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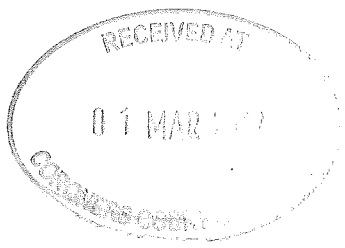

Coroner's Registrar
Coroners Court Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

29 February 2012

Dear Sir/Madam

Re: Peter Johnston Inquest – Court Ref: 5005/09

I refer to the Coroner's findings and recommendations dated 2 December 2011 into the death of Peter Johnston at Melbourne Central railway station on 22 October 2009.

Metro Trains Melbourne Pty Ltd (MTM) assumed control of the Melbourne metropolitan rail network from the previous franchisee on 30 November 2009, post incident event. Therefore, our comments will be limited to the three recommendations made by the Coroner.

Recommendation 1
That MTM ensure that all trains in service have the modification MTM developed to alert the operator of a defective ACC switch, to be undertaken not later than March 2012.

Response
The Coroner's recommendation will be implemented not later than 31 August 2012. To date MTM has scoped, designed and trialled the Comeng train modification. An engineering change, to support the change to Metro's safety management system, has been prepared and approved and a preferred contractor selected to undertake installation works. The current program for completion of the works under the contract is expected to end in August 2012.

Recommendation 2
That MTM re examine the possibility of fitting an audible alarm system designed to alert a driver to a door having been forced after departure.

Response
The Coroner's recommendation is not accepted for implementation. In response to the Coroner's finding and recommendations, MTM has further consulted stakeholders and end users, and has conducted a preliminary human factors assessment on the fitting of an audible alarm system.

This exercise has not changed our view that installing a separate audible alarm would require considerable reconfiguration of the train circuitry and dash board alterations and is not guaranteed to prevent these occurrences.

It is unlikely that changing this system would eliminate the risk, due to the combination of time, options and performance of the train once the message was understood. Further, the tone may introduce further risk of train driver distraction and further clutter the audible tones that will be provided to the drivers.

MTM believes the focus of any solution should be on addressing the passenger/train door interface rather than altering the driver cab and practices.

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Recommendation 3
That MTM ensure that a revised instruction decal is placed in all trains in service, that clearly sets out how to operate the PEI, in order for passengers to effectively communicate with the driver.

Response
The Coroner's recommendation will be implemented not later than 31 March 2012. Wording of the PEI instruction decal has been completed and fleet installation should commence late February 2012.

Thank-you for the opportunity to comment on the Coroner's recommendations. Should you require any further clarification on the above matters, please contact Brian McIntosh, General Manager Safety Quality and Environment on 9610 2407.

Yours sincerely

Andrew Lezala
Chief Executive Officer
Metro Trains Melbourne