STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of FG*
Hearing dates:	23-24 October 2014
Date of findings:	23 January 2015
Place of findings:	NSW State Coroner's Court - Glebe
Findings of:	**Magistrate Michael Barnes, State Coroner**
Catchwords:	CORONIAL LAW – Railway overrun; responding to trespassers in the rail corridor
File number:	2013/367031
Representation:	**Crown Solicitor Lisa Molloy and Solicitor Advocate Jake Harris assisting the State Coroner** **Ms Jeunesse Chapman for Sydney Trains** **Ms Irene Ryan for DE** **Mr Michael Spartalis for New South Wales Police Force**

**Names of all family members have been changed by request.*

Findings:	**Identity of deceased**: The deceased person was FG* **Date of death**: FG died on 4 December 2013 **Place of death**: FG died at Roseville train station **Cause of death** The death was caused by multiple injuries. **Manner of death** FG suffered the fatal injuries when, while severely intoxicated, he went into the rail corridor at night and was struck by a passing train.

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The Coroners Act 2009 in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

*These are the findings of an inquest into the death of **FG***

Introduction

On 4 December 2013, FG celebrated the imminent festive season by having a meal and drinks with some workmates in the city. He was very drunk by the time he boarded a northbound North Shore Line train at Wynyard Station travelling towards his home in Waitara.

For an unknown reason, he alighted at Roseville Station, several stops before his intended destination.

He was seen by a passenger on the train to walk off the end of the platform, down a ramp into the rail corridor. She alerted police who contacted the rail system operators and attempts were made to ascertain if FG was in danger. Before this could be resolved, he was hit by a passing train and sustained fatal injuries.

The principal function of an inquest is set out in section 81 of the *Coroners Act 2009*, which requires a written record of the fact that a person has died and findings as to the person's identity; the date and place of the person's death; and the manner and cause of that death. The Act also authorises the coroner to make recommendations in relation to matters connected to the death that may reduce the likelihood of similar deaths occurring in future or otherwise contribute to public health and safety.

The evidence

Social history

FG was aged 36 at the time of his death. He was a Russian citizen. He met his wife, DE, in 2001 and they married in 2002. In 2005 they moved to Australia as skilled migrants. They had two children, A(5) and B(1). They initially lived at Parramatta and then Chatswood. In 2012 the family moved to Waitara, which is where they were living at the time of FG's death.

FG obtained employment in Australia as a Skilled Information Technology expert and he worked at a number of banks in Sydney. In August 2013 he obtained work through an agency as a software developer and was placed at Macquarie bank.

DE described her husband as being very happy working at the bank. She says he took care of all the family bills. He was physically healthy, had no mental health issues, he was not taking any medication and did not use illicit drugs. Significantly, DE also reports that he did not often drink alcohol.

FG's death has devastated his wife who has no other relatives or support in Australia. She has been left alone and unable to understand why the death occurred. I offer her my sincere condolences.

Events earlier in the day

On Wednesday 4 December 2013, FG attended work at Macquarie Bank in Sydney. At about 2:15pm he and seven of his colleagues went for Christmas drinks at the Lowenbrau Pub in The Rocks. It is unclear whether this was an official work function, but in any event that issue does not need to be resolved in these proceedings.

Over the course of the afternoon, the group all had meals and a number of drinks. Four of FG's colleagues left the party during the afternoon, and four people, including FG, continued socialising.

At about 7:20pm, the group of four attempted to enter the Argyle Hotel, located next door. The door staff refused to admit FG because he appeared to be intoxicated. He left but a short while later he returned to the Lowenbrau and from there he gained entry to the Argyle, probably by going through a fire exit which led between the two premises.

Once inside the Argyle FG joined his colleagues for more drinks. When the Argyle door staff spotted FG at around 8.15pm they asked him to leave and escorted him from the premises. FG and his colleagues then made their way towards Wynyard station, where they went their separate ways.

The investigation did not establish exactly how much FG had to drink but it is apparent from all accounts and a review of the groups bar tab that he consumed somewhere between 5 and 10 drinks. This quantity of alcohol may be more significant in light of the fact that FG did not often drink alcohol.

FG's colleagues told police that, while he was affected by alcohol when they parted ways, they did not believe he was so affected that he needed help getting home. [1]

I conclude that FG was well affected by alcohol by the time he made his journey home. This is supported by the video footage showing FG on board the train which is described below.

The train journey

At around 8:30pm FG boarded a northbound North Shore Line train at Wynyard Station travelling towards his home in Waitara. The North Shore Line runs north from Wynyard via Chatswood, Roseville, Lindfield and Waitara and terminates at Hornsby.[2]

Each train service operated by Sydney Trains is given a train run number. The train FG boarded was called train run 161U.

Closed circuit recorded vision shows that during the journey, FG rested his head on his arms against the seat in front and at one point can be seen resting against the window. Another passenger, Ms Kathryn Chan, had her attention drawn to FG

[1] Tab 36 at [12]; tab 38 at [7].

[2] A network map is located at tab 6 of the brief.

because his head was banging against the window as he was apparently falling asleep.[3]

At about 9:07pm train 161U arrived at Roseville station and FG alighted. Roseville station is located between the Pacific Highway to the west and Hill Street to the east, running more or less north/south.[4] Passengers enter and exit Roseville station via a footbridge located at the southern end.[5] The station has an island platform, with one train track running on either side. Looking north, the northbound platform 2 where FG alighted the train is on the left and southbound platform 1 on the right.[6]

The CCTV footage shows that FG was quite unsteady on his feet as he got off the train near the northern end of the platform. At the northern boundary there is a low white fence, which extends across the platform but terminates about 40cm short of the edges of the platform on both sides. As the train is leaving the station, FG can just be seen on the CCTV recorded vision walking along the edge of the platform, passing the end of white fence, and continuing down the ramp that leads into the rail corridor.

Neither the train driver nor the guard saw FG make his irregular exit from the platform.

It is not clear why FG exited the train at Roseville. DE told police that they used to live at Chatswood, which is one station prior to Roseville. FG had got off the train at Roseville on one occasion previously, thinking he had missed his stop[7], and accordingly this might explain his actions. There are other possible explanations. I cannot resolve that issue.

Ms Chan was sitting across the aisle from FG. She observed him stagger up the stairs and noted he appeared to be very unsteady on his feet, as he needed to use the handrail to maintain his balance. She observed FG get off the train, leaving his backpack behind. She looked out the window and saw FG walk up the platform in a northerly direction until he reached the white fence at the end of the platform. She observed him hold on to the fence and swing his body around it to get off the platform. She then lost sight of him as the train started to move in a northerly direction.[8]

Ms Chan gave evidence that she thought he "*probably wasn't safe"* and so she called 000 to report what she'd seen. That call was logged at 9:09:15pm and was completed at 9:12:06pm.[9] Ms Chan told the 000 operator that she:

> *Saw this man walk off the train without his bag, he seems a little bit um, either intoxicated or sleepwalking, and then, um I see him climb over the fence onto, on the platform and like near the rails*.[10]

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[3] Tab 39 at [5].

[4] Tab 5 for serial photograph of station;

[5] Tab 5.

[6] See CCTV footage at tab 45, and stills at Annexures "M" and "N".

[7] Tab 4 at [59] page 44.

[8] Tab 39 at [8]

[9] See incident log at tab [43].

Ms Chan was asked clarifying details about the station and was then asked if the bag looked suspicious. She said it did not. The 000 operator then relayed back to her what she had seen, namely that the man had left the train without his backpack and then was "*witnessed to climb the fence and access the track.*" Ms Chan agreed. Further details about FG's appearance were obtained and Ms Chan was informed that they would "*get police out there to keep a look out for him."*[11]

The fatal incident

After FG walked past the barrier at the end of the platform, he went out of the view of the CCTV from 9:08:30pm until 9:17:10pm - over 8 minutes. The investigation has not been able to determine where FG was during that time, although he was presumably still in the rail corridor.

After train 161U left, two other trains passed through Roseville station. None of the drivers or guards saw FG.[12] First, at about 9:10:30pm, train run 123D passed northbound through the station without stopping.

Then, at approximately 9:12:30pm, another train (believed to be train run 157T, although this may be an error) stopped at Roseville heading southbound. The driver, Mr Morgan, told police he had a vague memory of being told to be "*on lookout*", as there was someone in the rail corridor, and he switched on his headlights.[13] However, this account is considered unlikely as police had not at that stage contacted Sydney Trains.

At 9:17:10pm, the CCTV recorded vision shows FG walking back into view. FG walked south along the northbound tracks and then leant against the side of the platform, standing more on less on the tracks at the far northern end of platform 2.

At around 9:17:20pm, he turned northwards and then again leant over against the platform. FG remained in this position for about two minutes. During this period, FG is difficult to see. His white shirt is camouflaged against the white platform edge, and his dark trousers against the side of the rail corridor.

At 9:19:33pm, train run 901A, which was running straight through to Hornsby, entered the station along the same track. It collided with FG and caused fatal injuries.

Action taken by police

The brief of evidence included statements from a number of police, as well as the Incident Log which sets out the times that various police radio messages are recorded.

The incident log records the first radio broadcast about FG was made at 9:11:54pm. It included information that an intoxicated male person had gotten off the train without his backpack, and then was witnessed to climb the fence and access the tracks. The message stated the male was last seen at 9.08pm and provided a

[10] Tab 48, pg 1

[11] Tab 48 at page 1

[12] Versions in tab 4 at [46] and [47].

[13] Tab 4 at [48] page 37.

description of his appearance and clothing.[14] The job was classified by police as priority 2,[15] which according to evidence from Senior Constable Etches, requires an urgent response.

Constables Hopkins and Senior Constable Draper acknowledged the broadcast a minute and a half later at 9:13:21pm. Constable Hopkins gave evidence to the inquest that, at the time that call was broadcast, they were somewhere between Artarmon and St Leonards, travelling towards St Leonards. They turned around and proceeded to Roseville with lights and sirens (code blue).

According to the Incident Log, they arrived at the scene four minutes later at 9:17:21pm. Constable Hopkins gave evidence they parked on the southern side or the Pacific Highway side of the station, exited their vehicle and conducted some searches near the fence line of the station, and then proceeded onto the footbridge, where they were met by Sergeant Coleman. From there officers Hopkins and Draper made their way to the platform to look for FG with Hopkins heading north and Draper heading south. Each of the officers state that as they were on the bridge or going down the stairs toward the platform, a train passed through the station heading north. It appears likely that this was train 901A which collided with FG.

On the relevant CCTV vision, Constable Hopkins can be seen walking north along the platform from 9:20:30pm - that is, just under a minute after the collision. He discovered FG lying in the rail corridor at the northern end of platform 2. After a brief hesitation due to the fact that trains were still running, Constable Hopkins got down into the rail corridor to assess FG's injuries and requested an ambulance over the police radio at 9:22:50. A number of other police units attended at this stage.

FG was initially found unconscious but breathing, and he had a number of obvious and serious injuries. A short while later, police could not locate a pulse and Constable Simmons commenced CPR.[16] This was continued, with police taking turns, until Ambulance officers arrived at around 9:30pm.[17] Sadly, despite all efforts, FG could not be resuscitated and at 10:05pm efforts to resuscitate FG were abandoned.[18]

Action taken by Sydney trains

Ms Chan's 000 call ended at 9:12:06. At 9:13:02 pm, the police radio operator who had taken the call, Julie, contacted Isaac Nicolas, the Security Control Centre Operator, based at Sydney Trains Rail Management Centre at Central Station. The audio files provided by Sydney Trains have times recorded on them, and the video footage also has a time stamp. There may be some "clock drift" between different time sources. However, a comparison of the audio files with the video footage shows that they record more or less the same time.[19]

[14] Tab 43, page 2

[15] Tab 43, page 1

[16] Tab 22 at [16].

[17] Tab 35.

[18] Tab 34.

[19] Cf. tab 50, page 71 line 21 (audio file 107 at 2.53, or 10:02:16pm) and related video footage (10:02:16pm).

Julie informed Mr Nicholas that they had a "keep a look out at Roseville." The conversation relevantly included the following:

> JULIE: *Yeah. Um, it's come from a passenger, um, we're just advising you, IP* (intoxicated person) *male got off the train without his backpack, he was then witnessed to climb a fence and access the tracks after getting off the train, there's a train heading away from the city and it only occurred less than five minutes ago. He's described as 30 old, Caucasian, tall and skinny build, blond hair, white button up long sleeved shirt and black business pants. So he's left his backpack on the train, um, and he's climbed a fence and accessed the railway tracks, but they don't know where he went after that.*
>
> MR NICOLAS: *That doesn't make sense, he has to access the railway tracks then climb the fence to leave the area.*
>
> JULIE: *He may have done that.*

There is further discussion about FG's bag and Julie states that the *"backpack does not look suspicious. Um, yeah, but police want to know if you can warn the trains, he may still be somewhere on the track."*

I note that in his evidence, Mr Nicholas indicated that he had assumed that FG had entered the rail corridor and climbed the boundary fence. There was no basis for him to have done this. However, he claimed that this misunderstanding did not affect the action he took next.

As to the action required of Mr Nicolas, an extract from the SCC Standard Operating Procedures was produced to the inquest. Broadly it appears that Mr Nicholas followed the steps required by this SOP, though he did not recall advising police not to enter the lines (see items 9 and 10). He did not call station staff (see item 13) although he did not believe there were any staff at Roseville at that time.

At 9:15:12pm (while the police radio operator was still on the phone) Mr Nicolas contacted Andrew Crotty, the Train Controller, based at Operations Control also in the Rail Management Centre. Mr Crotty had responsibility for the "Main Board" that evening, which is an area from North Strathfield to Cowan and down to North Sydney. Mr Nicolas told Mr Crotty that he had police on the phone and asked what the last service that left Roseville on the down line (northbound) was. Mr Crotty said it was 123 Delta. The following conversation then occurred:

> MR NICOLAS: *123 Delta. I've had a report from a passenger on board that a male alighted the service, left his backpack on board then went into the corridor and jumped the fence. Police are requesting trains to be warned in case he's back into the corridor.*
>
> MR CROTTY: *At Roseville?*
>
> MR NICOLAS: *Yeah, and can we get someone to check 123, we don't know a position, we don't know a car number for a backpack.*
>
> MR CROTTY: *Righto.*

MR NICOLAS: *They don't deem it as hot it's, not - what was that radio? It's not suspicious –*

JULIE: *Well, they don't know if it's suspicious, I mean it's only from the caller, backpack does not look suspicious. He may just have been at work and he's been out for drinks and he's left it on the train.*

MR CROTTY: *All right, we'll get it checked out anyway.*

MR NICOLAS: *We'll get it checked out, and we'll let you know, can I get your CAD number thanks officer?*[20]

The SOP at item 12 states "monitor the incident via CCTV if possible and available". At 21:16:20 Mr Nicolas contacted the Security Monitoring Facility and asked the operator there to review the footage. He asked the operator to look at video footage from the time when FG exited the train in order to confirm he was not in the rail corridor.

Mr Nicholas gave evidence that, while he has the ability to review CCTV footage, he elected to ask the Security Monitoring facility to do that as their job is to review footage and then advise them if they find anything. He gave evidence that there are 15-20 CCTV cameras at Roseville which he is not familiar with. He also gave evidence that he works in a high volume call environment where he takes approximately 20-25 calls per hour and he was one of 4 or 5 Security Control Centre Operators that evening.

Meanwhile, at 9:16:30pm Mr Crotty, contacted David McLaughlin, the Area Controller or Signaller in the Sydney Trains Control Centre at Homebush. Mr Crotty told Mr McLaughlin:

> *We need traffic warned around Roseville please, apparently a person jumped off 123D, jumped the tracks and apparently left the corridor but police can't be sure, so if you can just get the next few trains to have a look down Roseville, see if there's anyone in the corridor please.*[21]

Mr Crotty gave evidence that while he did have the ability to contact drivers it is more efficient for him to contact the Signaller as the Area Controller monitors a larger area so it can be cumbersome for him to attempt to locate the relevant train.

Mr Crotty was asked whether it was part of his role to decide what action to take, and he stated that given the information he had, he was asked to warn trains by radio communications. He confirmed this was usually what he would do, as there are frequent reports of trespassers (between 6 and 12 a shift). He would only stop trains if there was "imminent danger to people and infrastructure". Mr Crotty accepted that when he received information that police were "on the tracks" following the incident, this represented an imminent risk.

Mr McLaughlin was able to view trains in his area in real time on a system called Automated Train Running Information Control System (ATRICS). A screen print

[20] Tab 50, page 4

[21] Tab 50, page 7

from the ATRICS system is within the brief.[22] It became apparent to Mr McLaughlin that train run 901A was approaching Roseville station heading north. There are controlled (or manual) signals, which can be operated by the Signaller. However, the nearest set of manual signals are at Chatswood or Lindfield, each one station away from Roseville. These signals could not have been used to warn train 901A, which Mr McLaughlin says had already passed the signal at the relevant time.

At 9:18:26pm Mr McLaughlin attempted to contact train run 901A using the MetroNet radio system. Contact was not established with the driver, although the call "connected".[23] On the audio recording, Mr McLaughlin can be heard attempting to contact the driver of 971 (the same train as 901A). That call commences at 21:18:26 and Mr McLaughlin can be heard saying "*Driver 971 North Shore panel. Driver 971, North Shore."* No reply is received and approximately forty seconds later Mr McLaughlin can again be heard saying; "*Driver are you there?".* No reply is received and, according to the records, the call concluded at 21:19:30.[24] As noted above, train 901A passed through Roseville station 3 seconds later at 9:19:33pm and collided with FG.

Mr McLaughlin gave evidence that he could see on his screen that train 901A had passed through Roseville so he then made contact with the driver of the next train (run 151V) who confirmed he would switch on his headlights and keep a look out.[25]

The driver of train 901A, Gary Tower, who has 38 years driving experience including as a driver trainer, gave evidence that on the evening in question he was taking a train for maintenance to Hornsby. Prior to his departure from Eveleigh he performed a number of checks, including to the brake system, and did not detect any problems with the train. He also checked the radio and made contact with the signal box.

He described his journey up to Chatswood where the signal showed two green signals, which means proceed at track speed. He therefore proceeded towards Roseville at track speed. He guessed he would have passed through Roseville at around 60 to 70kmph.

He described his ordinary practice on approaching a station. Ordinarily, he would not need to observe anything on the track, unless advised to do so by radio. He would try to be aware of his surroundings, but he would concentrate on the grade of the track and the signals. When passing through stations he is also aware of people on the platforms and would look to see that everything is okay.

On entering Roseville station on this night he observed the signals at the Hornsby end showed 2 green signals and he proceeded through. He did not see anything. He heard a loud bang, which he believed at the time was either the bogey hitting the undercarriage of the train, something placed on the tracks, vandals throwing something at the train, or a bird. At no stage did he think he had hit a person.

Mr Tower gave evidence that a message appeared on the screen of his radio after he had passed through Roseville, as he was coming into Lindfield, saying "speak to

[22] Tab 12.

[23] Tab 40E, annexure P-B3, Tab 40 at [8]

[24] Annexure P-B3, Tab 40 at [1]

[25] Tab 50, page 11

signaller" and he picked up the handset and stated "Driver 901A calling", but there was no reply. He then saw a message that said "transponder missed" which means there was no coverage for that second. He then pressed the hash key to restore the signal and tried to call the signaller, but could not do so. He assumed that the signaller would call if there was a problem.

Mr Tower's evidence was that usually, when you are notified of a speak to signaller message, there is an audible beep at the same time the message "speak to signaller" appears on the screen. However, on this occasion he responded to the screen only. Mr Tower gave evidence that while there are some "dead areas" he had not previously experienced any issues with the radio in the Roseville area.

Mr Tower was adamant that he did not receive any messages to contact the signaller until well after Roseville, however this is difficult to reconcile with the other evidence. For example, the radio records indicate that the attempt to call train 971 was made between 21:18:12 and 21:19:30.[26] The statement of Paul Bugeja, operational Technology Manager for Sydney Trains, indicates the "speak to signaller" message is automatically cleared when the signaller terminates the call.[27] The CCTV indicates the train passed through Roseville at 21:19:33, which suggests it was after the "speak to signaller" message would have cleared.

The fact that Mr Tower did not respond to the words spoken by Mr McLaughlin appears to suggest there was some technical issue with that call. Mr Tower gave evidence that if he had been warned about the presence of a trespasser on the tracks, he would have reduced the train to a speed of 10-20km/per hour which means the train is fully under control and able to stop and that he would have kept a vigilant look out.

Post incident events

At 9:22:26pm, police radio made a further call to Mr Nicolas to inform him that FG had been hit by a train. Efforts were then made to stop other trains approaching the station. It is noteworthy that Mr Crotty and Mr McLaughlin both attempted to contact train 151V again, which was approaching Roseville from the south. They were unable to do so.[28] As noted above, that driver was already aware that there may be a problem, and the video footage shows the train coming into Roseville at around 9:23:50pm and stopping.

Autopsy results

On 5 December 2013, an autopsy was conducted on FG's body by an experienced forensic pathologist. It found multiple fractures, lacerations and abrasions consistent with a train overrun and inconsistent with survival. Tests indicated he had a blood alcohol concentration of 0.209%

Conclusions

FG was obviously very intoxicated when he parted company with his work colleagues on the evening of his death. However, I expect they were also

[26] Tab 40E, annexure P-B3

[27] Statement of P Bugeja, Tab 40E, at [24]

[28] Tab 50, page 10 line to page 16.

significantly affected by alcohol and assumed that once he got onto a train he was capable of getting himself home.

As we now know that assumption was false. FG apparently became disorientated and alighted from the train at the wrong station and then walked from the platform into a dangerous area in the rail corridor.

An attentive and compassionate passenger, Ms Chan saw what was happening and recognised the danger. She called 000. Her public spiritedness is commendable.

The 000 call was commenced slightly more than 10 minutes before FG was struck by a train. In response to the call, general duties police officers rushed to the scene.

The first officers arrived outside the station about 2 minutes before the fatality and did not get onto the platform until after it had occurred. When FG was located, Constable Hopkins jumped down onto the tracks even though the trains had not yet been stopped, in a valiant but vain effort to provide first aid to the dying man. His courage is laudable.

In the meantime, the police radio officer who initially received the call immediately contacted Sydney Trains in an effort to warn train operators of the possibility of someone being in danger on the line. She accurately reported what she had been told by Ms Chan and asked that the drivers of trains on the line in question be warned of the possibility that there was a person in the rail corridor.

I do not accept the submission made on behalf of Sydney Trains that any lack of clarity in the 000/VKG operator's communication with Sydney Trains staff members hindered their understanding of what was occurring.

I am satisfied all NSWPF officers involved responded appropriately to the incident and could not reasonably have done more to prevent the death.

The response of Sydney Trains was not as efficient: the first person who received the information made an unwarranted assumption that the trespasser had left the rail corridor and attempts to communicate with the driver of a train using the line were unsuccessful. However, it is important to acknowledge that they had only about 4.5 minutes from when the call notifying them of the incident concluded until the collision occurred – a narrow window of opportunity.

I will deal first with the miscommunication. The 000 operator told the first Sydney Trains person she spoke to, the Security Control Centre Operator, that a person was seen to "*climb a fence and access the tracks after getting off the train*." That Sydney Trains operator then told the Train Controller that a person had gone into the corridor but he had then jumped the fence and police were requesting trains be warned "*in case he's back into the corridor."* The Train Controller told a Signaller that the person of interest had "*apparently left the corridor but police can't be sure."*

The Security Control Centre Operator also failed to pass on that the trespasser appeared intoxicated.

I conclude that a number of Sydney Trains staff members failed to accurately convey important information to other employees who were involved in responding to the incident.

I am not persuaded that this suboptimal conveying of information had any impact on the outcome in this case. However, it is easy to envisage situations where it could be crucial. I will return to the issue in the recommendations section of this report.

I will now deal with the failure of any effective warning being given to the driver of the train which struck FG that there was or might be a person in the train corridor.

The Signaller reasonably concluded that he could not stop the train approaching Roseville station using a signal as the train in question was too close to passing the only one available. He then had a number of options for making contact with the relevant train driver.

The Signaller gave evidence that he did not consider it appropriate to use the "broadcast function" which can send an auditory message to a number of drivers to warn the driver of a trespasser, as the driver cannot respond to a broadcast message and he considered he needed a response from the driver to confirm the message had been received. He also gave evidence that he did not consider conveying a message using the "group message" function as it is time consuming as the numbers for each driver to be included in the group must be entered manually.

He elected to use the Metronet radio system which is designed for immediate person to person contact. That was reasonable in my view. The evidence shows that he established contact with the relevant train before it reached Roseville but for some reason the driver did not hear the Signaller's attempt to contact him which would have been broadcast over a speaker in the cabin. The train driver's version of what occurred is not persuasive. I am unable to determine why the Signaller could not reach him. It is relevant that when the Signaller was told police officers were on the tracks attending to the man who had been struck, he tried to alert the next train running down the line in question and was unable to do so. Fortunately, the driver of that train saw the officers and stopped without direction as he had earlier received a warning.

In my view this raises a question about the effectiveness of the Metronet radio system, at least in the Roseville area. However, in view of Sydney Trains' advice that they are in the process of installing a new digital radio system no comment from me in relation to this issue would be of assistance.

The Signaller explained he did not use the "all stop" function available to him on the basis that the practice was to only do so when he was advised there was a direct threat to human life or harm to infrastructure. He said that in the case of a trespasser, the practice is to warn trains.

The Sydney Trains Group Manager, Rules and Compliance said that it was his expectation that when the Train Controller received information regarding a person on the railway, he or she would come to a decision about what to do, in conjunction with the relevant signaller.

The “Conditions Affecting the Network” (“CAN”) is the relevant policy which applies to any situation which might affect the operation of the railway network. The Group Manager, Rules and Compliance accepted it does not give instruction on when it is necessary to warn or stop trains, but said that his expectation is that they would be stopped if there was “*an immediate and present danger to human life”.* He stated that this was already addressed in training. He expressed the view that people cannot readily comply with detailed rules. In any event, the network operators do not use rules alone, they rely on their training. I am of the view the instructions given to Sydney Tains’ staff in relation to how they should respond to the potential of trespassers in the rail corridor is inadequate. I shall return to the issue in the recommendations section of this report

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was FG.

Date of death

FG died on 4 December 2013.

Place of death

FG died at Roseville train station in NSW.

Cause of death

The death was caused by multiple injuries.

Manner of death

FG suffered the fatal injuries when, while severely intoxicated, he went into the rail corridor at night and was struck by a passing train.

Recommendations

Pursuant to s 82 of the Act, Coroners may make recommendations connected with a death designed to contribute to public health and safety and/or to reduce the chances of deaths occurring in similar circumstances in future.

Two issues raised in this case warrant consideration from that perspective:

- Effective communication by some Sydney Trains staff; and
- Sydney Trains policy concerning trespassers in the rail corridor.

Communication

As detailed earlier, I conclude that two of the Sydney Trains staff who received and passed on information from a 000/VKG operator distorted and/or omitted significant aspects of it.

However, I am not persuaded that a coronial recommendation is a useful mechanism for responding to the issue. Effective communication is an essential competency for most modern business or service undertakings. I received no evidence about how Sydney Trains ensures its staff possess the requisite skills. In this case I will simply express the hope that the officers involved in this incident have drawn to their attention how they could have performed their roles more effectively.

Responding to trespassers

Apparently, Sydney Trains has no policy specifically advising its staff members on how they should respond to a trespasser being reported to be in the rail corridor. Rather, they are obliged to consider principles set out in a more general policy dealing with Conditions Affecting the Network and utilise their discretion when considering whether to stop a train on the affected part of the network or use one of the various means of communication to warn all or some train drivers.

It was suggested that a specific policy might be too prescriptive or overburden staff members with too many rules, degrading their capacity to comply. I am not persuaded by this analysis.

Recommendation – Sydney Trains trespasser policy

Having regard to the frequency with which trespassers are detected within the train corridor and the extreme danger this can pose, I recommend that Sydney Trains develops a comprehensive policy instructing its staff on what issues they should consider and what criteria they should apply when determining how to respond to these incidents.

I close this inquest.

Magistrate Michael Barnes
NSW State Coroner
Glebe