IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 3808/10

FINDING INTO DEATH WITHOUT INQUEST

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

I, K. M. W. PARKINSON, Coroner having investigated the death of WARREN MARKS without holding an inquest:
find that the identity of the deceased was WARREN JOSEPH MARKS
born on 24 February 1982
and the death occurred on 2 October 2010
at Clifton Hill Train Station, Clifton Hill, Victoria 3068

from:

1a. MULITPLE INJURIES – STRUCK BY A TRAIN

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

1. Mr Warren Joseph Marks was 28 years old at the time of his death. He was born on 24 February 1982. He is survived by his defacto partner, Ms Margaret Bamblett and his extended family.

2. Leading Senior Constable Gregory Ryan of Victoria Police Transit Safety Division provided a comprehensive brief of evidence to the Coroner dated 11 April 2011, which included an extensive incident report of investigations conducted by Metro Trains Limited Senior Safety Investigator, Mr Paul Downes. I have relied upon that material in my investigations and finding in this matter.

3. Mr Marks resided at Mill Park with his partner, Ms Margaret Bamblett. He had no history of self harm or psychiatric illness and irregularly attended upon the Aboriginal Health Service for routine health care matters. He had a significant alcohol addiction. Mr Marks had

sustained a significant injury to both of his ankles as a result of a fall in 2009. The injury had resulted in surgery and pins being inserted. As a consequence his agility was constrained.

4. On 2 October 2010, at approximately 6.40pm, Mr Marks, Ms Bamblett and his cousin Mr Philip Hayes, left a residential address at Rutland Street, Clifton Hill. They had spent the day watching the AFL Grand Final Replay and had consumed significant amounts of alcohol. They walked in a northerly direction along Rutland Street to Roseneath Street, with the intention of entering the Clifton Hill Railway Station at Hoddle Street. They were intending to travel on the outbound Epping line train service to Ms Bamblett's residential address in Thomastown.

5. Ms Bamblett and Mr Hayes continued to walk along Roseneath Street underneath the rail bridge which crossed the street. However, after an argument, Mr Marks separated himself from the group and continued walking in a northerly direction along a sealed service road, located to the east of the bridge. Ms Bamblett and Mr Hayes called for him to stop, however he continued along the road and increased his pace up the service road.

6. The service road runs North/South off Roseneath Street for a distance of approximately 100 metres, where it leads to the Metro Trains Signals Maintenance Depot at Clifton Hill. At this location there is a cleared flat area of land which runs across to the duplicate inbound and outbound rail tracks of the Clifton Hill rail segment. Police report that the area is not lit and there is minimal internal security lighting emitting from the rail yard adjoining the land. They also report that pedestrians are able to continue walking north on the land reserve on the east side alongside the railway tracks. There is a worn dirt track on the land reserve, which indicated to police that it was used as a short cut to the railway station.

7. Ms Bamblett and Mr Hayes report that they then observed Mr Marks to move onto the east in bound track of the dual rail line. They became aware of an approaching train and yelled at him in an attempt to warn him of the danger. Mr Marks was crossing the tracks on a diagonal and may have been unaware of the approaching train.

8. Mr Marks was struck by the 6.55pm Flinders Street to Hurstbridge train at approximately 7.02pm. The train was a Comeng type comprising six carriages. At the time of the collision there was also another train approaching on the inbound track from the direction of the Clifton Hill Railway Station. That train driver observed that there appeared to be another train

stationary along the track and proceeded slowly. The driver of the inbound train was not involved in the collision, however stopped to render assistance.

9. The train driver, Mr Alan Turner, a train driver of 34 years experience, reports that the journey had been uneventful and that the train was driving normally with brakes and whistles operating as required. He reports that it was dark, however visibility was clear in the train headlights. Track conditions were dry, it was not raining and there was no fog or mist.

10. Mr Turner states that he was travelling over the railway bridge to approach the Ramsden Street level crossing when he observed a flash of a person running into the train headlights. He observed Mr Marks running at an angle to the track and forward in the same direction as the train. Mr Marks was a short distance from the train, approximately 5 to 6 metres when he was first able to be seen by the train driver.

11. The driver immediately applied the emergency brake. He then heard the train impact with Mr Marks. There was no time for the driver to sound the whistle. He reports that the train came to a stop approximately two carriage lengths down the track.

12. The driver then notified emergency services and exited the train to see if he could render assistance. Mr Marks had sustained catastrophic injuries and died shortly after the collision at the scene.

13. Mr Paul Downes, Senior Railway Investigator, reports that the train data log files were analysed and indicated that the train was travelling at a speed of approximately 41 kph, when at 19:02:43 the emergency brakes were applied and the train came to a stand approximately 73.2 metres further north. Inspections revealed that the train headlamps were in the low beam position and that the train braked within expected performance limits. Mr Downs reports that the designated speed for that section of track was 55 kph. He states that the driver made a typical approach to the crossing.

14. Mr Downes reports there was no authorised pedestrian crossing at the location of the collision and no authority to access the rail reserve beside the tracks or the railway line. The driver's cabin of the Comeng train is partially divided about its centre by a floor to ceiling equipment case that abuts the leading bulkhead and windscreen. Mr Downes reports that the wall of switches to the driver's immediate right obscures his vision forward and laterally to that area before the right front quarter of the leading carriage. He reports that this, along with other factors, would account for the driver seeing Mr Marks only a moment before the collision. Mr

Downes also reports shadow over track at sunset as a result of high buildings at the boundary of the rail reserve and Mr Marks dark clothing would likely have impeded his visibility to the driver.

15. Railway investigators and police report that as Mr Marks had approached the north/south tracks on a northwest diagonal, he was likely facing away from the train and possibly unaware of its approach.

16. I am satisfied that the driver was operating within the designated speed limit for that section of track and that the emergency brakes were applied as soon as the driver observed Mr Marks. I am satisfied that the train was operationally sound and that there were no deficiencies in braking or other emergency operations. Whilst visibility from the train was momentarily limited as a result of the matters outlined by Mr Downes, that limitation was in the context of Mr Marks being on the railway track at an unauthorised location.

17. An inspection and report was undertaken by Dr Paul Bedford, Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Bedford reported that the CT scan revealed extensive lower leg injuries, skull fracture and mandible fracture. He reported that there was extensive destruction of the lower limbs. Dr Bedford stated that he commented that a reasonable medical cause of death was multiple injuries due to impact by train.

18. I note that the train driver involved in the collision and the other attending train driver, were understandably traumatised by this incident. It is appropriate to comment that the train driver responded appropriately in emergency braking and that there was nothing he could have done to prevent the collision.

19. The speed of the train was within the prevailing track speed and that the brakes were applied and operated as designed. The evidence of the driver is that the equipment, including the train brakes, were in proper working order. A preliminary breath test was administered to the driver and was negative.

20. There is no evidence to suggest that Mr Marks intentionally took his own life. Whilst he may have engaged in an argument with his friends shortly prior to the incident, it was a minor dispute and there is no evidence to satisfy me that he deliberately placed himself in the path of the train.

21. Toxicological analysis of post-mortem samples identified significant levels of ethanol (alcohol) at 0.27g/100mL. This level of alcohol intoxication would likely have impeded Mr Marks capacity to recognise and to respond to the approaching train. This factor together with his physical limitations likely contributed to his inability to identify or avoid the approaching train.

22. Victoria Police report no suspicious circumstances. I am satisfied having considered all of the evidence before me that no further investigation is required. I am satisfied that death was accidental.

23. I find that Mr Warren Marks died on 2 October 2010 and that his death was caused by multiple injuries as a result of multiple injuries he sustained when struck by a train.

Comments:

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

1. The railway investigator and police report that the area of land above the embankment on the eastern side of the railway reserve shows evidence of regular pedestrian trespass. Railway Investigator Downes stated that the indications are that pedestrians use the rail reserve and maintenance access roadway between the Ramsden and Roseneath Streets as a short cut. This is apparently the course taken by Mr Marks on the evening of the incident.

2. Whilst there is no doubt that Mr Marks level of intoxication was the most significant contributing factor to his death, the identification of regular pedestrian use at a location in such close proximity to a busy commuter railway station suggests that additional fencing measures are warranted.

3. Mr Downes states that consideration should be given to erecting a fence along the boundary between the maintenance access road and the rail reserve between Ramsden and Roseneath Streets to restrict pedestrian access and that assessment should be made of the need to reinforce the existing fence at the site, where the western side of the rail reserve meets Roseneath Street.

4. I agree that this would be an appropriate matter for the responsible authority to address in view of the evidence that the access made by Mr Marks was not an isolated event.

Recommendations:

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

1. That the responsible rail authorities erect a fence along the boundary between the maintenance access road and the rail reserve between Ramsden and Roseneath Street to restrict pedestrian access to the rail track.

2. That an assessment be made of the need to reinforce the existing fence at the site where the western side of the rail reserve meets Roseneath Street.

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

The family; Interested Parties; The investigating Member, Transit Safety Division Victoria Police; Mr Paul Downes, Rail Safety Investigator, Metro Trains Limited.

Signature:

K. M. W. PARKINSON
CORONER
23 April 2012