WHAT TO DO UNTIL THE CORONER COMES

Presenter: Phil A'Vard
Session Chair: Dennis O'Hoy

Session Secretary: Bill Kingsley

In the late 1950s a small group of people in Wales started a movement which was to be copied all over the world.

A dedicated band of young enthusiasts proved to the Government and to the population of England, that a railway could be restored and operated by volunteers, i.e. by ordinary people working in their own time.

The late 1950s and early 1960s saw this urge to preserve railways and tramways spread into all points of the compass, with the result that there are now hundreds of rail guided systems of one form or another, preserved and operated by amateurs in almost every country.

In the 1970s and early 1980s we saw these groups develop into small businesses in which well-wishing amateurs give their labour free to the enterprise, allowing them to invest their fares in capital development and in the employment of personnel to service their equipment and, in some cases, to operate and market.

Development and consolidation was perhaps not as difficult as one might think. The organisers, i.e. the management, had years of tradition and practice upon which they could model the development of each enterprise. There were existing rule books, practices and laws which would guide them in the restoration of their relics and satisfy the nostalgic needs of their volunteers, club members and patrons. In many ways the 80s were perhaps the halcyon years of the preservation movement.

The 1990s however, are different. These are the years in which the preservation movement will have to grow up. Forty years after the first act of preservation, we find that our preserved relics are now operating in a different world. We are still offering enjoyment to patrons and to volunteers. Their expectations are no longer those of people of the 1950s. Patrons see the enterprise as a tourist attraction (i.e. as a business) and have much less sentiment for voluntary operation. Volunteers today are now in a second generation phase, without the same dedication and wisdom of their earlier brethren. Most cannot recall the preservation phase and have joined the organisations for reasons other than that of saving it.

Something else has happened however, and it may be time for amateur management of preserved railways and tramways to become aware of this. I refer to the fact that in the 1990s the environment in which our businesses operate has changed dramatically! The rules of a century ago are no longer relevant or are under challenge.

Since the mid 1980s we've seen at least three changes which will, in time, have enormous effect on our businesses. There are more to come! The first of these changes was the lifting of the bans upon the legal profession advertising their services. This means every newspaper one turns to, will have ads claiming that one solicitor or another can "get you money" by acting on your behalf against the perpetrator of an outrage against you. The net effect of this is that we are moving very quickly to the American style of economy where the first words that are uttered after the word "ouch" are "who do I sue?"

The second change and probably the most far reaching, is the Occupational Health and Safety philosophy. This had its roots in the U.K. and Europe many years ago and has the effect of taking from government authority the responsibility for ensuring safety in the work place and other areas and transferring it to the occupiers or the proprietors of the work places. Occupational Health and Safety Acts do not prescribe any specific safety procedures, yet they have the power to "hang" anybody who does not follow one. They also have the power to trace responsibility for any negligence or malpractice down to an individual, be it a volunteer or an employee of the organisation.

A third one is director's liability. We have seen in the last decade, the removal of corporate protection of decision-makers and it is possible now for individuals serving on the committee or on the board of any of our preservation businesses to be sued by shareholders (i.e. members), or by the Australian Securities Commission for negligence in exercising their directorial duties. This almost means that every member of a board can be sued if an error is made in a balance sheet and not detected by their vigilance. It can also extend to management at all levels.

There are more changes in the pipeline. Recently, there came across my desk, a draft of a new Victorian Act, the "Equipment Public Safety Act, 1994". This had been issued for comment before being proclaimed. After proclamation, it will have, I believe, a substantial impact on all of our operations. The object of the Act is to secure the health and safety of persons in relation to the design, construction, manufacture, installation, erection, alteration, maintenance, repair and use of prescribed equipment to protect people generally against risks to health or safety in relation to prescribed equipment and to eliminate at the source, risk to health and safety of persons in relation to the design, construction, manufacture, installation, erection, alteration, maintenance, repair and use of prescribed equipment.

The definition of the words, "prescribed equipment" is given as "any equipment which is declared by the regulations as "prescribed equipment"". I have yet to find any reference to qualify this further other than a

reference to the fact that The Governor in Council may make regulations declaring any equipment to be prescribed equipment.

What is it that we are operating other than equipment? Implications behind this are not unlike that of Occupational Health and Safety. It places the onus of ensuring that the equipment is safe upon the proprietor, the designer and probably, the operator.

Let me ask you now, does any of us really understand the full design parameters of the ancient equipment that we are now running? Have we added to it in any way? In so doing, did we undergo a full analysis as to the safety of the particular item that we added? Has it been appropriately stressed from an engineering point of view? Was the timber used in a repair, the appropriate structural grade for the job to which it was being applied? What were the qualifications of the person who decided to make the repair and/or what were the qualifications of the person who designed the improvement? How many times have we, as amateurs, done things to our equipment and then placed it into public traffic? That individual as well as the employer can be culpable under the Act.

Neither the Occupational Health and Safety Act nor the Equipment, Public Safety Act, 1994 gives any guidance or clear definition for their term "so far as is practicable" with regards to safety procedures. They do provide, however for the relevant Minister to approve a code of practice. Compliance with such a code absolves individuals or organisations from civil or criminal proceedings. However, the preparation of such codes is not prescribed by any Act and requires a vast amount of spade work to be done by the organisations concerned.

The existence of these Acts brings into question the rules, regulations and practices which have been used by the preservation groups since they began and since the enterprises they preserve began. They also highlight the risks to which volunteers expose themselves in undertaking roles in operating under these rules, regulations and practices.

All is not as gloomy as it may sound. Fortunately, these same Acts also apply to the professional railways.

In Victoria and New South Wales, most of the preserved railways are supervised by their respective public transport commissions. Both of these States have now introduced a system of accreditation against which railways, professional or amateur, can be assessed. The process refers to any gauge 2ft. and upwards. This Railway safety accreditation process examines safe working procedures, administration, engineering practices and standards, training and certification of staff competency, emergency procedures and management policies. In fact, almost every aspect of operating the rail enterprise is subject to detailed examination.

At present, the system is being administered through the Public Transport Corporations of both states and applies to railways only. I however suggest it is only a matter of time before a National Rail Safety accreditation process will apply to every railway and tramway system throughout the country. While such a system will not replace Occupational Health and Safety and similar Acts it will provide the mechanism for the establishment for Codes of Practice.

It would behove all preservation groups to adopt common practices, standards and procedures so that a common code of safety practice would apply across all preserved railways. Victoria has taken a step in this by adopting standard regulations and safe working procedures which apply to all preserved lines.

The amount of work involved in this however, is prodigious. The rail safety accreditation process is not one which specifies the practice. It is, as the name says, one which gives accreditation to the practices and procedures which are adopted by the organisations.

Every organisation can submit its own set of practices to the process and be given accreditation individually. I suggest however that we would be better served if we were to establish an industry Code of Practice which would be approved under Occupational Health and Safety and similar Acts. The great advantage of this would be in the mobility of volunteers.

If safety procedures were standardised throughout the industry, the transition of volunteers between preserved systems would simply involve certification in local knowledge and practice rather than the full scale training and certification for each organisation.

Having painted a part-picture of the environment in which our enterprises now exist, I now turn to a small aspect of the scene in order to justify the colourful title of this paper. That of procedures in an emergency!

A detailed examination of such procedures will be one of the first aspects of your operation to be considered under any form of accreditation.

In its forty years of existence, the railway preservation movement in Australia has led a "charmed life" in so far as accidents are concerned. However, as the insurance companies say, "the longer you go without an accident, the bigger it will be when it happens". In short, the next big one could be just around the corner.

Avoid complacency! It can happen on your railway at any time! Already we have had, to my knowledge, two fatalities on preserved rail systems. Last year saw a boiler incident on a railway in South Australia in which at least one person was killed. I believe in New South Wales some years ago, a footplate man was fatally injured. We are operating dangerous equipment and despite stringent operating precautions, anything can and invariably, will happen. When it does, the entire reputation of your organisation which may have been built up over forty or more years, will be put to the test. After the crunch, you only have a matter of minutes in which to save the reputation, the organisation and perhaps its directors, staff and volunteers from prosecution.

Let me now paint another picture.

It is a quiet Sunday afternoon during the January school holidays. Most of your regular volunteers are on vacation, as is most of the executive management. Despite their best efforts, the roster officers have been unable to fill all operating positions for the day, so you are running slightly short-staffed. As most of your skilled and experienced volunteers are absent, the operation is being performed by those of lesser skills and experience. These may be very willing and, in fact, qualified personnel who are second or third generation volunteers. Even though qualified, they may not have the experience of older members or full time employees.

This, I am sure is a familiar scenario. Now let's introduce an unfamiliar one.

Through equipment failure, a tram loaded with people derails on an embankment. The trolley pole entangles in the overhead and brings it down, the tram rolls on its side down the embankment. The nearest road is 500 metres away across a field. Trapped in the tram are injured children, people possibly killed. The tram driver is unconscious. The conductor, a youth.

If this was your tramway, what would happen next?

* Would the conductor know who to call for assistance?
* Is there a communication system available for the conductor to use?
* Is there a senior person on duty for the conductor to contact?
* Has that senior person been trained in what steps to take in this situation?
* Has that senior person the means to make that contact?
* Is there a suitable qualified person on hand to disconnect the power supply?
* Does that senior person (if any) have instant access to telephone numbers for emergency services?
* Will he lose valuable minutes rummaging through the telephone directory?
* Does the tramway have emergency breakdown equipment available and does it have people available who are trained in its use?
* Is there a system whereby the location of the incident, can be identified clearly to emergency vehicles? There is no sense in telling the emergency services that the incident took place at "Fred Nurk's Curve" on the tramway.

Let's now assume that someone has managed to make the right decisions and that the emergency services have been called, the State Emergency Services, ambulances and fire trucks et alia have all turned up on the scene and the dead and injured are being taken away. The police arrive!

* Who represents the organisation on the scene, to the police? Bear in mind, the incident took place on your own property and is not a road traffic matter.
* Is there a mechanism in place for the gathering of information and evidence which can be used by the organisation to determine the cause of the incident?
* Is the mechanism sufficient to be used as a defence in subsequent litigation in a court of law or in the Coroner's Court?

* Is there a mechanism to protect volunteer staff from incriminating themselves when making statements to the Police?
* Has anybody thought of bringing out their camera and photographing the incident from every possible angle?
* Is there a competent person available to handle questions from the press?

Let us now move to events after the incident. The wreckage has been cleared away, the damage has been repaired and it is time for the great wash-up.

* Is there a formal mechanism for the evaluation of the evidence which was gained from the site?
* Has the cause of the incident been identified?
* Has appropriate action been taken to ensure that it will not happen again?
* If there is any blame, has it been apportioned?
* What disciplinary steps if needed, have been taken?
* Has the organisation a policy of assisting volunteers when in court?
* Has the organisation any system where a volunteer, who has been traumatised by an incident of this nature, can be counselled? In this case, think of the driver or the conductor or the first on the scene, each of whom has witnessed death and serious injury.
* Has the administration of the organisation evolved a system whereby reports arising from incidents of this and any other nature are systematically recorded?
  And last, but certainly not least;
* How far is the organisation prepared to go in supporting a volunteer whose negligence contributed to the accident and to the deaths of the people concerned? Employees generally, have their Unions. What support do volunteers have?

Most of the points covered above are sufficient to make our collective hair stand-on-end but I assure you they are real.

As mentioned at the beginning of this discussion, the emergency services vehicle will probably run neck and neck with the legal profession trying to get to the victims and law suits will follow an incident of this nature like waves on a beach.

"But that then, is the job of the insurance company", I can hear you saying. That may well be. The insurance company will certainly research behind the scenes, will take advantage of all the information you gather and will fight on your behalf, but it involves an enormous amount of input on your part. Volunteers will be called to give evidence. The integrity of your organisation will be called into question by the prosecution. The press will be in court seeing what dirt they can get upon you. Prosecuting barristers will have a field day about "amateurs playing trains or playing trams". The insurance company will certainly look after their interests in the case. They will not necessarily seek to protect volunteers or your organisation and they are not necessarily interested in "hosing down" the press. This leads to my first question - has your organisation the executive resource to oversee its interests in such a situation?

Now that's a grim picture and it's on the cards for every one of us. So, having terrified you, I hope, I'll now give you some examples of what my organisation has sought to do in these matters.

It's not possible to cover every contingency in planning emergency procedures, but with an incident such as that described, any procedures that have been laid down are going to save precious seconds, will save lives and may, in the long term, save your reputation and credibility as an operating entity. I ask you to use these ideas and examples not as a total solution to your problems but as a basis for you to form your own procedures.

Firstly, we have in place a system of incident reporting. Located in the kit of every guard on every train, in every signal box, in every station, in every office is a blue form or "The Incident and Defect Report" - the ubiquitous "I.D.R.". This is a form, which, if followed correctly, will note most important details surrounding an incident. We have conditioned our workforce, both voluntary and professional, that they must complete one of these forms when any incidents occurs that could cause injury, be of any embarrassment to the organisation, or be of potential damage or injury. These are collected by the station master every day and transmitted to the relevant divisional manager. After action, they are filed.

Secondly, we have invested heavily in communications. From the beginning, we had a telephone line which ran adjacent to the right of way between the terminal stations. Very early in our history, we went to train-to-

base communications by the installation of portable radios in each guard's van. We have latterly installed a far more flexible and wide reaching system and are encouraging now all drivers and guards to carry hand-held radios to supplement the main train-to-base system. The telephone line has been retained with a more sophisticated exchange system and we have installed telephone boxes along the track at approximately every 500 metres. Telephones are also located at every level crossing. As a backup to our own system, Telecom telephones are located at every station along the line. It is possible therefore for an officer on the train to have access to some form of communication within minutes of any incident happening.

Thirdly, we have evolved a system of identification for places along the railway. The poles of the old telephone system have been placed to good use. Starting at Belgrave, every telephone pole along the right of way has been numbered. The location of each pole has been recorded on a strip map of the railway line. Copies of this strip map have been distributed to the emergency services in the district, namely, the Fire Brigade and Ambulance services. Hence, it is possible for an officer of the railway to indicate to the Ambulance or the Fire Brigade the pole number at which their attention is required.

The service is then able to locate that number and its adjoining road by reference to the plan provided for their reference.

Located in every station along the railway line where they are constantly in view to senior personnel, are copies of the folder labeled "Emergency Procedures Manual". Personal copies of this manual have been issued to every Station Master on the roster along with instructions as to their use. Fortunately, from the very beginning the Puffing Billy organisation instituted an hierarchical structure where the station master of the Belgrave station was to be the key person in the day's operation. The station master is always in attendance at Belgrave whenever the train runs and therefore is a logical focus for the first point of call in an emergency. The emergency procedures manual defines incidents or accidents in a series of three categories.

The first being simple derailments, with no injuries being involved or simple level crossing collisions.

The second being incidents which occur on the property which result in injury or death to any person but not which we consider to be a disaster of major proportions.

The third is any incident or accident of major proportions such as a major derailment, major level crossing accident, fire, flood, landslide or other "Act of God".

The manual lists a set of contacts which must be made by the officer in charge or the station master for each of these categories. These range from a "call out" of staff for the first category, through to a major call out of Board members and senior management in the category three. It also indicates the emergency services to be called out in each category and lists the numbers of the services in the area.

Attached to the three main pages of the manual is a comprehensive listing of senior management, all operative staff and all Board members. With this manual the station master is able to assess the scale of the incident and contact the appropriate people to take the matter in hand thereafter.

The railway has invested heavily in a breakdown resource. Working on the premise that there are parts of the railway which are inaccessible for road vehicles containing heavy salvage equipment, a special van has been fitted out with jacks, oxy-cutting equipment, tackle, winches and other materials which may be required to move, re-rail or perhaps wreck equipment involved in an incident. This is located at the middle point of the railway line i.e. Emerald where, on most occasions, a small shunting locomotive is available to move the breakdown van to any part of the railway.

The senior management of the railway holds workshop sessions among themselves as to what would be required in the event of a disaster. At present, this takes the form of general discussions between people who are likely to be concerned. However, it is proposed in the future to conduct actual mock exercises.

We put our mechanisms to the test. In early 1994, the Emerald Tourist Railway Board co-operated with local authorities in staging a "disaster" which involved local police, local ambulance, local fire brigade and local emergency services. Thus, a mock accident was staged which involved a car colliding with a locomotive and a petrol tanker subsequently colliding with the side of the stationary train at a road crossing. Naturally, the exercise was conducted out-of-hours. The exercise was useful to all concerned as we all found the flaws in our arrangements, particularly in communications. I won't go into details with this paper; there is a handout in the

form of a reprint of an article from our magazine "Narrow Gauge", which will give a brief description of what took place on the day.

We have in place, mechanisms of inquiry into incidents and the reason for their happening, to make recommendations to see that they do not happen again and to apportion blame, if necessary.

These are on two levels. The lower level inquiry coincides with incidents in category one of the Emergency Procedures Manual. This takes the form of an inquiry conducted by the manager of the relevant division concerned with one other manager from a totally uninvolved area. The other form is a formal "board" of inquiry which is set up for incidents under categories two and three.

Each of these requires the gathering of written evidence generally on the I.D.R. forms mentioned above and interviews with people concerned with the accident or with eye witnesses. These reports are gathered, numbered and filed in chronological order on a master file which is kept permanently in the main office. Under the Act of Parliament which controls the Emerald Tourist Railway Board, the result of any board of inquiry i.e. for categories two and three, must be submitted to the Minister for Tourism.

I turn now to the item I was first asked to address in this paper; the matter of a Board of Inquiry.

In the event of a category two or three disaster on Puffing Billy, the role of the senior board member when summoned by the station master, is to attend the site and appoint as quickly as possible a board of competent people to inquire into the cause of the event. This board is generally made up of two members of the Emerald Tourist Railway Board, at least one manager of a division of the railways management whose division is not involved in the incident, if appropriate, the manager of the division involved and a person/persons with skills which relate to the perceived cause of the incident. For example, if the incident was caused by a safe-working misdemeanor, the appropriate person would be the railways safe-working officer.

To assist this group of people, some person with stenographic or secretarial experience is recruited. One of the board members selected for the board of inquiry is nominated as the convenor.

The board is convened as soon as possible after the event. This is necessary for obvious reasons, the closer to the event, the more accurate is the evidence to be obtained, recollection is sharp and the less opportunity there is for collusion. It is quite surprising that the longer the time lapse between the incident and the inquiry, the more identical does the evidence from all participants become.

The first role of the board is to examine all written submissions received and decide which witnesses should be interviewed. The conduct of the inquiry is done on much the same way as for a job interview. The person is brought into a full, formal interview situation and quietly asked questions with regard to what took place. Questions are based upon the previously obtained written submissions and other oral evidence received. Over a period of time, the board gains a fairly clear picture as to what took place at the event and where any faults may have lain. On occasions, a board has adjourned to inspect certain aspects on the site. In one case, a separate meeting was held on the site of a derailment along with the manager, mechanical engineering to check the gauge and cant of the curve at which the derailment took place.

Once the board has processed all the information and is satisfied that it has sufficient evidence, it then formulates its conclusion and any recommendations that it may see fit. This is then written and presented to the management of the railway.

The board is required to determine the reason for the incident and to apportion blame and to make any recommendations it sees fit to see that such an incident may not happen again.

The board does not discipline anybody. That is left to the management which may choose to withdraw qualification, suspend volunteers or reprimand staff. The report is generally signed by the convenor of the board and is forwarded to the Chairman of the Emerald Tourist Railway Board. The Emerald Tourist Railway Board then may accept the report and forward a copy to the Minister for Tourism as is covered by the Act of Parliament. Recommendations made by a board of inquiry become very important and must be acted upon or consciously rejected by management. If rejected, there must be very good reasons because obviously, if a board of inquiry has examined an incident and detected a fault in the system and if the fault should happen again and result in serious injury or death to a passenger or volunteer, the management itself will become culpable.

The Emerald Tourist Railway Board has a policy that in the event of an incident involving death or serious injury, its solicitor will be appointed as a member of the board of inquiry particularly to make certain that the correct questions are asked of all witnesses. This, of course, is in the interests of the Emerald Tourist Railway Board as the report from the board of enquiry is bound to finish up as evidence in a coroner's examination.

I see that the number of pages I have taken up in this paper is now approximating to a number of small trees. I will therefore finish.

I hope I have given you enough nightmares to keep you going for the rest of the year, but I'll leave you with just a number of questions which I hope you will mull over and may keep you awake for a few nights more.

How would your operation stand up to an "Occupational Health and Safety" audit? Does your organisation have a disaster plan? Have you documented your engineering, operating and training standards and have they been certified by some competent person? Have you developed a policy as to how much you would support a volunteer who has to confront a Coroner's court inquiry or in the case of litigation against your organisation? Does your first aid policy conform with the present day codes of practice?

If any of these or any of the questions I have asked throughout the paper cannot be answered in the affirmative, then I suggest my last question should be: "Have you taken out Director's insurance to cover the liability of your executive and management members?"

Editors Note:- The following article appeared in "Narrow Gauge" March 1994, the official journal of The Puffing Billy Preservation Society. It reports on their 'dry run' in graphic detail! We reprint it here with thanks to, and the permission of, the Editor of 'Narrow Gauge', Phil A'Vard.

RECIPE FOR DISASTER

By Don Marshall

At approximately 5.00pm on Saturday, February 5th, 1994, a special passenger train travelling in the Down direction collided with a car at the School Road Level Crossing at Menzies Creek.

The car, carrying two occupants, had been standing at the crossing waiting for the train to pass when it was struck from behind by a petrol tanker which lost its brakes coming down the steep hill on the approach to the crossing. The car was propelled by the impact onto the rails and was then struck by the locomotive of the train. The force of the second collision drove the car to the extreme down end of the crossing where it eventually came to a rest jammed under the front pilot beam of the locomotive.

The petrol tanker, after colliding with the car, slewed sideways, striking the first and second carriages of the train. The force of the impact derailed both carriages and turned the first one on its side. The second carriage, although badly damaged, remained upright and attached to the rest of the train.

The results of the collision were as follows:

1. MOTOR VEHICLE: badly damaged with occupants injured and trapped inside.

2. (a) LOCOMOTIVE: slight damage to front end. Front pony wheels, Front driving wheels and centre driving wheels all left the rails.

   (b) CREW: Both driver and fireman were dazed and shocked. The fireman had a burnt arm after making contact with the boiler backhead during the collision. The driver experienced a severe blow to the head.

3. (a) PETROL TANKER: Although relatively undamaged, the tanker came to rest alongside the two derailed carriages. Extensive damage, however, occurred to the control valve assembly and fuel discharging from the tanker ran down-hill from the Down side of the crossing to the Up side where it flowed down the embankment towards houses and the Selby-Aura Road. Fumes were evident.

   (b) TANKER DRIVER: Although injured in the collision was conscious.

4. (a) 1st CARRIAGE: This vehicle took the main force of the collision and was badly damaged. The carriage was derailed and tilted over on its side supported only by the Automatic Couplings. Injured passengers were still trapped inside while others were thrown out onto the ground and down the embankment. Petrol from the damaged tanker flowed underneath this carriage.

   (b) 2nd CARRIAGE: Although derailed, this carriage remained upright. The force of the collision, however, forced the doors open throwing injured passengers onto the ground and down the embankment.

5. REMAINING CARRIAGES: There were a large number of people in the remaining carriages behind the 2nd carriage.

Some of these people suffered minor injuries (bruising etc) but were able to walk.

The location, the terrain and the leaking fuel made it impossible to bring these passengers forward to School Road for alternative transportation.

The stuff nightmares are made of? Most certainly. Fortunately it didn't really happen on this occasion - but it could.

It all started one evening in September 1993 when the local fire brigade captain wandered into my home workshop where I was drilling holes and said "what about this emergency exercise we are always talking about?"

I eventually ran out of excuses and agreed that the Railway would be happy to participate. Following several meetings with representatives from the local emergency services e.g. Police, St John Ambulance, Fire Brigades and the S.E.S., the date was set for 5th February, 1994.

It was agreed that I would write the scenario, and pick a location which would present a degree of difficulty for all concerned.

In addition to testing the capability of the emergency service groups, the scenario was also designed to test the Railway's emergency procedures and expose operational staff to the problems which could be encountered should a real emergency ever eventuate.

The great day arrived and the "Disaster" train left Belgrave at 3.40pm on time to cross the last Up train from Lakeside at Menzies Creek.

Travelling on the train were 180 guides and scouts, many whom were made up to look like accident victims.

Following receipt of the ACRE message from No.20 Pass on its arrival at Belgrave, No.7A propelled the "Disaster" train in the Up direction clear of the School Road Level Crossing.

Fire Brigade workers then unloaded the collision car (a wrecked ....) and placed it in position at the Down end of the crossing.

The "Disaster" train was then bought forward so that 7A's cow catcher was in contact with the car.

In order to ensure authenticity, Driver Graeme Daniel gave the car a hefty nudge with 7A's auto coupling.

The petrol tanker was manoeuvred into position on the high side of the crossing to lie roughly parallel with the first two carriages. The control valves were then opened to allow coloured water to leak out of the tanker.

"Accident" victims were strewn out on the grass and down the embankment beside the train.

The locomotive crew, Graeme Daniel and Andrew Marshall, were suitably made up to reflect their injuries.

The scene was now set and four long blasts of 7A's whistle brought guard Tony Stratford to the front of the train to assess the problem and take appropriate action.

After absorbing the basic details of the accident, Tony called Belgrave Station Master Rob Emmerson from the Trackside phone at the crossing, relaying essential details and requesting assistance.

Utilising the Emergency Procedures Manual, Rob then triggered the exercise by calling the various emergency services.

In a short time the accident site was a hive of activity as the fire brigade attempted to deal with the problems of leaking petrol, the St John Ambulance attended to the "injured" passengers and the S.E.S. tried to assist the passengers of the wrecked car.

Residents turned up to survey the goings on, presenting police with a real problem of crowd control.

Back on the train our two Conductors, Errol Hermann and Doug McLeish, were attempting to control the remaining passengers and stop them from leaving the carriages.

In order to test the Railway's safeworking resources it was arranged for the Train Staff to be "lost".

Because in theory the remaining passengers could not be brought forward past the leaking fuel tanker a request was made to Belgrave for a relief locomotive to rescue the rear portion of the stranded train and to take the passengers to buses which would be waiting at the Selby Aura Road crossing.

With the Staff "lost", the Belgrave Station Master now ably assisted by personnel from the "Commissioners' Special" Train, instituted a form of Pilotman working in order to dispatch D21 to the accident site and return with the rear portion of the train. At Belgrave the "Commissioners' Special" crew moved to set up a "Damage Control Centre" to cope with public enquiries and enquiries from relatives of those travelling on the train.

From the accident site a request was made to the Station Master at Belgrave and to Signalman Peter Walker at Menzies Creek to make arrangements for the breakdown van to be bought down from Emerald.

This was done and in due course the breakdown van propelled by NRT1 and crewed by Alan Johnstone and Alan Gardner with Workshops Foreman Neil Mathieson in attendance made its way under the protection of a red flag to the accident site.

At the rear of the train, Guard Stratford, having protected his train in the rear, was guiding D21 onto the rear portion of the stranded train.

D21, crewed by Ron Gunn and Ian Newman together with co-opted Pilotman Chris Raggett, arrived at the accident site at 6.33pm, approximately one hour and twenty minutes after the emergency started which was a very creditable effort considering that the Driver was called from home.

Also at the accident scene were the Railway's Chairman and Vice Chairman who commenced to gather material for the Board of Inquiry and who provided support for the Railway's operating personnel where necessary.

Many other actions were of course taking place but which are too numerous to mention in this brief report.

By 8.30pm the accident site had been cleared and the remains of the "Disaster" train were moved to Menzies Creek where the train and emergency crew members were fed.

What did we get out of this?

As was intended, the exercise revealed a few weak spots in the emergency services activities.

These weaknesses ranged from poor, and at times, difficult communications with their own control HQ and each other, to simple matters such as the injured tanker driver who was left by himself without attention for a long period. Our own Driver and Fireman were also left unattended for a long period of time.

From where I sat, our Railway acquitted itself quite well.

There were problems with communications, particularly in the use of the trackside phone to contact Belgrave. Once the exercise got under way the Belgrave phone was continually engaged making phone communications difficult.

Radio communications using the small hand held portables was difficult but acceptable, at times requiring Menzies Creek to be used as a relay station. It was thought that the use of a mobile phone in this type of situation would have made communications easier. The lack of a PA system through our carriages made crowd control difficult for the train crew and is a matter that will need to be addressed in the future.

It is obvious that our Rules and Regulations need to be made more flexible in certain areas to allow easier provision of rescue trains.

The accident scenario made it almost impossible to institute Pilotman working in strict accordance with the existing rules.

All in however, a very satisfactory exercise and one from which we can all learn because that is, after all, what it was all about.

I would like to acknowledge the efforts of everyone who participated in the exercise and to especially thank all the volunteers and staff who gave freely of their own time to make it happen.

PUFFING BILLY PRESERVATION SOCIETY

CATEGORIES OF INCIDENT OR ACCIDENT, APPROVED REACTIONS AND PERSONNEL TO BE INVOLVED

Category 1

(a) Derailment of locomotive or carriage in station yards. No injuries
(b) Derailment of locomotive or carriage on Main Line. No injuries.
(c) Level crossing collision. No injuries.
(d) Any other incident involving E.T.R.B. property which could result in injury to the E.T.R.B.'s passengers or staff includes BUSHFIRE.

Category 2

Any incident or accident which occurs on E.T.R.B. property and which results in injury or death to any person but which would not be considered to be a disaster of major proportions, e.g.,

(i) Suicide
(ii) Level crossing accident involving a train and a passengers carrying motor vehicle.
(iii) A person or persons struck by a train operated by the E.T.R.B.

Category 3

Any incident or accident of major proportions which results in death or injury to more than one person, e.g.,

(i) Major derailment
(ii) Major level crossing accident
(iii) Fire, flood or landslide

CATEGORY 1 - Minor derailment, collision or other incident. NO INJURIES.

Final requirement:
1. Board of Inquiry
or
2. Managerial Investigation

CONTACT:

Weekdays:

1.	(a)	Nearest available Management Member	
		ON SITE Belgrave - Office	754 6800
		Internal - Don Marshall (713), Graham Archer (715), David Eaton (717)	
		Emerald Carshops	059 68 4548
		Pager 016030 number 357260	
		Internal - Mel Elliott (767)	
	(c)	Workshops Foreman - Neil Mathieson	B: 754 6522
		Internal (732)	
	(d)	Road Foreman - Tom Kilner	H: 756 7649
		Pager 264 1800 number 20038	B: 754 6522
		Internal (742)	
2.		FIRE BRIGADE (IF NECESSARY) - Belgrave	754 2992
3.		POLICE - if road vehicles involved	11444
		Belgrave	754 6999
		Ferntree Gully (24 hour)	758 3333
		Emerald	059 68 4422
4.		DIVISIONAL MANAGER concerned if not already co-opted in 1 (a) above	DIRECTORY
5.		Signal Fitter - if level crossing accident	DIRECTORY
6.		A Board member	DIRECTORY

Weekends or Holidays

1.	(a)	Nearest DIVISIONAL MANAGER at home	DIRECTORY
	(b)	Manager S & T - Mel Elliott	H: 874 5665
		Pager 016030 number 357260	
	(c)	Workshops Foreman - Neil Mathieson	H: 059 42 7218
	(d)	Road Foreman - Tom Kilner	H: 756 7649
		Pager 264 1800 number 20038	
2.		FIRE BRIGADE (IF NECESSARY) - Belgrave	754 2992
3.		POLICE - if road vehicles involved	11444
		Belgrave	754 6999
		Emerald	059 68 4422
4.		DIVISIONAL MANAGER concerned if not already co-opted in 1 (a) above	DIRECTORY
5.		Signal Fitter - if level crossing accident	DIRECTORY
6.		A Board member	DIRECTORY

CATEGORY 2 Injury or death to person or persons on E.T.R.B. property but NOT a disaster of major proportions

Final requirements:
1. E.T.R.B. Board of Enquiry
2. Possible Police Investigation
3. Possible Coronial Enquiry

CONTACT:

Ambulance		11440
DOCTOR(S)	- Belgrave	754 2019
	- Emerald	059 68 3733
POLICE	- Emergency (24 hours)	11444
	- Belgrave	754 6999
	- Emerald	059 68 4422
	- Ferntree Gully (24 hours)	758 3333
State Emergency Service - Sherbrooke		754 2981
Fire Brigade - Belgrave		754 2992

Hospitals (if necessary) - William Angliss	764 6111
Nearest available DIVISIONAL MANAGER	DIRECTORY
Nearest available BOARD MEMBER	DIRECTORY
Workshops Foreman - Neil Mathieson	B: 733/754 6522 H: 059 42 7218
Road Foreman - Tom Kilner	B: 742/754 6522 H: 756 7649
Signals & Telegraph Manager (if level crossing accident) - Mel Elliott Pager 016030 number 357260	B: 767/059 68 4548 H: 874 5665

CATEGORY 3 Incident or Accident of Major Proportions

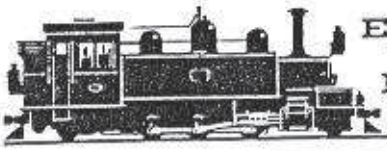
Final requirement:

1. Board of Enquiry
2. Police Investigation
3. Probable Coronial Enquiry

CONTACT:

Ambulance		11440
DOCTOR(S)	- Belgrave	754 2019
	- Emerald	059 68 3733
POLICE	- Emergency (24 hours)	11444
	- Belgrave	754 6999
	- Emerald	059 68 4422
	- Ferntree Gully (24 hours)	758 3333
State Emergency Service - Sherbrooke		754 2981
Fire Brigade - Belgrave		754 2992
Hospitals William Angliss		764 6111
All available DIVISIONAL Managers		DIRECTORY
All available Board Members		DIRECTORY
Workshops Foreman - Neil Mathieson		B: 754 6522 H: 059 42 7218
Road Foreman - Tom Kilner		B: 742/754 6522 H: 756 7649 Pager 2641800 no 20038
Local Shire		212 8222 (Sherbrooke)

Refer to Appendix A for Incident or Defect Report Form (pg 126)



EMERALD TOURIST RAILWAY BOARD

INCIDENT OR DEFECT REPORT (IDR)

NAME AND POSITION OF PERSON REPORT FORWARDED TO	NAME	POSITION

NAME OF PERSON SUBMITTING REPORT	NAME IN BLOCK LETTERS	POSITION OCCUPIED

NAMES OF OTHER PERSONS INVOLVED	NAMES IN BLOCK LETTERS	POSITIONS OCCUPIED

NAMES, ADDRESSES AND TELEPHONE No. OF WITNESSES	NAMES IN BLOCK LETTERS	ADDRESSES AND TELEPHONE Nos.

WHEN INCIDENT OR DEFECT OCCURRED OR OBSERVED & WEATHER	DAY	DATE	TIME	WEATHER CONDITIONS
		/ /	a.m. p.m.	

LOCATION	(use telephone pole numbers where applicable)

FULL DETAILS OF INCIDENT OR DEFECT	(if space insufficient, write on back or use additional sheets)

SIGNATURE OF PERSON SUBMITTING REPORT AND DATE SENT	SIGNATURE	DATE REPORT SENT
		/ /19

Where applicable, this Report must show locomotive numbers, number and class of vehicles, identifying numbers and names of equipment, Train numbers and sketch plan together with as precise a description of the incident or defect as possible and of subsequent action (if any) which was taken. THIS REPORT IS NOT A SUBSTITUTE FOR IMMEDIATE TELEPHONE ADVICE TO BRANCH MANAGERS AND OTHERS CONCERNED IN ALL CASES WHERE THIS IS NECESSARY.