IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 3483

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Vasileios Avtsidis
Date of birth:	12 November 1974
Date of death:	3 July 2021
Cause of death:	1(a) Head injuries sustained in a bicycle and train incident (cyclist)
Place of death:	Upfield rail line pedestrian rail crossing, intersection of Dunstan Parade and Augusta Avenue, Campbellfield, Victoria
Keywords:	Train collision, pedestrian railway crossing, cyclist, forward-facing cameras, in-cab audio and video recording, passenger train

INTRODUCTION

1. On 3 July 2021, Vasileios Avtsidis was 46 years old when he sustained fatal injuries in a collision with a train. At the time of his death, Mr Avtsidis lived in a share house in Broadmeadows.

2. Mr Avtsidis worked as a master welder/sheet metal fabricator for Road Runner Chassis Pty Ltd in Campbellfield. He was known to use an electric engine (assisted) bicycle as his primary mode of transport.

3. Mr Avtsidis had no known notable medical or mental health concerns in the lead up to his death.

THE CORONIAL INVESTIGATION

4. Mr Avtsidis'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.

5. 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.

6. 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.

7. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Avtsidis's death. The Coroner's 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.

8. This finding draws on the totality of the coronial investigation into Mr Avtsidis's death, 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

9. On 14 July 2021, Coroner Leveasque Peterson made a formal determination identifying the deceased as Vasileios Avtsidis, born 12 November 1974, based on DNA comparison analysis.

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

Medical cause of death

11. Forensic Pathologist, Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 5 July 2021 and provided an amended written report of her findings dated 19 July 2021.

12. The post-mortem examination revealed significant traumatic head injuries. Routine toxicological analysis of post-mortem samples did not detect any alcohol or any other commonly encountered drugs or poisons.

13. Dr Francis provided an opinion that the medical cause of death was *"1(a) Head injuries sustained in a bicycle and train incident (cyclist)"*.

14. I accept Dr Francis's opinion.

Circumstances in which the death occurred

15. At approximately 9.30am on the morning of 3 July 2021, an Upfield-bound train departed Flinders Street Railway Station in Melbourne. The weather that morning was described as sunny with good visibility. According to the train driver, the train performed as expected and the journey was generally uneventful.

[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.

16. The train arrived at Gowrie Railway Station, which is the second last northern station on the Upfield rail line, at 10.22am. After departing, the train continued its usual journey travelling at just below the speed limit.

17. The train continued north and crossed over the rail bridge of the Metropolitan Ring Road. Shortly thereafter, the train approached a pedestrian alone (that is, no vehicular traffic) rail crossing. The railway track here was straight and there were no visual obstructions south of the pedestrian crossing to obscure approaching rail traffic.

18. The west entry/exit to the pedestrian crossing was located off Garner Parade, Dallas, and the east entry/exit was located off Dunstan Parade diagonally opposite Augusta Avenue, Campbellfield. The crossing is known as the Augusta Avenue Pedestrian Crossing and is located about 550 metres south of the Upfield Railway Station.

19. The pedestrian crossing is a 'passive' pedestrian crossing as there are no power operated gates that close or sonic alarms that sound during the passage of trains. There are, however, signs prohibiting bicycle riding and advising users to 'Stop look out for trains' at both entries to the crossing. There are also painted lines on the bitumen surface at the end of the fencing advising users to 'Wait here' before the point at which the rail tracks and crossing pathway intersect.

20. The crossing is further protected by a galvanised pipe fence with two horizontal rails, which is constructed in a 'U' shape that requires pedestrians to walk parallel to the railway track prior to accessing the track area. This provides pedestrians with an opportunity to observe rail traffic travelling in both directions.

21. At about 200 metres south of the pedestrian crossing, the train driver sounded his whistle. At this time, he saw a male person later identified to be Mr Avtsidis standing stationary at the west side of the crossing and inside the fenced area.

22. The train driver continued through a green rail traffic signal at just below the speed limit of 80 kilometres per hour. Mr Avtsidis remained stationary within the safety zone.

23. At about 30 to 50 metres from the pedestrian crossing, the train driver observed Mr Avtsidis ride his bicycle forward and out of the west safety zone and onto the railway track. As the driver described it, *"he just rode out".*

24. The train driver immediately applied the emergency brake and again sounded the whistle. He stated, *"As soon as I hit the whistle, the guy looked around, got a shock and then he*

started pedalling harder. He was sort of wobbling on the bike a bit. It looked like he was trying to go a bit faster."

25. The train subsequently impact Mr Avtsidis and he was thrown forward onto the grass reserve on the east side of the tracks. The train came to a stop at about 168 metres north of the pedestrian crossing.

26. The train driver alerted Metrol who contacted emergency services. Responding Ambulance Victoria paramedics arrived at 10.20am and found Mr Avtsidis unresponsive with obvious significant injuries. With no signs of life, Mr Avtsidis was verified deceased at 10.25am.

27. Victoria Police members conducted a preliminary breath test on the train driver at the scene which returned a negative result for alcohol.

28. On the morning of 5 July 2021, Mr Avtsidis's employer reported him as a missing person to Victoria Police after he did not attend work and had not responded to multiple phone calls.

29. Victoria Police members subsequently conducted an inspection of Mr Avtsidis's bicycle, which did not reveal any faults, failures, or conditions that could have caused or contributed to the collision. The police also confirmed that Mr Avtsidis was not making a mobile phone call at the time of the incident but were unable to determine whether he was otherwise using his phone (such as using any apps or media).

30. A Metro Trains Melbourne investigator observed there was no damage or deficiencies in the infrastructure of the pedestrian crossing or signage that may have contributed to the incident. There were no visual obstructions south of the crossing that would have obscured the approach of rail traffic.

31. Senior Constable Gregory Ryan, Coroner's Investigator, concluded the collision was an accident. Mr Avtsidis appears to have been unaware of the train's approach and was not expecting it. He noted that it appeared Mr Avtsidis had been wearing a beanie, a bicycle helmet, and a rain jacket with the hood raised and pulled up over both. This and the relatively gusty conditions on the day may have impacted his ability to hear the train approaching. It appears he failed to look for approaching trains immediately before the incident and then 'panicked' when he saw one approaching.

32. I accept Senior Constable Ryan's conclusions as to the cause of the collision are plausible. There is no evidence before me to indicate Mr Avtsidis's actions were intentional and/or for the purpose of taking his own life.

FURTHER INVESTIGATION

33. As part of my investigation into the circumstances of Mr Avtsidis's death and to determine whether there were any opportunities to prevent similar deaths in the future, I requested data about similar train-related fatalities and information about the planned upgrade of the Augusta Avenue pedestrian crossing. In addition, I also requested information regarding any planned implementation of forward-facing cameras in trains, which would generally assist coronial investigations.

34. To assist my investigation into these issues, I obtained statements from Robert Duvel, Executive Director Zero Harm, Metro Trains Melbourne, and Brett Langley, Executive, Department of Transport.

Railway crossing fatality statistics

35. The Coroners Prevention Unit[2] (**CPU**) reviewed the Coroners Court of Victoria surveillance database, which contains information on all Victorian deaths reported to the coroner since 2000.

36. The CPU used the surveillance database to identify all Victorian deaths that were reported to the coroner between 1 January 2010 and 18 May 2022, where the deceased was riding a bicycle and died in an unintentional collision with a train. The CPU also used the surveillance database to identify all other Victorian unintentional deaths from 2010 to present of people struck by trains at the Augusta Avenue pedestrian railway crossing where Vasileos Avtsidis died. The CPU included both pedestrians and cyclists.

37. Having search the data, CPU identified two unintentional incidents where the deceased was a cyclist and was struck by a train between 1 January 2010 and 18 May 2022. One incident was the death of Vasileos Avtsidis. The other incident was the death of an elderly male which

[2] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

occurred in 2014. The latter death also involved the a 'passive' pedestrian crossing at Edithvale, which was already due for an upgrade to an active crossing with automatic gates.

38. The CPU noted a further death of an elderly male who was riding a mobility scooter when he was struck by a train at a railway station crossing in Moe.

39. The CPU did not identify any further fatalities at the Augusta Avenue railway pedestrian crossing, Campbellfield. I note however that Senior Constable Ryan identified a death of a young male occurring at the Augusta Avenue pedestrian crossing in 2016. This was found to have been an intentional death.

40. Train-related unintentional fatalities of cyclists are therefore relatively rare. However, there are many more 'near misses'.

41. The Victorian Railway Crossing Safety Strategy 2018-2027[3] recognises the need for an increased focus on pedestrian safety measures at level crossings due to a significant increase in reported incidents over the past nine years. It reports, for example, in 2009 there were 113 pedestrian incidents and by 2016 this figure had increased to 216. Further to this, in the metropolitan area, the average number of pedestrian incidents that occurred between 2009 and 2016 was higher than the number of road incidents.

42. Upgrading a passive railway pedestrian crossing to an active one with automatic gates and an audible warning device may not always prevent incidents and deaths. The Victorian Railway Crossing Safety Strategy 2018-2027 notes that the increase in the number of incidents at pedestrian crossings with active controls highlights that user behaviour is a key issue that needs to be addressed.

Upgrade of the Augusta Avenue pedestrian crossing

43. There are 65 passive pedestrian crossings within the Metro Trains Melbourne Network.

44. The Australian Level Crossing Assessment Model (**ALCAM**) Assessment is a risk model tool used to identify key risks at level crossings and to assist in the prioritisation of crossings for upgrades. In Victoria, ALCAM assessments are managed by VicTrack, a state-owned

[3] Victorian State Government, Department of Economic Development, Jobs, Transport and Resources, 'Victorian Railway Crossing Safety Strategy 2018-2027', <https://www.ptv.vic.gov.au/assets/default-site/footer/legal-and-policies/eac64e622a/Victorian-Railway-Crossing-Safety-Strategy-2018-2027.pdf>, accessed 20 May 2022.

organisation with an independent Board, which operates under the *Transport Integration Act 2010* (Vic).

45. VicTrack manage a rotating ALCAM assessment program for all crossings throughout Victoria. The Augusta Avenue pedestrian crossing is currently ranked No. 322. ALCAM is a dynamic model, and the rankings can be subject to change due to increases/decreases in pedestrian usage. Pedestrian usage is a key driver in the ALCAM pedestrian model.

46. Decisions to upgrade level crossings are made by the Victorian Crossing Safety Steering Committee (**VRCSSC**), which is a Ministerial Advisory Committee established under the *Transport Integration Act 2010* (Vic). Following the endorsement of recommendations from VRCSSC the process is managed by a subcommittee known as the Railway Crossing Project Delivery committee (**RCPD**). The RCPD prioritises crossings for upgrade and manages the delivery of pedestrian crossing upgrades.

47. The RCPD has established a set of Business Rules to prioritise crossing upgrades for pedestrian sites. This is based on a combination of the ALCAM relative risk ranking and the number of occurrences recorded at the crossing together with advice from Rail Transport Operators on human factors and operational experience.

48. Based on its low ranking, the VRCSSC has not included the Augusta Avenue pedestrian crossing in any planned upgrades. The prioritisation working group did consider the crossing following this incident, however it remains the case that it is not a current upgrade candidate.

49. For all the reasons set out above, I do not intend to make a recommendation to upgrade this crossing in response to this fatality.

Forward-facing cameras on trains

50. Senior Constable Ryan noted that during his investigation he was unable to obtain a signed statement from the train driver, in deference to a desire not to re-traumatize the driver. He was however provided with the driver's 'field notes.' SC Ryan noted that a statement was important in this matter as the train driver was the sole witness and there was no other corroborating evidence.

51. According to Metro Trains Melbourne train drivers are not required or directed to prepare or sign witness statements due to mental health and wellbeing concerns. I accept this is a valid concern and otherwise make no further comment.

52. Senior Constable Ryan therefore suggested a system of forward-facing train dashboard cameras mounted on the lead car should be considered. Such real-time evidence would assist similar investigations and eliminate the need for a signed witness statement from the driver or potentially other eye witnesses to such traumatic incidents.

53. Mr Duvel and Mr Langley both noted that in October 2021, the Office of the National Rail Safety Regulator (**ONRSR**) outlined its revised policy to mandate in-cab audio and video recording on mainline passenger and freight trains. The policy provides for access of recordings by ONRSR, Australian Transport Safety Bureau (**ATSB**), police, and coroners when undertaking investigations.

54. The ONRSR's policy recommends the Rail Safety National Law (**RSN**L) be amended to mandate that each passenger and freight train that operates on the mainline (urban or non-urban) that has an expected asset life of 10 years or more (from commencement of the legislation), must be fitted with an in-cab audio and video record in the driver's cab. The requirement would apply to new trains procured after the legislation's commencement, and a seven-year transition period for retrofitting the devices on existing rollingstock with an asset life of 10 years or more. This policy change has been endorsed by the Infrastructure and Transport Ministers' Meeting (**ITMM**), which comprises each state/territory transport Minister. Drafting will now commence on proposed amendments to the RSNL, with changes to the RSNL needing to be approved by the ITMM.

55. Mr Duvel noted that all rolling stock operated by Metro Trains Melbourne are assets owned by the Department of Transport. There are several different Rolling Stock fleets running on its network (being Comeng, Siemens, X'trapolis, and High-Capacity Metro Trains (**HCMT**)).

56. The Comeng trains are being retired but will operate until at least 2029. Forward-facing camera capabilities are installed in the HCMT fleet. The Department of Transport has approved a project to introduce forward-facing cameras into the Siemens fleet. Mr Duvel noted that testing is currently underway with the potential to introduce the capability to the Siemens fleet later this year, subject to First of Type testing being successful. A new X'trapolis 2 fleet will also be introduced onto the network in July 2024 which will also have this capability.

57. Scott Ryan, Director Network Safety, also provided advice that the Department of Transport's current position is to comply with the ONRSR mandate, which will mean retro-fitting of Siemens and X'trapolis fleets.

58. Mr Duvel noted forward facing-cameras will be a useful tool to analyse and respond to safety incidents after they occur, including considering further safety controls that may be available to prevent future incidents. However, to state the obvious, the installation of such a camera in the train involved in this incident would not have prevented Mr Atsidis's death. I agree with Mr Duvel on this issue.

59. I strongly endorse the ONRSR mandate. The availability of real-time video capturing the events leading to a death will assist coroners in the performance of their duties under the Act.

FINDINGS AND CONCLUSION

60. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Vasileios Avtsidis, born 12 November 1974;

    (b) the death occurred on 3 July 2021 at the Upfield rail line pedestrian rail crossing, intersection of Dunstan Parade and Augusta Avenue, Campbellfield, Victoria;

    (c) the cause of Mr Avtsidis's death was head injuries sustained in a bicycle and train incident (cyclist); and

    (d) the death occurred in the circumstances described above.

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 convey my sincere condolences to Mr Avtsidis's family and friends for their loss.

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

Alex Avtsidis, Senior Next of Kin

Department of Transport

Transport Accident Commission

Senior Constable Gregory Ryan, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 06 October 2022

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.