RAIL SAFETY INVESTIGATION REPORT


Released under the provisions of Section 45C (2) of the Transport Administration Act 1988 and Section 46BBA (1) of the Passenger Transport Act 1990
THE OFFICE OF TRANSPORT SAFETY INVESTIGATIONS

The Office of Transport Safety Investigations (OTSI) is an independent NSW agency whose purpose is to improve transport safety through the investigation of incidents and accidents in the rail, bus and ferry industries. OTSI investigations are independent of regulatory, operator or other external entities.

Established on 1 January 2004 by the Transport Administration Act 1988 (NSW), and confirmed by amending legislation as an independent statutory office on 1 July 2005, OTSI is responsible for determining the contributing factors of accidents and to make recommendations for the implementation of remedial safety action to prevent recurrence. Importantly, however, OTSI does not confine itself to the consideration of just those matters that contributed to a particular accident; it also seeks to identify any transport safety matters which, if left unaddressed, might contribute to other accidents.

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Once OTSI has completed an investigation, its report is provided to the NSW Minister for Transport and Infrastructure for tabling in Parliament. The Minister is required to table the report in both Houses of the NSW Parliament within seven days of receiving it. Following tabling, the report is published on OTSI’s website at www.otsi.nsw.gov.au.
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EXECUTIVE SUMMARY

On the afternoon of 10 August 2016, a NSW Trains passenger service pulled into Central Station. All the passengers disembarked except for two elderly passengers. They had delayed their disembarkation to allow other passengers to get off first. Unbeknown to them, the train was about to be amalgamated with another set. The train moved off to commence amalgamation with the two passengers still inside the carriage. The shunting force produced by the two trains amalgamating caused both passengers to fall down inside the carriage. The female passenger fell down the stairs and sustained injuries to her head and back. She died fifteen days later.

The family of the deceased contacted NSW Trains to inform them of the details of the incident. The Minister of Transport and Infrastructure then requested the OTSI Chief Investigator on 20 January 2017 to investigate and establish the facts in relation to the incident. OTSI then commenced an investigation on 23 January 2017.

The investigation found the passengers did not hear or did not register the announcements made on the train’s public address system to warn them of the amalgamation. It also found that neither the train crew nor the station staff conducted a physical check to see if passengers were still on the train. However, there was no procedural requirement for train crew or station staff to check if passengers were still on the train. Passengers were only provided a brief time to disembark the train before the amalgamation took place.

Recommendations made to NSW Trains included they ensure that any passengers remaining on board during amalgamation procedures are aware that shunting is about to take place and know the precautions that they should take. Also, they should ensure there is adequate time scheduled for passengers to disembark from the train. Additionally, they should require that staff should conduct a systematic walk through of the train before any amalgamation takes place and provide sufficient time for staff to complete all checks prior to the amalgamation of trains. They should also develop prevention measures to ensure that passengers do not board trains prior to amalgamation and review staffing levels at Central Station to ensure that there are adequate staff available.

Full details of the Findings and Recommendations of this rail safety investigation are contained in Parts 3 and 4 respectively.
PART 1  FACTUAL INFORMATION

Events leading up to the occurrence

1.1  At 1328\(^1\), on 10 August 2016, NSW Trains passenger service N154, a four car V Set, left Broadmeadow Station (near Newcastle) bound for Sydney’s Central Station (see Figure 1). The train crew consisted of a driver and a guard. The guard was located in the rear cab of the train with the driver in the front cab.

\[\text{Source: GeoScience Australia}\]

\[\text{Figure 1: Map of incident location}\]

1.2  After departing Broadmeadow, the train made a number of stops. At Woy Woy Station, two elderly passengers (a husband and wife), boarded the train and sat in the downstairs seating area of the second last carriage. The last stop before Central was Strathfield where the train departed at 1543. At 1556, on\[\text{\(1\) Times in this report are in 24-hour clock form in Australian Eastern Standard Time.}\]
approach to Sydney Terminal, the guard made a termination announcement. This announcement, made over the in-carriage public address system, informed passengers that they would shortly be arriving at Sydney Terminal and once the train was stopped they were to disembark as the train would be terminating.

1.3 The train arrived at Sydney Terminal two minutes behind schedule at 1558. The train pulled into platform 10, stopping just short of another four car V Set train (N150). N150 did not have any passengers or crew on board (see Figure 2).

![Figure 2: Sydney Terminal overview platforms 9-15](Image)

Source: Sydney Trains

1.4 After termination procedures were completed N154 was timetabled to amalgamate with N150. The two amalgamated V Sets would then form the 1615 service to Broadmeadow (N169).

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2 Amalgamation is the marshalling of two trains into one. Shunting is the process of moving one configuration to another. The report uses both amalgamation and shunting.
At 1558:38, once N154 was stationary, the guard opened all doors on the platform side and made a second termination announcement. According to the train’s data logger, the announcement was 11 seconds in length. A third termination announcement was also made approximately 47 seconds later which lasted for 6 seconds.

The two passengers allowed other passengers in their carriage to disembark first as they did not want to hold them up. They said that they did not hear any announcements aboard the train. Once the other passengers had disembarked they made their way from their seats towards the stairs.

At 1600:10 the guard closed the passenger doors. This meant that there was a little over a minute and a half for all passengers to disembark. The guard remained in the crew cab during the amalgamation. There were no station staff in attendance. Two cleaners waited outside the first and fourth car for the amalgamation to be completed in readiness to clean the train.

At 1600:16, six seconds after the passenger doors closed, the guard gave the driver a bell signal that it was alright to move the train. The driver then released the brakes and applied one notch of tractive power. N154 reached a maximum of 2 km/h prior to amalgamation. The guard recalled that an announcement was made by station staff via the platform public address system to stand clear as shunting operations were in progress.

The two passengers were still inside train N154 when the train amalgamation took place. They were not prepared for the reaction force of the coupling. The male passenger was at the top of the stairs in the mid-deck seating area. He said he was trying to collapse his wife’s walking frame to allow it to pass through the door to the vestibule from the mid-deck seating area. His wife was going to use the walking frame once she was on the platform. The female passenger was making her way up the stairs at the time of the train amalgamation.

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3 This speed was obtained from the train’s datalogger. The number should be treated as approximate only as the distance of movement was too short to be measured reliably.
1.10 The force of the amalgamation caused both passengers to fall back down the stairs. The male passenger said that “the train gave a tremendous jolt, it must have been at least 4 to 5 feet. We both went for six and fell down the stairs.”

Events following the occurrence

1.11 The two V Sets were amalgamated and then at 1600:18 the driver initiated a pull test to ensure the amalgamation was secure. The train then remained stationary. The waiting passengers on the platform then boarded the train which was due to arrive at 1615.

1.12 The driver changed ends of N154, from the Central end to the Redfern end, and spoke to the guard who was in the process of logging out of his workstation and packing up. The guard commented to the driver “that was a rough hit up”. The driver did not respond.

1.13 Both passengers sustained injuries in the fall. As the guard changed ends and walked along the platform the guard observed a male passenger standing at the top of the stairs in the area that led to the lower deck and went inside the train to investigate. The male passenger told the guard that his wife had fallen down the stairs; the guard helped her to her feet and asked if she needed medical assistance. She replied that she didn’t. Both the guard and the husband assisted the injured female passenger onto the platform and sat her on her walking frame.

1.14 The guard left the passengers and found a shift manager who called for first aid using his radio. They both then went back and assisted the two passengers to a seat on the platform and waited for first aid to arrive. The female passenger was bleeding from the back of the head and was given first aid by station staff on the platform.

1.15 An ambulance was called and when it arrived the ambulance officers made an assessment of the injured passengers. The female passenger was transported from the platform on a trolley while the male passenger was able to walk to the ambulance. The ambulance transported both passengers to hospital where the female passenger was admitted. She was allowed to return home after two days but her condition deteriorated. She was admitted to
another private hospital where she died on 25 August 2016, some fifteen days after the incident.

1.16 The guard was to continue with the scheduled journey to Hamilton on N169 but immediately prior to departure was relieved from duty. Instead the guard travelled as a passenger back to Hamilton on a different service.

**Incident location**

1.17 The incident occurred inside train N154 on platform 10 at Central Station. Central Station is the main rail station for the Sydney CBD. Interstate and country trains arrive and depart in the platform area known as Sydney Terminal (see *Figure 3*).

![Figure 3: A NSW Trains V Set at Sydney Terminal platform 10](source: OTSI)

1.18 Train movements in Sydney Terminal are coordinated by a yard controller. The yard controller communicates with signallers at Sydney Signal Box to organise the setting of signals and points to route the services in and out of specific platforms.
Environmental conditions

1.19 The afternoon of 10 August 2016 was dry and sunny. The Bureau of Meteorology recorded a temperature of 24.6°C at 1500 at the Sydney Harbour (Observatory Hill) weather station about 2.5 km north of the incident. It was determined that environmental conditions played no part in the incident.

Train information

1.20 The train involved in the incident was operated by NSW Trains, a state government owned entity. NSW Trains manage the operation of TrainLink services between Sydney and the Hunter, Central Coast, Blue Mountains, Southern Highlands and Illawarra and South Coast regions.

1.21 The four car V Set (V15) N154 consisted of carriage 8049 leading, and 8061 trailing. V Sets are a class of Australian electric multiple unit, double deck trains. V Sets were delivered over a 19-year period from 1970. This series 3 unit entered service in 1982. The carriage where the incident occurred was the second last carriage in the consist and was a trailer carriage (see Figure 4).

![Figure 4: V Set trailer carriage](image)

Source: NSW Trains

1.22 The passengers were making their way out of the train from the lower deck of the double deck train via the mid-level seating area. There is a space at the top of the stairs which is where the male passenger was standing when the
amalgamation occurred. The height of the steps from the bottom floor to the mid-level area was approximately 900 mm.

1.23 This mid-level seating area is connected to the vestibule area by a swinging single leaf door. The stairs have stainless steel handrails on each side. The floors of both levels are carpeted. At the front edge of each stair tread are rubber and aluminium non-slip edge protectors. The edge of the partition dividing the stairs has stainless steel rounded edges (see Figure 5).

![Figure 5: Location of fall inside N154](image)

Source: OTSI

**Train crew and passenger information**

1.24 The train crew of N154 and station staff were all employees of NSW Trains. The train crew was experienced and qualified for the route.

1.25 The two passengers, husband and wife, were both aged 91 years. The husband was in good health, mobile with good hearing and eyesight. The wife was less mobile, used a walking frame but was able to walk without it. She was being treated for a heart condition but was otherwise in good health prior to the incident. It was their first trip on this service and the male passenger said that they were not aware that the train was going to be amalgamated.
Related occurrences

1.26 There have been no other reported occurrences of persons injured inside a NSW passenger train during amalgamation or shunting operations since OTSI commenced in 2004.
PART 2 ANALYSIS

Introduction

2.1 The investigation focussed on the factors that contributed to the passengers remaining on board the train while the two four-carriage sets were being amalgamated, the actions of the train crew, the risk management and operating procedures in place at the time.

NSW Trains procedures

2.2 A number of procedures and instructions applied to the process of shunting and amalgamating trains. They included:

- Sydney Trains - Shunting with passengers on board - Operator Specific Procedures 17
- Sydney Trains - Responsibilities of train crews - Train Working Procedures 100
- Sydney Trains - Division and amalgamation of trains - Train Working Procedures 116

2.3 At the time of the incident most of the procedures were owned by Sydney Trains. NSW Trains is a separate organisation but, at the time of the incident, continued to use many of the operating procedures issued from Sydney Trains.4 NSW Trains were in the process of developing their own procedures but had not completed the transition to implementation.

2.4 The risk to passengers on board trains during shunting was known. A procedure titled ‘Shunting vehicles with passengers on board’5 was used by NSW Trains at the time of the incident. The introduction stated: ‘Amalgamating trains or dividing trains with passengers on board can pose
risks if passengers are standing and are not prepared for sudden movements’. The risk is identified in this procedure. It acknowledged that it is permissible to have passengers on the train during shunting and outlines some control measures. These include telling passengers:

- that the train is to be amalgamated
- the doors are closed, and
- they should sit down or, if standing, take a firm hold until the movement is complete.

There is no specification in the procedure about how passengers should be informed of train movements, whether face-to-face or via a general announcement using the train’s public address system.

2.5 There was no check by train crew or station staff if any passengers remained on this train. According to the Train Working Procedures ‘Responsibilities of train crews’\(^6\), the train did not need to be checked for passengers on board. A check was only required if the train was terminating before:

- entering a siding or a maintenance centre, or
- commencing a non-revenue service.

2.6 As this train was continuing in service there was no requirement to check that passengers were on the train before shunting took place. All the train crew and station staff correctly followed the procedures in place at the time.

2.7 Another procedure titled ‘Division and amalgamation of trains’\(^7\) stated that when a train is being amalgamated or divided, the train crew carrying out the movement must ensure that all persons on the train have been warned of the movement taking place.

2.8 The investigation found that there was evidence that announcements were made. The guard stated that termination announcements were made once the train passed Redfern Station and again when the train was stationary. The train’s data logger confirmed that the guard made a number of announcements prior to the train arriving at Sydney Terminal and again after

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\(^6\) Responsibilities of train crews -Train Working Procedures 100 (TWP 100) issued 29 November 2015 p.11.
\(^7\) Division and amalgamation of trains Train Working Procedures 116 (TWP 116) issued 27 May 2012 p.5.
the train stopped. These announcements informed the passengers that the train was terminating and they needed to leave the train once the train stopped.

2.9 However, the male passenger said that he did not hear any announcements. There were no other witnesses available to confirm if the announcements were heard in that carriage. When an OTSI investigator travelled in the same carriage a few months after the incident the public address system was working and audible. It is possible that the announcements were made but that the passenger did not notice or register that they were made.

2.10 Besides the operating procedures, there existed at the time of the incident a more specific general instruction issued by NSW Trains. This applied to NSW Trains’ intercity train crew and station staff at Central Station. This instruction specifies, amongst other things, the guard’s role during termination inspection. It instructs guards to ‘thoroughly inspect each carriage’, however as it was to be read in conjunction with TWP 100, this only applied to terminating trains not continuing in service.

Risk Management

2.11 Under the Rail National Safety Law Act 2012, NSW Trains are required to develop and implement a Safety Management System to manage the safety of its rail operations. Part of the Safety Management System is the Safety Risk Register which captures all reasonably foreseeable risks to which NSW Trains are exposed or contribute to.

2.12 The Safety Risk Register is the organisation’s repository for safety and environmental risk knowledge. The Safety Risk Register is a legislative requirement for Rail Safety, Work, Health and Safety. The hazard of ‘loss of balance inside passenger train during train operations’ is one that is documented in NSW Trains’ safety management system. The relevant risk control measures that address this hazard are captured in the various operating procedures that NSW Trains use.

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2.13 Monitoring and reviewing work procedures is part of the management of risks as set out in the safety management system. This incident highlighted a need for NSW Trains to review and identify any gaps in the control measures for terminating trains at Central Station. The operating procedures relating to the mitigation of this hazard were reviewed by NSW Trains following this incident.

2.14 NSW Trains identified a number of issues associated with trains terminating then being amalgamated at Central Station. The following were identified as the main reasons why passengers might be on the train during amalgamation:

- passengers not hearing announcements
- passengers slow to leave the train
- passengers boarding the train for the next service.

2.15 The issue of passengers boarding an empty train that has just terminated is an anticipated occurrence. When passengers waiting on the platform see an empty train which will be going to their destination it is expected that they will want to board. Also the doors on V Sets can be opened by passengers as the doors are not locked when the sets are terminated. Passengers boarding early to obtain a seat in peak hour may be reluctant to leave the carriage during shunting movements. If there is to be adequate checks for these passengers then there needs to be adequate station staff available to assist the successful transition from disembarkation to boarding.

2.16 The new intercity trains that will replace these V Sets are expected to be in service in 2019. The doors on these new trains will be able to be locked by the guard. Also, it will be possible for the guard to check on passengers using closed circuit television (CCTV), a feature which is not available on the V Sets. There is also expected to be improved public address system and visual displays. These features are expected to assist with the communication to passengers.

**Passenger actions**

2.17 The two passengers were seated downstairs and had waited until all the other passengers left the carriage before moving to make their way out onto the platform. The male passenger said that they did not want to inconvenience the
other passengers by holding them up, especially as he knew that a walking frame needed adjustment to be able to move it through the single door to the vestibule area.

2.18 The passenger said that he and his wife were caught completely unaware by the sudden jolt of the amalgamation. He said they were not holding on or braced for impact and were thrown down the stairs by the force of the impact. This was severe enough for the guard to make comment to the driver.

2.19 The time between the train stopping and the doors being closed was 92 seconds. The amalgamation took place six seconds after the doors closed. This time may be sufficient for alert and mobile passengers to disembark but it should be anticipated that elderly passengers are more cautious and slow moving. It is expected that they would be given sufficient time to disembark from the train. If they had previously notified NSW Trains by telling station staff at embarkation they could have received assistance from the station staff to disembark from the train.

Safety actions taken

2.20 NSW Trains are implementing a number of control measures to address issues surrounding the amalgamation of trains. The measures include:

- Issue a new general instruction for guards and station staff to walk through the terminated services prior to amalgamation. If passengers insist on remaining on board, or cannot leave the train without assistance, they will be advised to remain seated and brace themselves for the shunting movement. (see Appendix 2)
- Provide a device for station staff to lock the doors on the train once confirmed the carriage is empty. This will allow a second defence to check that the doors are locked to prevent passengers boarding the train prior to amalgamation.
- Request that the station manager display ‘shunting’ on the indicator board.
- Request a minimum fifteen minute turnaround time for amalgamations at Central Station. Ten minutes to disembark and check for passengers and five minutes to amalgamate.
• Review the number of crew and station staff at Central Station during afternoon peak.
• Develop a communication plan to educate customers not to board trains prior to and during amalgamation.
• Complete the transition of taking ownership of the standards and procedures from Sydney Trains.
PART 3 FINDINGS

From the evidence available, the following findings are made with respect to the passenger injury and subsequent fatality involving NSW Trains passenger service, N154 at Central Station, NSW on 10 August 2016.

Contributory Factors

3.1 The amalgamation of two V Set passenger trains at Central Station created sufficient force to cause two passengers, who were inadvertently still on board, to fall down the internal stairs of the train.

3.2 The two passengers decided to delay their disembarkation as a courtesy to other passengers. They did not realise that the amalgamation was about to occur and were not prepared for the impact associated with the shunting movement.

3.3 The two passengers did not hear or did not register announcements that were made on the train’s public address system to warn them of the amalgamation.

3.4 The train crew or station staff did not conduct a physical check to see if passengers were still on the train. There was no procedural requirement for train crew or station staff to conduct a physical check that passengers were still on the train.

3.5 There was only a short time available for the passengers to disembark the train once the train had stopped and before the amalgamation of the two sets took place.

Other Safety Factors

3.6 It is common practice for passengers to access carriages and be aboard the train during amalgamation procedures.

3.7 At the time of the incident there were a number of different procedures and instructions that applied to the amalgamation of trains.
PART 4 RECOMMENDATIONS

It is recommended that the following safety actions be undertaken by the specified responsible entity.

NSW Trains

4.1 Ensure, so as far as is reasonably practicable, that any passengers remaining on board during amalgamation procedures are aware that shunting is about to take place and know the precautions that they should take.

4.2 Notify train crew and station staff of the circumstances of this incident and the potential adverse consequences of passengers not being prepared for amalgamation.

4.3 Ensure, so as far as is reasonably practicable, there is adequate time scheduled to passengers to disembark from the train.

4.4 Require that staff should conduct a systematic walk-through of the train before any amalgamation takes place.

4.5 Provide sufficient time for staff to complete all checks prior to the amalgamation of trains.

4.6 Develop systems of work which will control, so as far as is reasonably practicable, the risk of passengers boarding trains prior to amalgamation.

4.7 Review staffing levels at Central Station to ensure that there are adequate staff available.

4.8 Review the procedures and instructions relating to amalgamation of trains to ensure consistency within the organisation.
PART 5 APPENDICES

Appendix 1: Sources, Submissions and Acknowledgements

Sources of Information

- NSW Trains
- Passenger on train

References

Sydney Trains - Shunting with passengers on board - Operator Specific Procedures 17 (OSP 17) issued 7 July 2014.
Sydney Trains - Responsibilities of train crews - Train Working Procedures 100 (TWP 100) issued 29 November 2015.

Submissions

The Chief Investigator forwarded a copy of the Draft Report to the Directly Involved Parties (DIPs) to provide them with the opportunity to contribute to the compilation of the Final Report by verifying the factual information, scrutinising the analysis, findings and recommendations, and to submit recommendations for amendments to the Draft Report that they believed would enhance the accuracy, logic, integrity and resilience of the Investigation Report. The following DIPs were invited to make submissions on the Draft Report:

- NSW Trains
- Office of the National Rail Safety Regulator
- Passenger on train

Submissions were received from all the DIPs / or the following DIPs:

- NSW Trains
• Office of the National Rail Safety Regulator
• Passenger on train

The Chief Investigator considered all representations made by DIPs and responded to the author of each of the submissions advising which of their recommended amendments would be incorporated in the Final Report, and those that would not. Where any recommended amendment was excluded, the reasons for doing so were explained.
Appendix 2: NSW Trainlink General Instruction 1012 - 2017

General Instruction
ATTENTION: Central Intercity, Gosford, Hamilton, Lithgow, Mt Victoria & Wollongong drivers & guards

NSW TrainLink Issue No 1012 – 2017 03 March 2017

Amalgamation / Division of Terminated Sets at Sydney Terminal

Recently an incident occurred at Sydney Terminal where a customer was injured. This General Instruction (GI) is to be followed in conjunction with OSP 17 Shunting vehicles with passengers on board and GI 1063 – 2015. Where practicable any amalgamation / division procedure is to be performed with no customers on board.

AMALGAMATION

Driver performing amalgamation
• Do not perform amalgamation until the guard is in place at the amalgamation point.
• If requested by the guard, insert a bell plug to keep the doors closed.
• When advised it is safe to do so by the guard, advise the shunter and perform the amalgamation procedure.

Guard performing amalgamation
Upon arrival of the incoming set:
• Guard to make terminated announcements, as per GI 1063 - 2015.
• When it is safe to do so and customers have alighted from the train, announce “Shunting is to take place on this train. If any customer is on board, please remain seated and advise staff of your presence as they come through the train.”
• Close the doors. If on a V set, request the driver to insert their bell plug to keep the doors closed.
• Cut out and secure cab. Walk via the upper deck and perform a visual check of the lower deck and toilets through to the amalgamation point. If any customers are encountered on board advise them “This train will be shunting shortly, for your safety please remain seated and keep a firm hold whilst this takes place. The doors are closed and will re-open after shunting has completed.”
• Upon arrival at the amalgamation point check with assisting guard / qualified station staff that the doors are closed on the stationary portion and about any customers on board. If required, close the doors and perform a visual inspection on the stationary portion.
• Make the announcement “Attention customers this train is about to be shunted please remain seated and keep a firm hold.”
• Advise driver it is safe to perform the amalgamation.
• After amalgamation, open the doors and announce “Shunting has completed, it is now safe to board / alight this train. Thank you for your assistance.”
Assisting Guard / Qualified Station staff – when scheduled / available
- Qualified station staff are to ensure shunting announcements are being made on the platform.
- On the stationary portion, perform a visual inspection to check for any customers on board and ensure doors are closed.
- Upon arrival of the incoming set, and after customers have alighted and doors closed, walk along the outside of the incoming portion, checking for customers on board.
- Advise guard at the amalgamation point of any customers that may be on board.
- Remain in position and vigilant until the amalgamation is completed.

DIVISION

Driver performing division
- Do not perform division until the guard is in place at the division point.
- At the division point cut in the driver’s controls.
- If requested by the guard, insert a bell plug to keep the doors closed.
- When advised it is safe to do so by the guard, advise the shunter and perform the division procedure.

Guard performing division

Upon arrival of the incoming set:
- Guard is to make terminated announcements, as per GI 1963 - 2015.
- When it is safe to do so and customers have alighted from the train, announce “Shunting is to take place on this train. If any customer is on board please remain seated and advise staff of your presence as they come through the train.”
- Close the doors. Check the driver has cut in ready to divide. If on a V set, request the driver to insert their bell plug to keep doors closed.
- Cut out and secure cab. Walk via the upper deck and perform a visual check of the lower deck and toilets through to the division point. If any customers are encountered on board advise them “This train will be shunting shortly, for your safety please remain seated and keep a firm hold whilst this takes place. The doors are closed and will re-open after shunting has completed.”
- Upon arrival at the division point check with qualified station staff / assisting guard about any customers on board.
- If no assisting staff are in place, check the Sydney end four cars for customers and the doors are closed, then return to the division point.
- Make the announcement “Attention customers this train is about to be shunted, please remain seated and keep a firm hold.”
- Advise driver it is safe to perform the division.
- After division, open doors and announce “Shunting has completed, it is now safe to board / alight this train. Thank you for your assistance.”
Assisting Guard / Qualified Station staff – when scheduled / available
- Qualified station staff are to ensure shunting announcements are being made on the platform.
- If available, assisting guard and qualified station staff to confirm set is being divided and agree who will walk through Sydney end cars.
- After doors have closed, on the Sydney and four cars, walk via the upper deck and perform a visual check of the lower deck and toilets through to the division point. If any customers are encountered on board advise them “This train will be shunting shortly; for your safety please remain seated and keep a firm hold whilst this takes place. The doors are closed and will reopen after shunting has taken place.”
- Advise guard at the division point of any customers that may be on board.
- Remain in position and vigilant until the division is completed.

NOTE: If a train is not in service and amalgamates / divides upon arrival to Sydney Terminal, the doors are not to be opened until the amalgamation / division procedure has been completed.

Customer Service Team Leaders
Sydney Trains Station Passenger Information (SPI) will make announcements regarding shunting operations.
- Customer Service Team Leader (CSTL) to notify Station Passenger Information (SPI) operator prior to the arrival or separation of sets to commence pre-recorded announcements.
- SPI operator to confirm with CSTL announcements loud and clear on platforms.
- CSTL to confirm with the SPI operator that amalgamation / division operations have been completed; SPI operator to continue announcements until amalgamation / division operations have ceased.
- SPI operator to announce that customers can commence boarding the train service.

If you have any questions regarding any of the above, please contact your local NSW TrainLink Standards Officer.

George Peters
Operations Manager
Operational Excellence