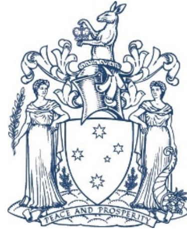

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005507

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Andrea Dorothy Milner
Date of birth:	2 October 1966
Date of death:	23 September 2022
Cause of death:	1(a) Multiple injuries sustained in a train incident
Place of death:	The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	suicide

INTRODUCTION

1. On 23 September 2022, Andrea Dorothy Milner was 55 years old when she passed away at the Alfred Hospital from injuries sustained in a train incident.

2. Andrea was the second eldest of four children and was born with medical complications. She was diagnosed with cerebral palsy shortly after her birth. She was non-verbal and used eye and head movements to communicate with others. Andrea required assistance with most activities of daily living, including administering medication, feeding, showering and hygiene. When she was 28 years old, Andrea obtained funding through the NDIS for a motorised wheelchair, which significantly increased her independence. Andrea was able to communicate to others through an iPad connected to the wheelchair.

3. Andrea lived in the family home until 2018, when her mother passed away. Andrea was very close to her mother and her passing affected her significantly. After her mother's death, Andrea moved to an apartment of her own in Cheltenham. Support staff from Melba Support Services attended the home Monday to Friday in the morning and afternoon, to assist her with her activities of daily living. Andrea stayed with her father, Harold, from Friday night until Sunday night, returning to her home during the week. Andrea and her father enjoyed attending activities and events together, such as the football, horse racing and family events.

4. Andrea had a complex medical history which included cerebral palsy, depression, anxiety, bursitis, and left hip pain. In September 2021, Andrea had a PEG tube inserted due to difficulty she was experiencing with swallowing. She was prescribed diazepam for spasticity and mirtazapine and later, escitalopram, for depression.

5. Andrea worked with psychologist Andrew Buchanan in 2016 to 2017, to assist with her experiences of low mood and need for psychological support. Mr Buchanan stopped working for Scope in about 2018, but re-engaged with Andrea in early-2019 when he was working for AFFORD. From 2019, Andrea's psychological needs changed, and she required support following the death of her mother and moving into new accommodation. Mr Buchanan worked with Andrea on solution focused therapy, acceptance and commitment therapy (**ACT**) and interpersonal skills therapy. Andrea presented with suicidal ideation on several occasions, although she always denied any intent or specific plans. Mr Buchanan noted that her suicidal ideation often occurred in the context of an acute issue or perceived crisis, which usually responded well to collaborative problem-solving and/or ACT techniques.

6. Andrea's most recent psychologist, Gavin Woolley, last consulted with her on 30 August 2022. She presented with suicidal ideation, as she often did, however denied any plan or intent to act on the thoughts. Mr Woolley worked with Andrea to strengthen her problem-solving skills and interpersonal skills. Andrea was otherwise future-focused, and was excited about an upcoming holiday, seeing her family, and continuing her art engagement.

7. Andrea last consulted with her general practitioner (**GP**), Dr Ian Roberts, on 13 September 2022. She reported anxiety and low mood over recent months, however her left hip pain was under control. Dr Roberts commenced Andrea on escitalopram to manage her symptoms of depression and anxiety and reduced her mirtazapine dose to avoid interactions between the two medications.

THE CORONIAL INVESTIGATION

8. Andrea's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. Victoria Police assigned First Constable Holly Fogarty to be the Coronial Investigator for the investigation of Andrea's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of Andrea Dorothy Milner including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

13. On 23 September 2022, Andrea Dorothy Milner, born 2 October 1966, was visually identified by her father, Harold Milner.

14. Identity is not in dispute and requires no further investigation.

Medical cause of death

15. Forensic Pathologist Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 26 September 2022 and provided a written report of her findings dated 20 October 2022.

16. The post-mortem examination revealed multiple injuries consistent with the reported history. Examination of the post-mortem CT scan showed a right parietal haematoma, a subarachnoid haemorrhage, compression of the lateral ventricles and transtentorial herniation and no skull fracture. It also showed a C5 anterior vertebral body fracture, right proximal femur fracture, distal right tibia/fibula fractures, right great toe fracture, right scapula fracture, right surgical neck of humerus fracture, bilateral intercostal catheters with subcutaneous emphysema, bilateral haemopnuemothoraces, right pelvic fractures, lateral 4th to 9th rib fractures, posterior left 4th and 7th rib fractures. Incidental findings included a fatty liver and left renal cyst.

17. Toxicological analysis of ante-mortem samples identified the presence of isopropanol,[2] morphine, diazepam and its metabolite, midazolam, citalopram, mirtazapine, ondansetron and paracetamol. Morphine, midazolam and ondansetron were administered by paramedics/medical staff.

---

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Isopropanol is an endogenous compound, solvent, chemical intermediate and 70% aqueous solution as a rubbing alcohol. When present in post-mortem blood, it may derive from food deprivation, infection, alcoholism, diabetic ketoacidosis, and/or decomposition.

18. Dr Ho provided an opinion that the medical cause of death was 1(a) *multiple injuries sustained in a train incident.*

19. I accept Dr Ho's opinion as to the medical cause of death.

Circumstances in which the death occurred

20. On 21 September 2022, Andrea informed her carer, Tamara, that she was experiencing bowel issues, and she was concerned about her father needing to change and clean her. As it was a long weekend, Andrea was due to visit her father from Thursday 22 to Sunday 25 September 2022. She was embarrassed about her bowel issues and told Tamara not to discuss any personal details about her bowel care with her family members. She also asked Tamara to stay at home for an additional evening (22 September) and planned for her father to pick her up at 11.00am on 23 September 2022.

21. On the evening of 22 September 2022, Andrea was with one of her carers, Paul. He assisted her with showering and her physiotherapy exercises, made dinner and listened to Andrea's favourite album. After dinner, Andrea and Paul played UNO, which was Andrea's favourite card game.

22. On the morning of 23 September 2022, Andrea was noted by staff to be laughing and joking, as per her usual self. Staff attended from 7.00am to 8.30am and advised they would return in about 45 minutes to assist to put some laundry out to dry. This was not uncommon, and Tamara noted that Andrea could send messages from her iPad to support staff, if she required additional assistance in the interim.

23. When staff returned to Andrea's home, they discovered that she was not home. Staff immediately called her father to see if he had collected Andrea earlier than expected, however he confirmed he had not seen her. Staff then commenced a search of the local shopping village to see if she could be located.

24. At 9.25am, Andrea arrived on Platform 1 at Cheltenham railway station. She boarded a city-bound train, and the driver asked if she was travelling to Flinders Street. Andrea nodded and made a sound to confirm that was her intended destination.

25. At 9.40am, the city-bound train arrived at Ormond railway station. Andrea exited the train unassisted and navigated her wheelchair on Platform 1. After exiting the train, Andrea navigated her wheelchair up the ramp and towards the elevator. When she reached the

elevator, she did not enter but instead turned her wheelchair around and navigated back towards the platforms.

26. Andrea travelled down the ramp, onto Platform 2 and stopped her wheelchair at the end of the platform, with the front wheels just over the yellow tactile lines. Andrea navigated the wheelchair forward and drove off the platform edge, onto the tracks below. There were no other patrons on the platform, and no one witnessed the incident.

27. At 9.43am, a Frankston-bound train was approaching the tunnel leading into Ormond station. The train driver observed an obstruction on the tracks and placed the train into emergency braking. The Frankston-bound train was unable to stop in time and the first carriage collided with Andrea and her wheelchair. The remaining five carriages were situated off the platform and did not collide with Andrea.

28. The train driver contacted the train controller, Metrol, and advised that he collided with debris, which he believed to be 'a pram' on the tracks. The driver spoke to the Train Controller (**TC**) at Metrol and said that there was no one acting erratically or panicked on the platform (as would be expected if someone witnessed a pram being struck by a train) and thought someone may have thrown an item from the bridge he passed under. The driver offered to exit the train and check for debris, however the TC instructed him to remain in the cab, as per Metro Trains Melbourne (**MTM**) protocol.

29. The TC consulted with the Senior Network Controller (**SNC**), who happened to be standing behind him when the incident occurred. The SNC attended the Security Operations Centre (**SOC**) and spoke to two of the live CCTV monitoring operators (**LMO**). The SNC advised the two LMOs that a train had struck debris at Ormond station and requested they review the CCTV footage to identify what the debris was. The two LMOs have differing accounts of what occurred – one stated that the request to review the CCTV occurred whilst the train was stationary at Ormond, whilst the other stated that the request occurred after the train left Ormond.

30. The SNC stated he reviewed some of the footage, then advised the TC that the train was clear to proceed. The TC informed the train driver that the CCTV footage had been reviewed, nothing could be seen and instructed the driver to travel at extreme caution to the next fixed signal. The train departed Ormond at 9.51am.

31. After the SNC left the SOC, the two LMOs continued reviewing the CCTV and located additional footage in which Andrea was observed to move off the edge of the platform and onto the tracks, shortly before the train arrived at Ormond railway station.

32. Meanwhile, the station officer (**SO**) at Cheltenham railway station overheard the emergency call made by the train driver, so he decided to check the CCTV at Ormond. He observed what he thought was a child on the tracks next to Platform 2, so he used the PA system at Ormond to request members of the public to press the emergency button. A passenger waiting on the platform pressed the emergency button and was guided by the SO to check the tracks. The passenger confirmed there was a person on the tracks, so the SO immediately notified Metrol. Metrol contacted emergency services and requested attendance at Ormond railway station.

33. At 9.53am, the SNC contacted the train driver and told him to stop at the next station (Bentleigh), advising that he needed further information about the incident.

34. Victoria Police arrived at Ormond railway station at 9.58am, followed by Ambulance Victoria at 10.04am. Paramedics assessed Andrea and rendered assistance, before transporting her to the Alfred Hospital via ambulance.

35. Investigations at the Alfred Hospital determined significant injuries, which were deemed unsurvivable. Andrea passed away surrounded by her family at 1.20pm that afternoon.

36. The train driver completed mandatory post-incident drug and alcohol testing, which were both negative.

MTM AND ONRSR INVESTIGATIONS

37. Following Andrea's passing, MTM and the Office of the National Rail Safety Regulator (**ONRSR**) conducted investigations into the incident. A summary of their findings is included below.

Review of equipment and environmental factors

38. MTM and ONRSR confirmed that at the time the driver spotted the 'debris' on the train tracks, the train was travelling at a maximum speed of 66 km/h, which is under the speed limit for that section of the line. When the driver engaged the emergency brakes, the train was travelling at a speed of 59 km/h, and it came to a stand about 108m later. This was within its expected performance. Testing of the train involved revealed no faults or failures that may have contributed to the collision.

39. The weather was not considered to have been a contributory factor in this incident. However, it was daylight at the time, and the driver transitioned from a tunnel into bright daylight, on approach to Ormond. The ONRSR report noted that the different luminance levels associated with the different lighting sources (i.e., natural light, no lighting, artificial lighting) can create glare and contrast issues. This would have made it difficult for the driver to discern the 'debris' he observed on the track, hence his confusion about what he saw.

Requirement to leave train to inspect track

40. In a statement to the Court, MTM explained that there is no requirement for a train driver to exit the train to visually inspect the tracks after a collision with debris. MTM explained that this is due to safety concerns, including driver trauma, and network reliability performance reasons.

41. I accept that it would be traumatic for a train driver to exit the train, check for debris on the track, and instead locate a person trapped under a train and/or seriously/fatally injured by a train. Additionally, depending on the visibility, location and size of the person, a driver may exit the train and still be unable to see anyone under the train.

Decision-making process by MTM staff

42. The driver's belief that the 'debris' was a 'pram' was due to its appearance on the track, being upside down with a shiny chrome bar towards the centre of the tracks, towards the sleepers. This belief was further influenced by the differing levels of light, as noted above. According to the ONRSR, the conversation between the driver and the TC suggested that "*anchoring to the hypothesis of the pram as debris occurred in the first 23 seconds of the conversation*". However, the ONRSR also noted that the TC appropriately sought further information, which supported confirmation of the hypothesis, and there was no conflicting evidence provided to suggest otherwise. The ONRSR concluded that the data gathered by both the driver and the TC supported the hypothesis, which was not unreasonable in the circumstances.

43. The ONRSR was unable to confirm precisely what the SNC overheard or was told by the TC, however it appeared that further anchoring occurred as the SNC sought visual confirmation of the 'debris' via CCTV. In his interview with MTM, the SNC explained that when he attended the SOC and asked to view the footage, he did not know which views/angles were presented to him. This is due to the fact that the cameras are not clearly labelled on the software package and there are numerous camera angles. The LMOs opened a few different

views for the SNC to review, and reversed the footage to prior to the train's arrival, however nothing could be observed during this review.

44. Based on his review of the CCTV, the SNC instructed the TC (and thus the driver) to proceed with caution. His decision-making process for this was based on the following factors:

    a) If the driver had stated that he had struck a pram (as opposed to debris), he would not have authorised the train to move. However, he was under the assumption that the train struck debris, and *not* a pram.

    b) Reports of debris are generally associated with objects being deliberately placed on the track. This occurred under the overpass, suggesting that the item may have been thrown from the bridge.

    c) The CCTV footage showed other patrons on the platform walking and waiting normally, without any obvious sign of alarm or concern. If a patron observed something on the tracks or witnessed someone fall off the platform, their behaviour would be panicked or concerned.

    d) Ormond is an unmanned station, so there was no ability to contact staff there to check the tracks.

    e) CCTV cameras were viewed, and the reported debris could not be identified.

45. In his interview with MTM, the SNC explained that the cameras are not labelled clearly, so when viewing the cameras, the user does not know which camera angle they are going to see, until the file is opened. In this case, the LMOs opened cameras 1072, 1086 and 1087. These three views did not depict the wheelchair on the track. Camera 1053, which was reviewed after the train departed, *did* depict the wheelchair on the track. It is unfortunate that the LMOs and the SNC were unable to view camera 1053, prior to giving the driver the direction to move.

46. The MTM report included a picture of camera labelling at Ormond railway station, which MTM advised is typical of the camera labelling at other locations. The picture "*illustrates that the cameras at Ormond Station are not presented in a sequential number order (e.g. all platform 1 cameras, then all platform 2 cameras etc) nor are they grouped in an alternate systemic fashion which allows for easy navigation through the station cameras (e.g. all middle platform views, all UP end platform views, a geographic representation etc).*"

47. I therefore make no criticism of the LMOs and SNC, as they navigated multiple computer monitors, all depicting different camera angles that are not named in a logical fashion. Grouping the cameras based on location and/or including a geographic representation of the cameras within the railway station would provide better visibility for LMOs/SNC and would enable staff to quickly identify the camera angle they need, without having to open and close other camera angles first. In circumstances where railway stations have several cameras with various angles, it would seem prudent that the system for reviewing this data is as simple to navigate as possible. This would be beneficial in time-critical situations such as this one, where staff need to quickly review CCTV footage, to make a decision about whether to allow a train to proceed. I therefore intend to make a recommendation to MTM that it update its CCTV system to include appropriate labelling of all camera angles and/or a geographical representation.

Preventability of death

48. Sadly, regardless of whether Andrea and her wheelchair were identified by the SNC/LMOs prior to the train departing, the outcome may not have differed. Andrea would have sustained significant injuries during the initial collision with the train, and therefore I cannot determine that if the appropriate camera angle was reviewed prior to the train's departure, that she would have survived. Extraction from under the train, once it came to a stop, may not have been possible, and it is still possible that she would have succumbed to her injuries during this time.

49. Based upon a review of Andrea's medical records and statements from her treating clinicians, there were no obvious warning signs that she was experiencing increased suicidal ideation or distress. Her carers did not observe anything out of the ordinary, and whilst she presented with chronic suicidal ideation to her GP and psychologist, she denied any intent to act on these thoughts. I am satisfied that the treatment Andrea received was appropriate and reasonable in the circumstances.

FINDINGS AND CONCLUSION

50. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Andrea Dorothy Milner, born 2 October 1966;

    b) the death occurred on 23 September 2022 at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from 1(a) *multiple injuries sustained in a train incident*; and

c) the death occurred in the circumstances described above.

51. Having considered all of the circumstances, I am satisfied that Andrea intentionally took her own life.

RECOMMENDATIONS

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

(i) That **Metro Trains Melbourne** review and update its CCTV viewing infrastructure to include appropriate labelling of all camera angles and/or a geographical representation.

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

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

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

Harold Milner, Senior Next of Kin

Alfred Health

Metro Trains Melbourne

NDIS Quality and Safeguards Commission

Office of the National Rail Safety Regulator

First Constable Holly Fogarty, Coronial Investigator

Signature:

Judge John Cain
State Coroner
Date: 4 March 2025

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.