IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004069

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

I, Coroner David Ryan, having investigated the death of Mr LM[1] (**LM**) and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008* (**the Act**):

a) the identity of the deceased was LM, born 8 April 1945;

b) the death occurred on 21 July 2022 at a railway pedestrian crossing adjacent to the intersection of Smeaton Avenue and Railway Crescent, Dallas, Victoria (Smeaton Avenue Pedestrian Crossing), from injuries sustained when struck by a train; and

c) the death occurred in the circumstances detailed below.

Circumstances in which the death occurred

1. LM was 77 years old at the time of his death and lived alone in Broadmeadows. He is warmly remembered by family as a hardworking and kind man who was an enthusiastic supporter of the Collingwood Football Club.

2. LM had long suffered from an untreated herniated disc in his back that required fusion. Otherwise, he was not diagnosed with any other notable physical or psychological conditions.

[1] This Finding has been de-identified by order of Coroner David Ryan which includes an order to replace the name of the deceased and his brother with pseudonyms for the purposes of publication.

He relied on a mobility scooter for transportation. LM's family reported that he was attentive to this scooter and actively maintained it.

3. In the evening on 21 July 2022 at 5.37pm, an empty Metro train departed Craigieburn Railway Station en route to Southern Cross Railway Station. It has been recorded by Metro Trains Melbourne (**MTM**) investigators, who had access to relevant data logs, that the train travelled through Coolaroo and under the Barry Road Bridge towards Broadmeadows at or below required speed limits.

4. Approximately 500 metres before the Smeaton Avenue Pedestrian Crossing, the train driver observed a large shadow ahead of the train. As required by MTM policy, they scanned the tracks for any hazards. The driver assessed that someone had placed an object on the tracks, an occurrence that was reportedly common at this location.

5. At about 5.42pm, when the train was approximately 150 metres from the Smeaton Avenue Pedestrian Crossing, the driver recognised the object as a mobility scooter which was obstructing the train's path and realized that that a collision may occur. The driver then engaged full-service braking and sounded the whistle for approximately six seconds.

6. After sounding the whistle, the driver observed LM, who was standing beside the scooter, turn his face towards the train. He was wearing dark clothing and the scooter did not have any illuminated lights or a flag. After seeing LM, the driver recalled applying the emergency brake.

7. Despite the engaging of the brakes, the driver was unable to avoid a collision with the mobility scooter. When the train came to a stop, they reported the incident to Metrol.[2]

8. Emergency services were contacted and arrived at the Smeaton Avenue Pedestrian Crossing a short time later and located LM lying face down approximately 10 metres from the point of impact. Debris from the scooter was observed approximately 100 metres from the point of impact. Responding paramedics were unable to find signs of life and pronounced LM deceased at 5.55pm.

9. Victoria Police examined the scene but did not identify any suspicious circumstances. The scene was then handed over to MTM investigators to conduct an internal investigation.

[2] Metrol is the central control centre of the Melbourne suburban rail network.

10. MTM Investigators found that the Smeaton Avenue Pedestrian Crossing had functional overhead lighting. Similarly, they recorded that the surface of the path was in a satisfactory condition. However, I note from reviewing the photographs of the scene that the path over the tracks is uneven in some places

11. While data loggers are not in use for pedestrian crossings, the automated gates and audible alarms were tested onsite and deemed to have been operating as designed. Moreover, inspection of the site surrounding the Smeaton Avenue Pedestrian Crossing showed that all signage was in place, visible and in good condition.

12. Forensic Pathologist Dr Joanna Glengarry of the Victorian Institute of Forensic Medicine performed an external examination and reviewed a post-mortem computed tomography (**CT**) scan on 22 July 2022. She provided a report of her findings on 28 July 2022.

13. Dr Glengarry's examination revealed that LM had significant traumatic chest, pelvic, spine and limb injuries, sufficient to cause death. These included several fractures and bilateral haemopneumothoraces.

14. Toxicological analysis of post-mortem samples detected the presence of alcohol (ethanol). I am satisfied, based on the elevated alcohol levels (0.16 and 0.169g/100mL in blood and vitreous humour, respectively), that LM was intoxicated at the time of his death.

15. Dr Glengarry provided an opinion that in the absence of a full post-mortem examination, a reasonable cause of death may be formulated as *1(a) Injuries sustained when struck by a train*.

16. I accept Dr Glengarry's opinion.

17. In the circumstances, it is unclear precisely why LM was on the tracks immediately prior to the collision and the events were not captured by closed-circuit television footage. I am satisfied that a collision would not have been able to be avoided even if the train driver had applied the emergency brake at the time that they recognised that there was a mobility scooter on the tracks. There is no available evidence to suggest the scooter suffered a mechanical failure although it is possible that it became stuck at some point on the crossing. On the evidence provided about LM's mental state and relevant medical history, there is nothing to suggest he intended to take his own life.

18. I am satisfied, however, that the level of alcohol in LM's system likely played a role in his death, affecting his judgment and reaction time.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation:

1. That Metro Trains Melbourne review the condition of the Smeaton Avenue Pedestrian Crossing to determine whether it requires remedial works to ensure the safety of the public.

Pursuant to section 73(1A) of the Act, I order that a de-identified version of this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I convey my sincere condolences to LM's family for their loss.

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

Mr EM, Senior Next of Kin

Metro Trains Melbourne

Sergeant Ashok Dangal, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 19 September 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.