



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Janice Faye McDermott

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

- (a) The identity of the deceased is Janice Faye McDermott;
- (b) Mrs McDermott died as a result of multiple injuries due to being struck by a train as a pedestrian at the level crossing on Box Hill Road, Claremont;
- (c) Mrs McDermott died on 5 June 2014 at Royal Hobart Hospital, Hobart in Tasmania;
- (d) Mrs McDermott was born in Hobart, Tasmania on 18 August 1951 and was aged 62 years at the time of death; Mrs McDermott was divorced and worked as a domestic helper.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs McDermott's death. The evidence comprises a detailed report by crash investigators; footage from the train at the time of the collision; an opinion of the State Forensic Pathologist as to cause of death; relevant police and witness affidavits; medical records and reports; and forensic evidence.

I make the following further findings, based upon the evidence, as to how Mrs McDermott's death occurred.

At approximately 9.30am on Thursday 5 June 2014 Mrs McDermott was walking in a southerly direction along the bicycle track in Claremont ("the bike track"). The bike track runs parallel to the train tracks. She was walking briskly with her dog. Her manner of walking and the time at which she was walking is consistent with witness evidence that indicates she walked fast, with purpose and regularly at the same time of day each day.

A train was approaching the level crossing on Box Hill Road. The train was owned by TasRail and comprised a lead engine, locomotive and fifteen loaded wagons. The crossing lights were activated and the sirens were operating. The train was travelling at 35 kmh at the time of the collision. The speed limit in this area for the train is 30kmh. The fact that it was travelling above the zoned limit did not contribute to the collision.

Mrs McDermott was walking with her back to the train and in the same direction. However, the crossing lights were clearly visible and the crossing sirens audible to a pedestrian in her situation. There was a taxi stationary at the crossing lights. Mrs McDermott turned left from

the bike track at its intersection with Box Hill Road. In doing so she stepped onto the train track and into the path of the oncoming train. The train footage shows her on the track and also that she did not look before turning left and crossing into the path of the south bound train.

Mrs McDermott was tragically struck by the front right corner of the train in the vicinity of its lower head lamp.

I am satisfied that the intersection at the point of the collision contained sufficient precautions for pedestrian safety. It was well signed, warning road users of the tracks and impending trains. The audible alerts were working correctly as were the red crossing lights facing traffic on both sides of the tracks. The train's horn was heard by a witness waiting at the crossing just prior to the collision.

At the time of the collision it was daylight and the weather was clear. The train and the railway were in good condition. The train was displaying six headlights, two at the top of the lead engine and two below the driver's windscreen and two small LED lights. The train driver blew the engine whistle twice on approach to the level crossing causing the bottom two headlights to flash. The train driver was experienced and familiar with the track, train and route he was travelling. The lead locomotive was new and in good working order. The emergency brake when activated stopped the train in a timely manner after the collision.

Emergency Services attended the scene. Mrs McDermott was not conscious. She was conveyed to the Royal Hobart Hospital where she died later in the evening.

Mrs McDermott lived near the train tracks and had done so for some 18 years. She was accustomed to the train noises and level crossing alerts, which may have led to complacency on her behalf in not being aware of the train on this occasion. Mrs McDermott's daughter states that her mother had a number of matters on her mind at the time. The footage shows a person who seemingly does not register the presence of the train. I am satisfied on the evidence that Mrs McDermott did not intentionally put herself in the path of the train with a view to ending her life. I am satisfied that the collision was unintended and caused by her inadvertence with respect to the crossing warning and the presence of the train.

Comments and Recommendations:

On 22 June 2014, 17 days after the death of Mrs McDermott, the final train travelled to Hobart. Trains no longer travel through the city or through the intersection in question. The last train stop is at Brighton on the outskirts of Hobart.

Incident data from TasRail indicates that there are regular incidents throughout the state whereby pedestrians, motorists and cyclists have crossed deliberately or without care at level crossings, in some instances narrowly avoiding being struck.

There are many active level crossings remaining throughout the state. I remind pedestrians, cyclists and motorists that vigilance is required when using these crossings.

I extend my appreciation to Sergeant Rod Carrick and Senior Constable Kelly Cordwell for their high quality investigation and report.

The circumstances surrounding this matter do not require me to make any recommendations pursuant to section 28 of *Coroners Act* 1995.

In concluding, I convey my sincere condolences to Mrs McDermott's family and loved ones.

Dated: 26 April 2016 at Hobart in the state of Tasmania.

Olivia McTaggart
Coroner