metrol of the trespasser. However, using Vigilance, Control and Event Recording System (VICERS) data, he calculated that she misreported the location of Mr Daly by approximately 800 to 900 metres.

28. Investigator Scott noted that a period of approximately 11 minutes passed between the conclusion of the first driver's report to Metrol of a trespasser at 4.00pm, and the application of the incident driver's emergency brake at 4.11pm. It was possible that the location of the trespasser would have altered during this period.

29. Following the incident investigation, Investigator Scott opined that the incident train driver could not have avoided the collision, and was operating under the maximum line speed of 115kph and the speed curve restriction of 95kph when it occurred. Investigator Scott noted that it was possible that the reporting train driver had misreported the location of the trespasser by providing her current location to Metrol, rather than where she first sighted the trespasser.

30. In addition, Investigator Scott noted that MTM procedures do not specify when Victoria Police are to be called in relation to trespassers. Train controllers use additional information from train drivers operating through a section of track at extreme caution where a trespasser has been reported to determine a cause of action. Police were not immediately contacted in relation to the report by the train driver who reported sighting Mr Daly. Investigator Scott was unable to speculate whether, had the police been contacted and provided these details, they would have been able to apprehend Mr Daly prior to the incident.

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[5] Extreme caution is defined as being able to stop the train in half the distance that can be seen ahead, not exceeding 25kph or the posted track speed if that is lesser.

31. At the conclusion of the report, Investigator Scott made a number of recommendations to clarify and expand upon the existing work instructions and improve information available to train controllers, recommending that:

    a. document L2-SWS-PRO-009, 'Dealing with an Incident or Condition Affecting the Safety of the Network' be reviewed. Investigator Scott noted that the process of reviewing this document was underway.

    b. consideration be given that additional training be provided to train controllers to give them a better understanding of route knowledge and that relevant training modules be reviewed for consistency. This recommendation was made in light of Investigator Scott's observation that train controllers did not appear to have detailed route knowledge of areas under their control. He noted that a training packing in relation to route knowledge was currently under development for use at Metrol.

32. Investigator Scott also noted that train controllers could not identify the exact location of trains in certain areas. He added that there are natural limitations on the ability to know with certainty where a train was at any given observation of a trespasser. MTM had previously identified the need to look into Global Positioning Systems (GPS) on trains, so as to allow for coordinates of trains to be accessed quickly and accurately.

33. Investigator Scott added that the information in relation to Mr Daly was broadcast to train drivers according to procedures, but suggested that some of the communication may have been a distraction to the safety critical nature of the initial report. Investigator Scott suggested that MTM considered a review in the current communication procedures and conduct additional audits to ensure adherence to policies.

Correspondence from Metro Trains Melbourne

34. I sought further information from MTM, in relation to the action taken in response to Investigator Scott's recommendations. By way of letter dated 4 May 2016, Senior Litigator and Commercial Solicitor Rohan Barton provided information to the Court. Mr Barton reported that MTM was actioning all of Investigator Scott's recommendations.

35. In particular, Mr Barton noted that the L2-SWS-PRO-009 document was being reviewed and a new procedure was now in the latter stages of development. In addition, extra training was

being provided to train controllers to improve their route knowledge: train controllers would now travel 'in-cab' to unfamiliar locations and receive 'in cab' training to enhance route knowledge, and route knowledge videos were being developed for specific lines. Mr Barton also reported that MTM have submitted a proposal to Public Transport Victoria (PTV) for the development phase of a project for GPS on trains, to allow for coordinates of trains to be accessed quickly and accurately. The project was subject to funding and approval by PTV. Mr Barton wrote that training has been provided to all train controllers in relation to current communication procedures, and communication audits are being conducted on train controller communications. A project plan was being developed to review and improve safety critical communications, including the monitoring and auditing of quality of radio communications.

COMMENTS

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

1. I acknowledge that the Metro Trains Melbourne employees appear to have complied with procedural requirements in the circumstances surrounding Mr Daly's death. However, I note that the evidence indicates that 11 minutes elapsed between the conclusion of the first driver's report to Metrol of a trespasser at 4.00pm, and the collision involving Mr Daly at 4.11pm. While I acknowledge that a line call was made by Metrol to train drivers at 4.01pm, it is unfortunate that more could not be achieved in this window of time to minimise risk. I concur with Investigator Scott's opinion that it cannot be known whether police would have been capable of apprehending Mr Daly prior to the incident, if they had been informed of the details provided by the reporting train driver of a trespasser. I note that the Metro Trains Melbourne documentation uses the phrase 'if necessary' in relation to calling police in the event of a trespasser. However, given that Mr Daly was reported to be in a state of undress, it would have been reasonable to assume that some form of police intervention was required in the circumstances. I note that the line controller was distracted by an unfolding contemporaneous incident on the Craigieburn Line, which prevented him from contacting the driver of the TD4652 train. Again, it is impossible to speculate as to whether the making of this call would have prevented the outcome, as the driver sped up after believing he had left the area where Mr Daly was seen.

2. I acknowledge and welcome the efforts made by Metro Trains Melbourne to implement the recommendations made by Investigator Scott. I note that in the circumstances surrounding Mr Daly's death, the inability of the reporting train driver to rely on GPS coordinates to give an

accurate report of his location, meant that the driver of the incident train was relying on information that the trespasser was 200-300m west of Berwick Station, whereas the collision occurred approximately 1013m from the station. The GPS project awaiting funding by Public Transport Victoria will hopefully serve to ameliorate responses to like events in the future. Enhanced training for train controllers in relation to route knowledge should also serve to improve the response of Metrol to incidents of trespass.

RECOMMENDATIONS

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

1. The evidence suggests that the availability of a Global Positioning System (GPS) would have enabled the provision of more accurate information about Mr Daly's location on 22 August 2015, which may have in turn altered the outcome. With a view to avoiding like deaths, supporting train drivers and providing precise location coordinates at any one time, **I recommend** that Public Transport Victoria both accept, and provide the requested funding for, the Metro Trains Melbourne GPS proposal.

FINDINGS

The investigation has failed to elucidate any evidence that Mr Daly was suffering from significant physical or mental health issues in the lead up to his death. I note that Mr Daly does not appear to have consulted with the medical profession in a number of years. Moreover, Mr Daly's father and friends have indicated that he was a motivated, intelligent and hard-working young man who exhibited some degree of social anxiety. I note Mr Daly's familial history of suicide, but in the circumstances I am unable to find that he intended to take his own life. Rather, it appears that Mr Daly was under the influence of lysergic acid diethylamide (LSD), to the extent that he was incapable of forming such an intention, when he placed himself in front of a train on 22 August 2015.

I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that Michael Sean Daly died from injuries sustained when struck by a train.

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

Mr Ross Daly

Office of the Chief Psychiatrist

Ms Kym Peake, Secretary of the Victorian Department of Health and Human Services

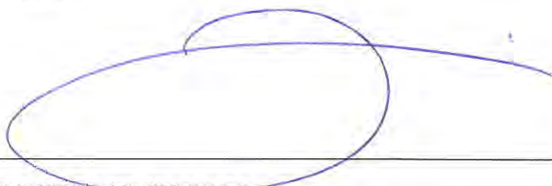
Ms Louise Johnson, Department of Economic Development, Jobs, Transport and Resources

Ms Elizabeth Muhlebach, Transport Safety Victoria

Todd Bentley, General Manager – Safety, Environment & Risk, Metro Trains Melbourne

First Constable Claire Macaulay

Signature:



AUDREY JAMIESON

CORONER

Date: **28 June 2016**