QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the deaths of Hayden Duncan, Glen Duncan and Reginald Fisher**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 868-870/06
DELIVERED ON:	23 December 2009
DELIVERED AT:	Brisbane
HEARING DATE(s):	7 October 2009, 24 – 26 November 2009
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Inquest, multiple deaths due to train overrun; rail operators policies concerning trespassers on the rail corridor, use of head lights on trains.

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Families of the deceased boys:	Ms Maria Rinaudo Lewis (ATSILS)
Mr Dennis Smith:	Mr Barry Ryan
Mr James Fisher:	Ms Catherine Hartigan (instructed by Maurice Blackburn Lawyers)
Senior Constable Kym Gralton:	Mr Criag Pratt (Gilshenan and Luton Lawyers)
QR Limited, QR Passenger Pty Ltd & QR Network Pty Ltd:	Mr Paul Favell (instructed by QR Corporate Counsel)
Dept. of Transport and Main Roads:	Ms Premika Prasad (Crown Law)

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The *Coroners Act 2003* provides in s45 that when an inquest is held into the death of a child, the coroner's written findings must be given to the family of the children who died, each of the persons or organizations granted leave to appear at the inquest and to the children's commissioner. These are my findings in relation to the deaths of Hayden Duncan, Glen Duncan and Reginald Fisher. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Introduction

Hayden Duncan, 10, his brother Glen, 8, and their cousin Reginald Fisher, 9, spent the afternoon of 11 March 2006 together traversing areas of Redbank, Gailes and Goodna. Shortly before 6:30pm the three were observed near rail lines between the Redbank and Goodna stations, throwing stones at a Brisbane bound train.

The driver of the next Brisbane bound train saw the boys in the form of 'shadows', crouching between the tracks when the train was only about 20 - 30 metres from them. There was no possibility of his stopping in time and the boys were hit. All three died instantly from multiple severe injuries.

These findings:-

- Set out the matters required by s. 45(2) of the Act; namely the identity of the deceased, how, when, and where they died and what caused their deaths;

- Consider the actions of the train driver to determine whether the deaths were reasonably preventable and/or whether his conduct should be the subject of a referral for prosecution or disciplinary action.

- Consider whether a police officer who spoke to the boys at the Redbank Railway Station approximately 50 minutes before their deaths adequately discharged her duties;

- Critique the appropriateness of QR's policies concerning:-
    - the use of train headlights in metropolitan areas; and
    - the response of train crews and train control to reports of trespassers in or near the rail corridor

The investigations

The incident was investigated by five agencies which looked at different aspects of it. A summary of those inquiries follows.

QPS investigation

Detective Sergeant Tania Plant of the Goodna Juvenile Aid Bureau (JAB)

oversaw the police coronial investigation.

CCTV footage was seized from QR. Checks were conducted with the Department of Child Safety (although no documents obtained).

As a result of his measurements and observations, Sergeant Darryl Morrison prepared a detailed forensic map of the scene.

Detective Sergeant Plant compiled and submitted a report to the Office of the State Coroner detailing the extent of her investigation. Necessarily, reliance was placed on the technical expertise of QR and Queensland Transport investigators with respect to many elements of the investigation. Although statements taken from the QR personnel involved in the incident were brief, Detective Sergeant Plant was entitled to proceed on the expectation that a more detailed and technically relevant interview would be conducted through other channels insofar as it related to, for instance, the manner in which the train was driven. The QPS liaised with the other investigators to an appropriate extent.

The bodies were formally identified by two relatives chosen by the family, Jody Jackson and Stacey Boyd.

Child death case review

In accordance with chapter 7A of the *Child Protection Act 1999* an external reviewer and senior Department of Child Safety Officers reviewed the previous involvement of the department with the families of the children. The review was reported to the Child Death Case Review Committee together with the department's response to the review's recommendations.

The review found no connection between the department's involvement with the families and the children's death.

In view of the exhaustive nature of that review process I determined it was unnecessary for the inquest to investigate the interaction between the Department of Child Safety and the children who died.

QR investigation

QR commissioned three senior officers with risk management and train operations experience to conduct a safety analysis. The purpose was said to be to identify the causes and contributing factors of the collision. Because it was an administrative inquiry not clothed with the protections provided by part 6 of the *Transport Infrastructure Act 1994,* the safety analysts were concerned that material provided to them might not be privileged and consequently they did not seek to interview or obtain statements from QR employees directly involved in the collision.

As a result the material they had to work with was limited. The analysts recognised this and noted QR would need to depend upon the more detailed investigation being commissioned by Queensland Transport and the coronial

investigation. It nonetheless provided useful insight into aspects of train operations that have since been reformed.

The QR report made only one non-specific recommendation:

> *'It is recommended that the accident and associated risks and control measures be reviewed consistent with risk management principles and legislation.'*

Workplace Health and Safety Queensland

WH&SQ limited its investigation to the fencing of the rail corridor. WH&SQ was aware of the other investigations being undertaken and considered there was therefore no need for a more extensive investigation by it. Its findings were not relevant to the issues considered at this inquest.

Queensland Transport Investigation

Queensland Transport appointed an interstate consultant to chair a three person investigation panel to conduct an investigation pursuant to the provisions of the *Transport Infrastructure Act 1994*. Its report contained a number of recommended safety actions.

It would have been desirable for Mr Smith, the driver of the incident train, to have been questioned more specifically in relation to the manner in which train #10M1 had been driven after leaving Redbank station. The tape recording of the interview reveals a rather shambolic, rambling and unstructured interchange. The panel chair stated at the inquest he had taken some comfort from knowing that a coronial investigation was to follow. However, subsequent events have revealed this to be illusory. While there is no doubt the panel members had high level content knowledge, it might be desirable in future to include a person with forensic expertise.

The reports of each of these investigations were tendered into evidence and considered during the course of the inquest as were further statements and reports commissioned for the inquest. As a result I am confident the inquest had access to all information relevant to its function, save and except hearing evidence from the driver of the incident train. An application to excuse him from giving evidence was based on his suffering depression and post traumatic stress disorder as a result of being involved in the fatalities. I accepted the evidence of his consultant psychiatrist that there was a real likelihood the driver would suffer significant psychological injury if forced to given evidence.

In preparation for the inquest QR arranged for me, those assisting me and the legal representatives of those granted leave to appear, to ride in the same electrical multiple unit or EMU (the industry term for the self propelling trains used by QR in the metropolitan network) that was involved in the incident over the same section of track where it occurred. That greatly assisted my understanding of the evidence and I record my appreciation for that assistance.

The evidence

I turn now to the evidence. Of course I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Social history

Hayden Eric Duncan was born on 3 September 1995 and was 10 at the time of his death. His brother Glen Russell Duncan was born on 15 July 1997 and was 8 when he died.

The boys were among seven children to Joseph Duncan and Norma Boyd. The boys' older brother, Joseph Duncan Jr., died in June 2006 as a result of a car accident which followed a police chase.

The boys resided at Mt Gravatt with their parents. Both were attending primary school. The boys had been the subject of notifications to the Department of Child Safety (DOCS) but none had been judged to warrant coercive intervention.

Reginald Roy Fisher was born on 19 October 1996 making him 9 years of age at the time of his death.

He was one of 7 children to his mother Kelly Boyd; four (including him) being fathered by Roy Fisher. Kelly Boyd is the sister of Norma Boyd making Reggie the cousin of Hayden and Glen Duncan.

Reggie resided at Carole Park with his mother and siblings and was attending primary school. DOCS had contact with the family in relation to him from January 1997. However, there had never been an instance of statutory or voluntary departmental intervention by DOCS in relation to him.

Hayden's mother described him as an adventurous and curious child, who loved Hip Hop and R & B music. He also enjoyed watching and performing Hip Hop dancing and playing computer games on his *X-Box*.

Glen was described by his mother as a quieter and more introverted child. He idolised and looked up to his older brother, Hayden. His main interest was playing computer games.

Glen enjoyed school and was a good student, whereas Hayden was somewhat less focused on his school studies.

Both boys loved watching their favourite rugby league team, the Brisbane Broncos.

Reggie, as the family called him, played rugby league for his local team, the Forest Lake Falcons.

All three boys are fondly remembered and sadly missed by their parents, siblings, and the many members of their extended families and school friends.

I offer their families my sincere condolences.

Events 11 March 2006

On the day of the accident, Reggie Fisher had played football at Forest Lake and returned home to Carole Park at lunch time. The Duncan family had arrived there at about the same time.

After lunch, the boys told their parents they were going for a walk to meet up with other children in the area with whom they frequently played. They were told to be home before dark which was the usual rule and Ms Boyd said that generally *"they keep that rule pretty well*."

Over the next three or four hours they were seen by a number of people in various locations between Carole Park and Redbank. On each of these occasions the three boys were together, without any other company. They appeared to be "mucking around", as boys of their age are wont to do.

CCTV footage shows the three boys entering Redbank Train Station at 5:52pm. Two cross the railway tracks by stepping down from the platform and climbing up the other side. The third uses the pedestrian overpass. The three are shown to meet up at a drinking fountain on the Ipswich bound platform.

Between 5:50pm and 6.00pm Senior Constable Kym Gralton of the QPS Railway Squad was preparing for her shift at Redbank train station when she observed the boys on the platform.

She watched the boys from her office adjacent to the platform via CCTV. She saw them throwing soft drink over each other and generally sky larking before two of them walked to the edge of the platform and sat down with their legs dangling over the tracks.

The officer was concerned about the danger of this. She approached the boys, told them to move and that the station was not an appropriate place to play. She asked them who they were with and one, likely to be Hayden, told her "*us three*." The boys were not receptive to the officer's approach and swore at her. She ushered them off the platform and spoke sternly when one of them appeared to pick up a stone and motioned to throw it at her.

She last saw them walking out of the station car park in the direction of Goodna.

Sergeant Geoffrey Cree, another QPS Railway Squad officer observed the latter part of this exchange. He estimated the boys to be aged "*around 10.*"

The boys are observed on the tracks

At 6:16pm a passenger on an Ipswich bound train, #1550, observed the three boys in the rail corridor. They were about 1.1km east of Redbank station and appeared to be picking up bits of the gravel bedding on which the tracks are laid. This information was reported to the train guard.

The guard of train #1550 radioed the train controller at the Mayne Control Centre and advised of the boys' location; that they were picking up ballast and that they had walked over the tracks and passed behind train #1550. The boys were described by the guard as "*youths.*" All trains in the metropolitan area use a single radio channel and so this broadcast would have been audible to all train crew monitoring the radio in their train.

However, in accordance with QR policy, the train controller also contacted the driver of the next train due through the area – the Brisbane bound train #1155 - to confirm the driver of that train, Mr James Fischer, had heard the radio communication from #1550. He had, and he agreed to contact the train controller if anyone was sighted.

Train #1155 left Redbank station at 6:26pm. Mr Fischer, stated at the inquest that as a result of hearing the communication from #1550, when he left Redbank station he drove the train about 20km/hr slower than he would otherwise have done.

This is corroborated by the evidence of the guard on train #1155, Warren Luchterhand, who told the inquest that he understood there to be a requirement that trains be driven at a maximum of 75% of the speed limit in circumstances where there had been a report of trespassers.

The driver said he understood his responsibilities in relation to the sighting of people on the track were to *"report it to control and keep an eye out for th*em." As a result he did not dim his headlight to avoid blinding motorists on Ipswich Road as was the usual practice when traversing this part of the line

As train #1155 reached a point near some billboards between the two stations the driver observed the three boys between the Ipswich bound track and the fence. This was several hundred metres further east from the point where the boys had last been reported. Two of the boys ran towards the train causing him to slow the train further from around 40km/h to 15-20km/h. This was at a point where the speed limit was 60km/h. When it became clear the boys weren't intending to run onto the tracks he sped up again.

The train's guard, Warren Luchterhand, had heard the call from #1550, and observed the three boys near the billboard as the train passed. He saw them run out on to or near the Ipswich bound tracks and throw rocks. He estimates 5 or 6 rocks hit the train.

Coincidentally, Mr Luchterhand was at that time speaking with the train controller about an earlier unrelated incident and so he provided an excited

contemporaneous account of the events involving the three Aboriginal boys, suggesting that his train was being hit from "*either side"*. He gave a description of the three boys as *"lads"* and estimated them to be 10-14 years of age.

The incident train is advised

Mr Luchterhand then contacted the train he knew would be next along the Brisbane line, train #10M1, to advise its crew of the incident and its location. The conversation was recorded:

> Guard 1155*: When you come around the 60K curve between Redbank and Goodna there's 3 little (indecipherable) sized kids up there throwing rocks smashing windows as the trains go by. Just as you come round there the big billboard, mate*
> Guard10M1*: OK. I'll keep me eye open*
> Guard 1155*: Thank you very much*
> Guard10M1*: And me head down'.*

The guard of train #10M1 was John Kathage. He told the inquest that after receiving this message he contacted the driver of the train, Dennis Smith, via the internal intercom system and told him what he'd just been told by Mr Luchterhand.

Mr Smith makes it clear in his statement to police he was expecting the train to be hit by rocks. In a recorded interview with Queensland Transport Rail Safety investigators he confirmed he had been contacted by Mr Kathage and warned about the rock throwing incident concerning train #1155 and its location. He also says he heard the reports made by Mr Luchterhand.

As a result he took steps to reduce the chances of his being struck by rocks or glass fragments if the windows shattered. This involved pulling mesh screens down over the side windows of the cabin and covering the two outer panels of the front windscreen with blinds while leaving enough room under the blind in the centre panel for him to see the track ahead. He said in his statement; *"I had my head down making sure I wasn't going to get hit*." In his interview he said; *"we were just worried about just not getting rocked, to be honest with you."*

In his interview with Qld Transport investigators Mr Smith stated that "*as soon as I hit the road*" he flicked his headlights off. He also said that he *"did not know where they were*', meaning, I take it, the precise location of the boys, despite, having heard Mr Luchterhand's conversation with the train controller.

In his police statement Mr Smith estimated that as he approached the point of collision he was travelling at around 80km/h. This is consistent with the estimate of speed given by Mr Smith to the train controller in the minutes after the collision. It is clear from his statement and subsequent interview that he understood this to be the maximum allowable speed on this stretch of track (although in fact it is 100km/h). At no point in his interview with investigators or

his statement to police does Mr Smith say that he reduced the speed at which the train was driven in response to the report concerning the boys.

Mr Smith says that when he first saw the boys they were crouched between the tracks and by that stage he was "*right on them*". He hit the brakes but "*knew there was no chance*." The emergency brakes of the train were engaged and it stopped approximately 375m after the point of collision.

When they were struck by the train the children were 460 metres further towards Goodna from where they had last been seen by the crew of train #1155 and 360 metres along a straight section of track.

The best estimate of the time of the collision is 6:39pm.

Immediately after the collision, Mr Smith made radio contact with the train controller to say; "*We've just collected those three kids."*

That evening, Senior Constable Warren Gunson, attached to the QPS Railway Squad, was monitoring the QR radio network at Mayne Central Control as part of his duties. He heard the communication relating to the throwing of rocks and contacted the Police Communication Centre at Ipswich to pass on the information. This occurred at 6:30pm. There is no evidence relating to what action was taken by police as a result of this communication.

Actions of the boys' parents

Norma Boyd says she started to worry about the boys when they hadn't returned by 6.00-6:30pm.

At 7.00pm she and Joe Duncan began to drive around the local area looking for the boys. This included searching the local streets followed by Wacol and Gailes train stations, Redbank Shopping Centre, then Redbank and Goodna train stations. After returning briefly to the residence of Kelly Boyd they drove on to Inala Shopping Centre, before searching other parts of the Inala and Forest Lake areas.

Norma Boyd says she told her sister, after the search had been fruitless, that they would have to '*call the police soon'*.

Norma Boyd and Mr Duncan returned to their residence at Mt Gravatt. Some time later Norma Boyd went to the nearest phone box and telephoned Sergeant Jim Bellos at Upper Mt Gravatt police station to tell him that her two children, along with their cousin, were missing.

The police summary of events in the Form 1 states that this call was made at 11:15pm.

Ipswich JAB officer, Detective Sergeant Troy Salton, attended the residence of Kelly Boyd at 2:30am. After identifying pictures taken from the CCTV footage Ms Boyd was advised of the accident.

There were ten children in the house at this time (a mixture of Ms Boyd's children and cousins). Police arranged, on the request of Ms Boyd, to transport her and the ten children to the Mt Gravatt residence of Norma Boyd and Joe Duncan. Police had earlier attended that residence to notify Hayden and Glen's parents of the accident.

The investigation results

Senior Constable Gunson heard the communication from train #10M1 and immediately contacted Ipswich police as well as Sergeant Cree and Senior Constable Gralton. He commenced a running log.

The two rail squad officers arrived to find QFRS and QAS personnel already on the scene. Sergeant Cree spoke to the driver of train #10M1, ascertained the situation and began searching the tracks. QAS officers told him that three bodies had been found. He observed the bodies and immediately recognised them as being the three boys he had seen at Redbank station earlier.

Senior Constable Gralton stayed with the driver and conducted a breath test on him. This showed a blood alcohol concentration of 0.00%.

Officers from the Ipswich JAB were informed of the incident details. Sergeant Darryl Morrison of the Ipswich Accident Investigation Squad and a police photographer attended the scene and the investigation detailed earlier commenced.

The Queensland Transport investigation report concluded the children were between the rails of the Brisbane bound track apparently engrossed in picking up ballast from the track. As a result of noise from the nearby freeway they did not hear the train approaching until it was 20 to 30 metres away.

It noted the speedometer on the train had a 5km/h discrepancy to the extent that it showed the train travelling 5km/h slower than the actual speed and came to a stop 373 metres after the point of impact. During the view it was apparent that after exiting the 60 km/hr curve at the commencement of the straight, a driver would not have time to accelerate much past 80km/hr before the accident site was reached. Normal emergency braking distance for a train travelling at 80km/h, allowing for reaction times, would be 265 – 307 metres. However I do not think this data enables me to make a precise finding as to the speed of the train at the time of the impact, and nor is one required. Rather, I find that the train was travelling at about 80km/hr which the driver apparently believed was the maximum allowable speed.

There is no evidence that the train was not fit for service, nor that any mechanical or operational defects affected its handling or in any way contributed to the crash.

There is no evidence that the train driver was not appropriately accredited in the relevant competencies or that either the driver of the train or the train

controller were adversely affected by alcohol, drugs or fatigue.

All three post mortem examinations took place on the morning of 15 March 2006.

Dr Milne examined the bodies of Hayden and Glen.

Hayden Duncan

- The examination revealed multiple severe injuries including separation of the brain from the skull.
- Toxicology showed the presence of cannabis metabolites in the blood and urine. The blood also showed the presence of toluene. The latter is a component of some paints, and its presence in the blood is most likely due to chroming.
- The cause of death was found to be:
    1(a) Multiple injuries, *due to, or as a consequence of*
    1(b) Train accident

Glen Duncan

- The examination revealed multiple severe injuries including separation of the brain from the skull.
- Toxicology showed no alcohol or drugs in the blood or urine.
- The cause of death was found to be:
    1(a) Multiple injuries, *due to, or as a consequence of*
    1(b) Train accident

Reginald Fisher

Dr Ong performed the post mortem examination on Reggie's body and observed '*the body of a well-nourished and well developed Aboriginal boy measuring 118cm in height and weighing 26kg*'. ECG pads were present on the body.

Dr Ong made these findings:

> '*There were extensive injuries to the deceased. In particular, the head was crushed with extensive fractures. The brain was severely lacerated. The injuries on the head were not compatible with life.*
>
> *Other significant injuries….were serious and might have caused death, the severity of the head injuries meant that the deceased had succumbed before these other injuries would affect the body.*
>
> *No natural disease that might contribute to death was identified. The toxicology examination was negative.*
>
> *The injuries were consistent with that sustained in a train accident.'*

The cause of death was found to be:

1(a) Head injuries, *due to, or as a consequence of*

1(b) Train accident

Mercifully, the medical evidence makes clear the deaths would have been almost instantaneous with the collision.

Findings required by s45

I am required to find, as far as is possible, who the deceased were, how they died, when and where they died and what caused their deaths. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, the material parts of which I have summarised above, I am able to make the following findings.

Identity of the deceased – The deceased persons were:-

Hayden Eric Duncan, 10
Glen Russell Duncan, 8
Reginald Roy Fisher, 9

How they died - The boys died as a result of being struck by a train at night while they were gathering stones from between the rails

Place of death – They all died at Goodna in Queensland

Date of death – They all died on 11 March 2006

Cause of death – Hayden and Glen Duncan died as a result of multiple injuries due to a train overrun.

Reginald Fisher died as a result of head injuries due to a train overrun.

Concerns, comments and recommendations

Section 46 provides a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The investigation of these sad deaths has established a police officer had some limited contact with the boys at Redbank Railway Station about 40 minutes before the accident. Thereafter, a number of QR employees, including the driver of the relevant train, were aware three young boys were on or about the railway lines between Redbank and Goodna stations in the dark. Notwithstanding this, the driver of the train switched off his head light and proceeded at full speed. As a result he did not see the boys until he was 25 to 30 metres from them. Because he was travelling at about 80km/hr he had insufficient time to stop or to sound his whistle; the boys had insufficient

time to get off the tracks.

These circumstances require I consider:-

- whether the police officer who spoke with the boys at the Redbank Railway Station acted appropriately;

- whether QR's policies and procedures stipulating how its train crews should respond to people being on railways lines are appropriate; and

- whether I should refer the conduct of the driver to the appropriate authorities for the consideration of criminal or disciplinary action.

Response of police

In response to concerns raised by members of the dead boys' families the inquest considered whether Senior Constable Gralton acted appropriately by simply ushering them away from the Redbank train station when she saw them skylarking there at around 6.00pm on the day of their deaths.

While the primary responsibility of ensuring the safety of children clearly rests with their parents that does not excuse public officials from exercising their powers and responsibilities if necessary. In this case it was suggested the police officer could have taken the children into protective custody and made enquiries as to the whereabouts of their parents.

Senior Constable Gralton was quite defensive and to some extent non-responsive when this issue was raised with her at the inquest. She stated she had no power to arrest the children and therefore could take no action in relation to them. Obviously this is not the case. Even on her evidence it is clear the children may have been guilty of minor street offences that could have warranted their arrest; although I do not suggest that would have been an appropriate exercise of her powers.

However, it may have been appropriate to consider the use of the power contained in section 18 of the *Child Protection Act 1999* which authorises a police officer investigating a risk of harm to a child to take the child into custody if the officer reasonably believes the child is likely to suffer harm otherwise.

In this case the police officer was faced with three young boys aged 8, 9 and 10. The younger two were very small for their age being 1 metre and 1.2 metres in height and 20kg and 26kg in weight. On the other hand it was still daylight and the boys did not seem to want any assistance from the officer. The families' submission is implicitly critical of her not asking them if they needed help, but according to the officer, they very rudely deflected attempts by her to inquire into their circumstances. It seems Senior Constable Gralton came to the conclusion that as they had got themselves to the station and

appeared to know their way around, they were not in any immediate risk of harm once she had ushered them away from the train track. While we now know her confidence in that regard was misplaced that does not necessarily mean the officer should be criticised for taking no action. Indeed, it is difficult to see what she could reasonably have done. I doubt the boys would have agreed to wait quietly in her office while she made inquiries to locate their parents.

On balance I consider it was not unreasonable of Senior Constable Gralton to consider the children would find their way home unscathed and I therefore refrain from making any findings adverse to her in relation to this issue.

QR policies and procedures

The transport investigation report accurately summarises the position:

> *The trespasser response in place on 11/3/06 is more a practice based on custom and tradition rather than a documented procedure.*

QR Standard 0036/SWK does make it clear at module GS 1.15.1 that:

> *When a train crew on a moving train see a trespasser on QR property, they must give details to the Train Controller as soon as possible.*

However, the only other policy which may be relevant is module GS 2.2.1 which imposes an obligation on the train controller to record and report any unusual incidents and to liaise with emergency services where necessary.

Notwithstanding the absence of a comprehensive written policy, all of the QR employees who gave evidence recognised the need for train drivers to modify their manner of driving when they became aware of people being in the rail corridor.

It is apparent a practice had developed whereby incidents of rock throwing were reported to a train controller and passed on to other train crews in the area. It was then the responsibility of the driver to regulate the speed of the train approaching the relevant area having regard to all of the circumstances.

At the inquest Mr Stone, Mr Shields, Mr Fischer, Mr Luchterhand and Mr Raine gave evidence that a driver would be expected to drive at below the maximum allowable speed where there has been a report of trespassers. This was demonstrated by Mr Fischer driving 20km/h less than the speed limit in response to the reports of the boys being near the track.

There was also evidence that in these circumstances drivers would be expected to "*proceed with caution"* and/or "*proceed with extreme caution"* and although an expert witness was of the opinion these terms had a precise meaning, it did not seem to be commonly understood by the train crew members who gave evidence. Rather their view was because situations varied so much, the magnitude of the reduction in speed should always be at

the discretion of the driver. The train controller would be expected to pass on the information and urge caution but not be prescriptive as to how the train should be driven.

In this case we know the train controller in fact provided no information about the rock throwers to the train crew of the train involved in the deaths – apparently he was too busy attending to other matters. All the information given to Mr Smith came via the guard on his train passing on information from the guard of the previous train who saw the boys, and he failed to mention the explicitly mention boys were within the rail corridor, although it was clear they were close by.

QR Standard 0037/SWK provides guidance on the use of visibility lights and headlights. Module SG 10.4 of the standard dictates visibility lights must remain on at all times when the train is moving. It explains that the purpose of visibility lights is to allow trains to remain visible to oncoming traffic or workers when headlights are switched off.

Module SG 10.5 deals with headlights and starts from the position that they must be on when the train is operating at night. It provides a list of circumstances where it is permissible for headlights to be dimmed or turned off, including where they may interfere with road traffic, although the policy makes it clear headlights are to be switched back on to high beam immediately these situations no longer apply.

The policy says nothing in relation to the use of headlights in circumstances where there have been reports of trespassers on the rail corridor. However, in my view, Mr Fischer again demonstrated the actions of a reasonable driver in these circumstances by keeping the headlight on high when traversing part of the track where he would usually dim or extinguish it.

The QT investigation report concluded that travelling with the train headlights on would not have prevented the collision. I am not so sure. The track for over three hundred metres before the location at which the children were struck is relatively straight. As a result of viewing the illuminating effect of the headlight of the train I am of the view that had the head light been on high beam the driver, if keeping a proper lookout, would have seen the children at least 100 metres further from them than he did. This would have given him more time to sound the horn to warn them off the track. Similarly, the children are more likely to have seen the train approaching. Even if they were not looking in its direction, the illumination of the children and the surrounds would have been noticeable to them. In my view driving with the head light off increased the risk of the children being struck. It seems this may have been a deliberate strategy on the driver's part. He told police "*if you have the headlights on and people are throwing rocks it advertises where you are and makes it easier for them to see you."*

I do not accept the QR submission that various reaction times and delays would accumulate to mean that if the train had its high beam illuminated the

accident would still have occurred. While I can not find that had the headlight been on the fatalities would not have occurred, I am persuaded the risk would have been significantly reduced, and even more so had the driver moderated the speed of the train.

In my view, at the time of these deaths, QR's written policies regulating the response of train drivers to people being within the rail corridor were inadequate: they were uncertain and gave too much unstructured discretion to train drivers. QT's investigation report concluded:-

> *QR procedures did not require that the risk of continued operations be specifically considered by the operating staff involved or that normal train operations be restricted or altered. It is not clear who should take the responsibility for making such a decision.*

It recommended:-

> *QR should review its procedures for managing situations where persons are reported or known to be on or near the track. Consideration should be given to ensuring QR's procedures provide clear guidance and appropriate tools to evaluate the risk and take appropriate and consistent action in such circumstances. The considerations include*:
>
> - *allocation of responsibilities*
> - *identification and consideration of the increased risks involved with the relevant operational staff*
> - *consistent use of terminology when describing persons on or near the track*
> - *determining any appropriate change to normal train operations. This process may include considering the suspension or restriction of train operations, speed reduction and the use of the train's horn and headlight; and*
> - *development of an appropriate tool for ensuring that all information necessary to correctly assess risks is gathered (e.g. checklist)*

The material provided by QR and the now Department of Transport and Main Roads satisfies me that these recommendations have been accepted and acted upon. *Module EP – 1-20 Persons on QR right of way* imposes on train drivers an obligation to notify train control whenever they see persons suspected of being unauthorised on or near the rail corridor and to relay numerous particulars about the person and their activity. The train controller has an obligation to manage the situation with support from his/her superiors. The train driver has the option of stopping the train if necessary, having regard to risk factors set out in a flow chart annexed to the module. It appears to balance the need for a clear decision making process while allowing train drivers to retain an appropriate degree of discretion. It directs the drivers' attention to aspects of the incident that increase the risk of injury or death and provides for the stopping of rail traffic in high risk situations. The use of horns

and the reduction of train speed are mandated when the risk matrix leads to a conclusion that the risk is lower and does not warrant the cessation of train movements.

I am satisfied it addresses the issues set out in paragraph 25 of the submission of the Federated Union of Locomotive Employees. I do however accept the union's submission that the meaning of the term "*proceed with caution*" which is used in that policy and others should be clarified. By its nature the term will not be able to be defined in numerically precise terms – context will usually be relevant - but it was apparent from one of the external experts who gave evidence that other rail operators have developed a standardised meaning and guidelines as to how train crew should proceed when ordered to proceed in that manner. I recommend QR do likewise.

The inquest heard details of the stringent audit process adopted by the Department of Transport and Main Roads in its role as rail safety regulator which seeks to ensure compliance with these and other policies. Apart from one other matter which I shall deal with next, I am satisfied the deficiencies in QR policies for responding to people within the rail corridor have been addressed.

The union's submission drew attention to some anomalous provisions in a *Notice to traincrew no. 134/2008 – Enhancing the safety of traincrew.* It purports to detail how traincrew should respond to incidents of rock throwing. It could be interpreted as indicating that only after a third train is hit by the same rock thrower(s) should consideration be given to stopping train movements.

As already detailed, the *Module EP – 1-20 Persons on QR right of way* sets out how traincrew should respond whenever they see unauthorised persons *"on or near the QR corridor*". This would clearly cover rock throwers, even if they were outside the rail corridor. As described earlier, it mandates a comprehensive risk management approach which may well result in the immediate cessation of train movements if the risk posed by rock throwers was high.

Recommendation 1 - Review of Notice to traincrew no. 134/2008

I recommend QR review Notice to traincrew no. 134/2008 to ensure its consistency with Module EP – 1-20 Persons on QR right of way.

Recommendation 2 - Standardised terminology

I recommend QR develop and use in all its policies and notices to employees a standardised meaning for the terms "proceed with caution" and "proceed with extreme caution."

Criminal or disciplinary action

The Coroners Act by s48 requires a coroner who, as a result of information obtained while investigating a death, "*reasonably suspects a person has*

committed an offence," to give the information to the appropriate prosecuting authority.

I take "*committed an offence*" to mean that there is admissible evidence that could prove the necessary elements to the criminal standard.

The Act also provides in s48(4) that a coroner may give information about a person's conduct in a profession or trade to a disciplinary body for the person's profession or trade if the coroner believes the information might cause the organisation to inquire into or take steps in relation to the conduct.

In my view those provisions require me to consider whether I should refer the conduct of the train driver to the Director of Public Prosecutions to enable him to determine whether a charge under section 328A of the Criminal Code - dangerous operation of a vehicle causing death - should be preferred. I also need to consider whether I should give the information gathered during the course of the investigation to the CEO of QR to enable him to consider whether disciplinary action should be taken.

Clearly, it would have been preferable had the children not been allowed to roam the suburbs unsupervised – they were clearly too young to take adequate care of themselves. However that does not mean that anyone involved in causing them harm should necessarily be excused.

It is obvious the train driver, Mr Smith, has suffered significant psychological injury as a result of being involved in these fatalities, the effects of which are ongoing. It is easy to understand why this would be so: the experience must have been truly horrifying. Of course I have sympathy for Mr Smith's position but that can not be allowed to deflect consideration of whether his conduct warrants some sanction.

Referral to the DPP

The Criminal Code in section 328A(4) creates an offence in the following terms: "*A person who operates…a vehicle dangerously in any place and causes the death... another person commits a crime*".

Section 1 defines a "*vehicle"* to include a train.

In determining whether a vehicle was being operated dangerously it is appropriate to apply an objective test – *R v McBride* [1962] 2 QB 167. For this reason the accused person's state of mind – that is whether he or she intended to drive carefully or dangerously is irrelevant and the offence does not require proof of criminal negligence – see *R v Wilson* [1965] QWN 42. It is simply a question for the jury to determine whether the manner of driving was dangerous in all of the circumstances.

For many years Queensland courts had held when determining whether a person was guilty of dangerous driving the Crown must show some fault on the part of the driver which caused the danger to the public – see *R v Webb*

2[1986] 2 Qd R 446. However that is no longer the law. In *R v Wilson* [2008] QCA 349 it was confirmed that the High Court decision in *Jiminez v R* (1992) 173 CLR 572 obviated this. In the leading judgement of the court McMurdo P stated; "*it follows from Jiminez that in a trial for an offence against section 328A the jury need not be told that fault is an element of the charge. That is not to say that in establishing the offence any consideration of the offender's mental state must necessarily be disregarded. Section 24 and other provisions of chapter 5 Criminal Code like section 23, section 25 and section 31 are sometimes raised in such cases*".

Applying that law to the circumstances of this case I am of the view that a jury is likely to conclude that driving a train at 80 kilometres, in the dark with the headlights turned off when there were children on the track was objectively dangerous. The question then becomes whether the Crown could negate the defence provided by section 24 - Mistake of fact. That is, could the Crown prove that Mr Smith did not have an honest and reasonable belief that it was safe to drive in the manner in which he did because there was no likelihood of any person being on the track.

In assessing that issue it is necessary to consider what Mr Smith knew about the circumstances in which he was operating the train.

Although the broadcast from the first train to encounter the boys indicated they were on the track when they crossed the line behind the train, it can not be shown that Mr Smith heard that broadcast. It seems likely his train was still in the stable being prepared for its first run of the evening. Mr Smith may have been in the train's cabin or he may have been elsewhere, we simply don't know.

The broadcast from the guard on the second train to come across the boys to the guard on Mr Smith's train, that Mr Smith did hear, was specific about where the incident was occurring, but said only that there were *"kids up there throwing rocks, smashing windows as the trains go by".*

The evidence indicates that people frequently throw rocks at trains from vantage points outside the rail corridor and usually leave soon after doing so to avoid apprehension.

In the circumstances while I consider Mr Smith did operate the train in a dangerous manner, there is little or no likelihood of his being convicted of an offence against s328A of the Code because the Crown could not negative a defence clearly raised by the evidence. I will not therefore refer the material to the DPP.

Referral for disciplinary action

Mr Smith was an employee of QR Passenger Pty Ltd. That entity has a code of conduct: breaches of it can result in disciplinary action which can, among other things, lead to dismissal. Misconduct is defined in the code to include "*conduct that causes imminent and serious risk to the health or safety of a*

person". Further, in the section headed "*Responsibilities of employees"* it provides; "*All employees shall carry out their duties in a manner that is safe."*

I have found that Mr Smith failed to modify the manner in which he drove the train after being told information that should have alerted him to the possibility of children being in the train corridor. Instead, he pulled down the blinds in the cabin to protect himself, drove at full speed and turned off the head light. While QR's policies were deficient in not explicitly detailing what was required, according to the experienced train crew who gave evidence it was accepted custom to "*proceed with caution*" in such circumstances. The train which preceded the incident train was driven by Mr Fischer who demonstrated what should be done: he drove much slower than the maximum allowed and kept his headlight on. When he saw the boys he slowed further until satisfied they were not going to run onto the track.

The defence that would protect Mr Smith from a criminal conviction has no application in the disciplinary forum because it would not be alleged he caused the deaths but simply that he failed to drive the train safely in accordance with accepted custom and practice as required by the code of conduct. Accordingly I shall refer the material gathered by the inquest to the CEO of the employing company to enable him to consider whether disciplinary action should be taken.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
23 December 2009