IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2014 001033

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Mitchell Luke Callaghan

Delivered On:	31 August 2026
Delivered At:	Coroners Court of Victoria Southbank, Victoria
Hearing Dates:	10 October 2024 3 December 2024
Findings of:	Coroner Catherine Fitzgerald
<u>Representation:</u>	
Counsel Assisting the Coroner	Rachel Ellyard Instructed by George Carrington & Eden Stubbings, Solicitors, Coroners Court of Victoria
Counsel for Belinda & Mark Callaghan, Senior Next of Kin	Damian Sheales Instructed by Alessi Legal
Counsel for Russell Dickson	Matthew Hooper KC Instructed by HWL Ebsworth
Counsel for Metro Trains Melbourne	Robert O'Neill KC Instructed by Herbert Smith Freehills
Counsel for the Department of Transport and Planning	Andrew Imrie Instructed by MinterEllison
Keywords	Railway Station, accidental death, Metro Trains Melbourne

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INTRODUCTION

1. On 23 February 2014, Mitchell Luke Callaghan was 18 years old when he died at Heyington Railway Station.

2. On that night, Mitchell was socialising with friends at a birthday party. Not long before midnight, he left the party with a large group of people who walked to Heyington Railway Station to catch a train into the city. At the station, Mitchell was running to board a moving train when he accidentally fell into the wide gap between the platform and the train, and was fatally injured. His death at such a young age was an unimaginable tragedy for his family and large circle of friends.

3. Mitchell's death raised questions about how such an accident could occur at a busy suburban railway station, and the events which led to it have been the subject of several investigations in addition to the coronial investigation. These findings recount what occurred in relation to those investigations, and what is known about the cause and circumstances of Mitchell's death. There is therefore a necessary focus on the events which led to the accident and why it occurred. I acknowledge that the findings cannot capture how deeply loved and missed Mitchell is by his family and all those who knew him, and I offer my sincere condolences to them for their loss.

THE CORONIAL INVESTIGATION

Jurisdiction

4. Mitchell's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

5. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[1] A coroner investigating a reportable death must, if possible, make the findings set out in section 67(1) of the Act, namely:

    a) the identity of the deceased;

    b) the cause of death; and

[1] Section 1(d) and 89(4) of the *Coroners Act 2008*.

c) the circumstances in which the death occurred.[2]

6. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths through findings and recommendations made by coroners. Coroners are also empowered to:

   a) comment on any matter connected with the death they have investigated, including matters of public health and safety or the administration of justice;[3] and

   b) make recommendations to any Minister, public statutory authority or entity on any matter connected with the death, including public health and safety or the administration of justice.[4]

7. The power to comment and make recommendations arises from the obligation to make findings. The powers are not free-ranging and are inextricably connected with, rather than independent of, the power to enquire into a death and the obligation to make findings. They do not enable a coroner to conduct investigations for the sole or dominant reason of making comment or recommendations.[5]

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[6] Coroners are not empowered to determine any civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[7]

Standard of proof

9. The standard of proof for coronial findings is the civil standard of proof, on the balance of probabilities.[8] The strength of evidence necessary to prove relevant facts vary

[2] Subject to statutory exemptions in the *Coroners Act 2008*.
[3] *Coroners Act 2008*, s 67(3).
[4] Ibid, s 72(2).
[5] *Harmsworth v The State Coroner* [1989] VR 989 at 996; See also *Thales Australia Limited v The Coroners Court of Victoria & Anor* [2011] VSC 133 (11 April 2011), [75] in which Beach J adopted the interpretation of Muir J in *Doomadgee v Clements* [2006] 2 QdR 352 that 'there was no warrant for reading "connected with" as meaning only "directly connected with"', and that the range of matters connected with a death, for the purpose of comments or recommendations, can be 'diverse'.
[6] *Keown v Khan* [1999] 1 VR 69.
[7] *Coroners Act 2008*, s 69(1). However, a coroner may include in a comment a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death: see sections 69(2) and 49(1) of the *Coroners Act 2008*.
[8] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363; *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

according to the nature of the facts and the circumstances in which they are sought to be proved.[9]

10. Coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.[10] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[11] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences.[12]

11. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

Causation

12. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

13. The "circumstances of the death" do not refer to the entire narrative culminating in the death, but rather to those circumstances which are sufficiently proximate and causally related to the death. Findings as to circumstances may necessarily include findings as to which events caused others, in what combination they played this causative role, and to what degree.

[9] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[10] (1938) 60 CLR 336.
[11] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-3 per Dixon J.

PROCEDURAL HISTORY

Criminal Proceedings

14. Following the report of the death to the coroner, conduct of the coronial investigation was assumed by the previous coroner with carriage of the case. Victoria Police commenced investigations on behalf of the coroner with the intention of preparing a coronial brief of evidence, but during the early stages of the coronial investigation, police formed a belief that criminal offences may have been committed in relation to the incident.

15. From the outset of the coronial investigation, Mitchell's parents, Mark and Belinda Callaghan, raised significant concerns about how Mitchell's death occurred. On 13 May 2014, they filed a *Form 26 Request for Inquest into Death* with supporting correspondence.[13]

16. In response, the coroner authored a memorandum that was provided to Mr and Mrs Callaghan's legal representatives advising that the application for inquest had been considered and, pursuant to section 52(6)(c) of the Act, no decision was made as to whether an inquest would be held at that time. The coroner noted that investigating police may refer the matter to the Director of Public Prosecutions, and the request for inquest would not be considered again until it was known whether there would be a criminal prosecution. At that time, the coronial brief was not yet complete.

17. On 21 May 2014, police requested that the driver of the train involved in the incident, Mr Russell Dickson, participate in an interview. This was declined. On 13 January 2015, Mr Dickson was charged with indictable offences of Reckless Conduct Endanger Life pursuant to section 22 of the *Crimes Act 1958*, and Reckless Conduct Endanger Serious Injury pursuant to section 23 of the *Crimes Act 1958*. As a result of the criminal charges, the coroner paused the coronial investigation. At that time, no decision had been made regarding the application for inquest by Mr and Mrs Callaghan.

18. The criminal prosecution proceeded to a committal hearing at the Melbourne Magistrates' Court commencing on 14 December 2015. Over 6 days, witnesses were called to give evidence and submissions were made.[14] Mr Dickson maintained his right to silence throughout the criminal investigation and proceedings.

[13] Coronial Brief Version 1.2 (21 August 2023), 277-280. (**'CB'**)
[14] Committal Transcript of 14, 15, 16 and 17 December 2015; 25 and 29 January 2016, CB 1233-1730.

19. On the final day of the committal, 29 January 2016, the presiding Magistrate ruled that there was insufficient evidence to support a conviction and Mr Dickson was discharged.[15] A decision was subsequently made by the Director of Public Prosecutions (**DPP**) not to proceed with a direct indictment.[16]

20. On 14 January 2019, Mr and Mrs Callaghan wrote to the DPP and requested that criminal charges be laid against Mr Dickson by direct indictment.[17] On 21 March 2019, the DPP responded to Mr and Mrs Callaghan and reaffirmed the original decision not to proceed by way of direct indictment.[18]

21. Separate to the criminal prosecution of Mr Dickson, on 4 January 2017, Metro Trains Melbourne (**Metro Trains**) was charged by Transport Safety (Victoria) (**TSV**) with offences under the *Rail Safety Act 2006* related to the infrastructure at Heyington Railway Station and the operation of X'Trapolis trains at the time of Mitchell's death.[19]

22. In December 2017, Metro Trains applied to the Supreme Court of Victoria seeking to prevent the committal hearing from proceeding.[20] The application by Metro Trains was subsequently dismissed, enabling the charges against Metro Trains to proceed to a committal hearing.

23. However, in July 2018, the Magistrates' Court dismissed the charges against Metro Trains on the grounds that when the proceeding was initiated, the Informant did not have the requisite authorisation under the relevant legislation to lay the charges. In March 2019, the Director of TSV made application to the Supreme Court of Victoria to quash the decision of the Magistrate. The legal challenge was unsuccessful, and the application was dismissed.[21]

24. In April 2019, TSV sought and was granted authorisation from the DPP to prosecute Metro Trains pursuant to the provisions of the *Rail Safety Act 2006*. However, in February 2020, the DPP withdrew the authorisation, with no charges having been laid by TSV at that time.[22]

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[15] Committal Transcript, CB 1700-1735; Certified Extract, CB 1736.
[16] Letter from the DPP to Mark and Belinda Callaghan dated 21 March 2019, CB 309-310.
[17] Letter from Mark and Belinda Callaghan dated 14 January 2019, CB 305-308.
[18] Letter from the DPP to Mark and Belinda Callaghan dated 21 March 2019 CB 309-311.
[19] Specifically, offences under ss 20 and 21 of the *Rail Safety Act 2006* (Vic).
[20] *Metro Trains Melbourne Pty Ltd v Paciocco* [2017] VSC 778, [3].
[21] *Director, Transport Safety v Metro Trains Melbourne Pty Ltd* [2019] VSC 215.
[22] See letter from the DPP to Mark and Belinda Callaghan dated 24 March 2020, CB 313-314.

25. On 6 March 2020, Mr and Mrs Callaghan wrote to the DPP seeking an explanation for the withdrawal of authorisation for the prosecution of Metro Trains.[23] In correspondence dated 24 March 2020,[24] the DPP responded and explained that upon review of the case, the authorisation was withdrawn and no further authorisation would be granted on the basis that it was not in the public interest for a prosecution to commence against Metro Trains.

26. As the charges against both Mr Dickson and Metro Trains were dismissed, there were no findings of fact made in relation to Mitchell's death in the criminal jurisdiction.

The Coronial Investigation and the Requests for Inquest

27. Following the completion of all criminal proceedings arising from, and related to, Mitchell's death, the Court wrote to Mr and Mrs Callaghan and advised that the coroner intended to finalise the coronial investigation pursuant to section 71 of the *Coroners Act 2008* (**the Act**). [25] That section specifies that a coroner is not required to make any of the findings in section 67 of the Act where:

    a) an inquest has not been held because a person has been charged with an indictable offence in respect of the death; and

    b) the coroner considers that the making of the findings would be inappropriate in the circumstances.

28. On 29 May 2020, legal representatives for Mr and Mrs Callaghan sent correspondence to the Court confirming that they maintained their request that an inquest be held, and filed another *Form 26 Request for Inquest into Death* with associated submissions and materials in support.[26]

29. On 21 July 2020, the Court was informed that counsel had been engaged by Mr and Mrs Callaghan and further submissions were filed regarding their request for an inquest.[27] Further correspondence was exchanged between the Court and the legal representatives

[23] Letter from Mark and Belinda Callaghan to the DPP dated 6 March 2020, CB 312.
[24] CB 313-314.
[25] Correspondence contained in the Court file.
[26] CB 281-315.
[27] CB 316-321.

for Mr and Mrs Callaghan in 2020. A proposed mention hearing to address the request for inquest in late 2020 was not held due to the COVID-19 pandemic.[28]

30. In early 2021, the Court was advised by legal representatives for Mr and Mrs Callaghan that civil proceedings had been commenced in relation to the death.[29] On 15 February 2021, the Court contacted the legal representatives and advised that the coroner intended to hold the coronial investigation in abeyance having regard to the civil proceedings.[30]

31. On 9 March 2022, the Court wrote to legal representatives for Mr and Mrs Callaghan and again advised that the coroner intended to discontinue the investigation pursuant to section 71 of the Act.[31] On 31 March 2022, a request was made by the legal representatives for Mr and Mrs Callaghan that the investigation not be discontinued and an application for further time to make submissions was made on the basis that new counsel needed to be engaged, amongst other reasons.[32] The request for additional time was granted by the coroner and the coronial investigation was therefore not finalised.[33]

32. In April 2022, I was allocated carriage of the coronial investigation. At that time, the request for inquest application had not yet been determined.

33. On 22 June 2022, I granted the request for inquest. I was of the view that the coronial investigation was incomplete and further investigations were necessary prior to the inquest hearing.[34]

34. One consequence of the protracted criminal proceedings and the resulting pause to the coronial investigation was that no statement had been requested from Mr Dickson as part of the coronial investigation. This was a significant evidentiary gap which was not addressed by other available evidence.

35. Although Mr Dickson completed an "Incident Report" for his employer, Metro Trains, on the night of the fatality, it contained no substantive account of his actions or knowledge of the incident. Whilst Metro Trains completed an investigation into the incident and

[28] Correspondence contained in the Court file.
[29] Correspondence contained in the Court file.
[30] Correspondence contained in the Court file.
[31] Correspondence contained in the Court file.
[32] Correspondence contained in the Court file.
[33] Correspondence contained in the Court file.
[34] Transcript of mention hearing on 22 June 2022.

prepared an "Incident Investigation Report", Mr Dickson declined to provide a statement as part of that process.

36. The only available account from Mr Dickson was contained in the "Transport Safety Report" produced by the Australian Transport Safety Bureau (**ATSB**) regarding the circumstances of Mitchell's death.[35] Following his discharge at committal, Mr Dickson was interviewed by the ATSB using its compulsory powers and a summary of his response was included in the publicly available report. However, upon request by the Court for a full transcript of the interview, the ATSB advised that provision of the material was prohibited pursuant to the *Transport Safety Investigation Act 2003* (Cth). I considered that the explanation that was provided to the ATSB by Mr Dickson for his actions was potentially contradicted by other evidence in the coronial brief, but due to the unavailability of the full ATSB interview, the extent of the inconsistencies in the evidence could not be ascertained, and it was not known if Mr Dickson had been asked about or presented any of the other evidence.

37. Another consequence of the procedural history of the case was that the investigation which initially occurred was ultimately completed for the purposes of the criminal prosecution, which fundamentally differs in nature from a coronial investigation. Notably, the potential for criminal charges led to several key eyewitnesses and Mr Dickson refusing to provide police with witness statements. By the time the coronial investigation resumed, a substantial period of time had passed. By that time, many of the witnesses had already been the subject of cross-examination at the committal proceedings regarding their observations of an incident that was traumatic in nature. Updated information was also needed regarding changes that had been made since the fatality to determine whether any prevention opportunities existed.

38. Decisions regarding the next steps in the coronial investigation were made having regard to the objects and purposes of the Act, including the need to avoid unnecessary duplication of the other inquiries and investigations which had occurred,[36] and the need to accord procedural fairness regarding any potential adverse findings. Having regard to all these factors, it was apparent that there were still reasonable lines of enquiry which required investigation for the purpose of making the findings required by section 67 of the Act.

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[35] *ATSB Investigation reference RO-2014-005 Fatality at Heyington Railway Station, Toorak, Victoria on 22 February 2014*), published on 27 April 2016, CB 322-348.

[36] Section 7 of the Act.

39. On 3 May 2023, I issued a *Form 4* request for information to Mr Dickson pursuant to section 42 of the Act. Mr Dickson's legal representatives initially indicated that he would provide a statement in compliance with the *Form 4.*[37]

40. An inquest hearing was listed on 13-16 June 2023; however, the dates were vacated when Counsel Assisting became unavailable at short notice, and I note that some relevant evidence was still yet to be received. It also became apparent that Mr Dickson may object to complying with the *Form 4*.[38] His legal representatives subsequently filed submissions advising that Mr Dickson objected to responding to the *Form 4,* relying on section 50 of the Act on the basis that the preparation of the statement would tend to incriminate him.[39]

41. The inquest was re-listed to commence on 28 November 2023, and Mr Dickson was served with a summons pursuant to s 55(2)(a) of the Act requiring that he give evidence at the inquest. On 14 November 2023, Mr Dickson's legal representatives advised the Court that Mr Dickson would object to giving evidence at the inquest pursuant to section 57(1) of the Act and that he would not be willing to give evidence under a certificate issued under section 57.[40] A timetable was set for written submissions.

42. The inquest was re-listed for hearing on 10 October 2024. Mr Dickson maintained his objection to giving evidence.[41] Pursuant to section 57(2) of the Act, I determined that there were reasonable grounds for the objection, namely, that the evidence may tend to prove that Mr Dickson had committed an offence against or arising under an Australian law. Mr Dickson was informed of the required matters in section 57(3) of the Act and he confirmed he would not willingly give evidence if granted a certificate under section 57.[42] Further oral submissions were made. By written ruling dated 18 October 2024, I required that Mr Dickson give evidence pursuant to section 57(4) of the Act, and the inquest hearing was listed for further hearing on 3 December 2024.

The Inquest

43. The scope of the inquest was confined to Mr Dickson's observations, actions and knowledge relating to the incident on 22 February 2014, and he was the only witness

[37] Correspondence contained in the Court file.
[38] Transcript from the mention on 4 May 2023.
[39] Ruling on Russell Dickson's reliance on section 50 of the *Coroners Act 2008* dated 13 October 2023.
[40] Written submissions on behalf of the Applicant dated 14 November 2023 at [4] – [6].
[41] See Inquest Transcript 10 October 2024.
[42] See Inquest Transcript 10 October 2024.

called. Submissions by Counsel Assisting set out the nature of the questioning which was anticipated.[43]

44. The coronial brief was tendered following the completion of the evidence. There was no application by any Interested Party for other witnessed to be called.

45. Counsel Assisting and all Interested Parties filed written submissions, with the final submissions filed on 6 August 2025.[44]

Sources of evidence

46. This finding is based on the entirety of the investigation materials comprising the coronial brief, the evidence from the inquest, and the exhibits. I do not purport to summarise all the evidence in this finding, and will refer to it only in such detail as is relevant to comply with the relevant statutory obligations and as is necessary for narrative clarity. All the investigation materials will remain on the coronial file and comprise the investigation into the death of Mitchell Luke Callaghan.

47. I have considered all the submissions filed following the conclusion of the inquest, but will refer to them only in such detail as is necessary.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

48. On 26 February 2014, Coroner Iain West made a determination that the deceased was Mitchell Luke Callaghan, born 10 July 1995.[45]

49. Identity was not in dispute and required no further investigation.

[43] Submissions by Counsel Assisting dated 21 November 2023, [31].
[44] Submissions by Counsel Assisting dated 19 March 2025; Submissions by Metro Trains Melbourne Pty Ltd dated 22 April 2025; Submissions by the Department of Transport and Planning dated 22 April 2025; Submissions on behalf of Mark and Belinda Callaghan dated 26 May 2025; Submissions on behalf of Russell Dickson dated 24 June 2025; Submissions in reply by the Department of Transport and Planning dated 29 July 2025; Submissions in reply on behalf of Mark and Belinda Callaghan dated 6 August 2025.
[45] Form 8 Determination by Coroner of Identity of Deceased, CB 8-9.

Medical cause of death

50. On 25 February 2014, a post-mortem examination was conducted by Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine.

51. Dr Burke provided a written report of his findings dated 1 April 2014.[46] The post-mortem examination revealed injuries consistent with the reported circumstances of the death.

52. Routine full toxicology testing was performed, and no alcohol or commonly encountered drugs or poisons were detected in the post-mortem blood samples.[47]

53. Dr Burke formulated the cause of death as "1(a) Head and neck injury in a train incident".

54. I accept Dr Burke's opinion. The cause of death was not in dispute and required no further investigation.

Circumstances in which the death occurred

55. On 22 February 2014, Mitchell attended an 18th birthday party at a house with a large group of friends and acquaintances.[48] Many of the group consumed alcohol throughout the evening and were affected by alcohol to varying degrees.[49] However it was observed by many people at the party that Mitchell was not drinking, and he was generally not known to drink alcohol.[50]

56. At about 11:30 pm, Mitchell was part of a large group of approximately 15 to 20 people who left the party to catch a train into the city to go to the White Night Festival. The group walked to Heyington Railway Station in Toorak (**Heyington Station**), which was a short distance away. During the walk the group divided up into smaller groups, meaning that they did not all arrive at the station at the same time.

57. At 23:51,[51] a citybound train arrived at platform 1 of Heyington Station. This was the scheduled 23:28 service from Glen Waverley Station to Flinders Street Station.[52] Upon arrival at Heyington Station, train telemetry data recorded that the doors open button was

[46] VIFM Medical Inspection and Report; CB 1-4.
[47] VIFM Toxicology Report, CB 5-7.
[48] Statement of James Mulcahy, CB 11.
[49] Ibid, CB 12; statement of Andres Torcello, CB 25; statement of Finn Pedersen, CB 42.
[50] Statement of James Mulcahy, CB 11.
[51] ATSB Transport Safety Report, CB 326. Times from this point are expressed in 24-hour time in accordance with the time recording on CCTV footage and train telemetry data logging.
[52] Ibid, CB 326.

activated by the train driver at 23:51:11. This opened the left side doors for passengers to exit and enter the train on platform 1.[53]

58. Some members of the group from the party were close enough to Heyington Station that they saw the train arriving and ran to catch it. They boarded the train through the centre door of the fourth carriage[54] whilst it was stationary at the platform.[55] The centre doors of this carriage sat in line with the platform 1 entrance.[56] CCTV footage from the station and from inside the carriage depicts several people from the group running past the platform 1 entrance and entering the fourth train carriage between 23:51:21 and 23:51:40.[57] Members of the group thought that their friends were not far behind them and they shouted for the remainder of the group to hurry up so that they could also board the same train.[58] At that time, Mitchell was with a group of people who were yet to arrive at Heyington Station.

59. At 23:51:23, train telemetry data recorded that the doors close button was activated by the train driver, which commenced a 60-second "Traction Delay" period, during which it was not possible for the train driver to move the train by requesting traction power if the doors remained open.[59] It was also recorded that the train whistle sounded one second later at 23:51:24,[60] which was used by the driver to indicate train departure.[61]

60. However, some of the group who had boarded the train stood in the middle doorway of the fourth carriage and forcibly held the doors open to prevent them from closing. This was variously described as being done by people using hands, or by leaning up against the doors using their body weight.[62]

61. It was observed by witnesses inside the carriage that the carriage doors attempted to close whilst they were still being held open by members of the group, with some witnesses

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[53] ATSB Transport Safety Report, CB 326; Metro Trains Melbourne Incident Investigation Final Report, CB 728 – train telemetry data.
[54] Carriage 162M
[55] ATSB Transport Safety Report, CB 326.
[56] Metro Trains Melbourne Incident Investigation Final Report, CB 742.
[57] Metro Trains Melbourne Incident Investigation Final Report, CB 713.
[58] Statement of James Mulcahy, CB 12; statement of Harrison Brettell, CB 34; statement of Finn Pedersen, CB 44; statement of Jonty Pedersen, CB 57; statement of Kathryn Wellings, CB 68; statement of Sarah Holmes, CB 76; statement of Amy Plunkett, CB 91; statement of Simon McMahon, CB 100.
[59] ATSB Transport Safety Report, CB 728.
[60] Ibid, CB 728.
[61] Ibid, CB 743.
[62] Statement of James Mulcahy, CB 12; statement of Harry McCallum, CB 22; statement of Anders Torcello, CB 25; statement of Harrison Brettell, CB 34; statement of Finn Pedersen, CB 43; statement of Jonty Pedersen, CB 57; statement of Kathryn Wellings, CB 67; statement of Sarah Holmes, CB 75; statement of Megan Dal-Ben, CB 85; statement of Amy Plunkett, CB 91; statement of Aisling Leonard, CB 95; statement of Simon McMahon, CB 100-101; statement of Mitchell Smart, CB 104.

hearing the doors beeping as part of the door closure process.[63] It was also noted that the doors were being held open after all the other doors on the train had closed[64] and as a result, the train was being delayed at the station.

62. At some point, the train driver used the PA system on the train to make an announcement. The witness accounts varied regarding what was said by the train driver and whether there was an announcement made on more than one occasion. However, the general tenor of the evidence was that the train driver was asking people to move away from the doors to allow the train to depart[65] and that the train could not move until the doors were clear.[66]

63. Despite the train driver's request, the doors continued to be held open by members of the group. Witnesses described that the doors continued to beep as they were trying to close.[67]

64. Between 23:51:21-22 and 23:53:35, CCTV footage at the station and inside the train carriage depicts several people entering onto the platform and into the train carriage through the middle doors of carriage four on different occasions.[68] It is therefore apparent that members of the group who were still arriving at the station were only able to board the carriage due to the doors being forcibly held open, which was keeping the train delayed at the platform.[69]

65. A person from the group of friends jumped off the train and again shouted for the rest of the group to hurry up, and then he re-entered the carriage.[70] During this time the doors were clearly still being held open for the expected arrival at the station of more people from the group of friends travelling into the city.

66. It was also during this period of time, at 23:51:29, and again at 23:51:54, that traction power was requested by the driver to move the train, according to train telemetry data.

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[63] Statement of Harry McCallum, CB 22; statement of Sarah Holmes, CB 76; statement of Amy Plunkett, CB 91; statement of Aisling Leonard, CB 97.
[64] Statement of Mitchell Smart, CB 104; statement of Georgia Sze-Tho, CB 131.
[65] Statement of James Mulcahy, CB 12; statement of Harry McCallum, CB 22.
[66] Statement of James Mulcahy, CB 12; statement of Harry McCallum, CB 22; statement of Harrison Brettell, CB 35; statement of Finn Pedersen, CB 44; statement of Jonty Pedersen, CB 57; statement of Vinodh Krishnan, CB 80-81; statement of Megan Dal-Ben, CB 86; statement of Aisling Leonard, CB 96; statement of Simon McMahon, CB 101.
[67] Statement of Harry McCallum, CB 22; Statement of Vinodh Krishnan, CB 81; statement of Aisling Leonard, CB 96-97.
[68] Metro Trains Melbourne Incident Investigation Final Report, CB 713-716.
[69] Statement of Finn Pedersen, CB 44; statement of Jonty Pedersen, CB 58; statement of Sarah Holme, CB 75-76; statement of Vinodh Krishnan, CB 81; statement of Aisling Leonard, CB 97.
[70] Statement of James Mulcahy, CB 12; statement of Kathryn Wellings, CB 68; statement of Aisling Leonard, CB 96; statement of Simon McMahon, CB 101; and CCTV footage as referred to in Metro Trains Melbourne Incident Investigation Final Report, CB 713-716.

On both occasions the train could not move away from the platform because the doors remained open, and the two requests for traction occurred within the 60-second delay period which commenced when the door close button was activated, rendering traction unavailable whilst all doors were not detected as being closed.[71]

67. At 23:52:22, according to train telemetry data, traction power became available as the 60-second time period had elapsed.[72] However, the train was still stationary at the platform as no traction power was requested at that time.[73]

68. At 23:53:30, train telemetry data recorded that traction power was successfully requested by the driver and the holding brake disengaged, allowing the train to move. The data also recorded that at least one door was indicated as open at that time.[74]

69. The train commenced moving away from Heyington Station at approximately 23:53:32-34, initially travelling at 3 km/hr according to train telemetry data and CCTV footage.[75] There was a conflict in the evidence regarding whether the middle doors of carriage four, which had been held open by members of the group of friends, were open or closed at that time, although it was not in dispute that all other doors on the train were closed.[76]

70. When the train commenced pulling away from Heyington Station, Mitchell and others from the group were still arriving. Mitchell had been walking down to the station with a male friend and a female friend, talking together as a group of three.[77] Whilst walking down the ramp to the station, the male friend could see the stationary train, and observed that people were holding the doors open. The male friend asked the female friend if she was going to run for the train, and Mitchell also said, "Let's run". In what has been described as a decision made "in a split second" and a "quick and instant decision", the male friend and Mitchell began to run for the train.[78]

71. CCTV footage from the station cameras depicted that the male friend was several steps in front of Mitchell as he ran past the station entrance onto platform 1 at approximately 23:54:34, with Mitchell passing the veranda post onto the station platform only a second

[71] Metro Trains Melbourne Incident Investigation Final Report, CB 728.
[72] Ibid, CB 728.
[73] Ibid, CB 728.
[74] Ibid, CB 728.
[75] CB 728 and CB 713. As depicted in CCTV footage CB 713
[76] CB 25
[77] Statement of Finn Astle, CB 70-71.
[78] Statement of Finn Astle, CB 71; statement of Georgia Sze-Tho, CB 130-131.

later at 23:53:35.[79] Whilst there was CCTV footage which depicted that the train had just commenced moving prior to their arrival onto the platform, there was no CCTV footage which captured a view of the relevant area of the platform where the young men were running or the exterior of the carriage four doors as the train pulled away.

72. Both the male friend and Mitchell were observed running onto the platform and alongside the train by several witnesses, including a member of the group who was holding the doors open. The male friend ran alongside the train and jumped through the open carriage doors at 23:53:35-36.[80] It was observed by witnesses that he did so easily and it appears that the train was not moving at a fast rate of speed at that time.[81] As the male friend entered the open carriage doors, he felt the train jolt, and he described the movement of the train at that time as an "almost instant acceleration without warning".[82] The male friend was the last person to board the train, two seconds after it began to move away from the platform.[83]

73. It was generally observed that after the male friend boarded the train, it picked up more speed and was noted to do so quickly.[84]

74. As Mitchell and the male friend were running for the train, they were being followed onto the platform by the last members of the group from the party who were still arriving at the station. These witnesses observed Mitchell running down the stairs at the station and onto the platform at a fast rate of speed as the train was moving away. As Mitchell attempted to jump into the open doorway of the train carriage, he tragically missed or tripped, hitting the side of the train and falling into the large gap between the platform and the train.[85] The incident was described by those who saw it as a "freak accident" which occurred in "a split second".[86]

75. A number of witnesses inside carriage four also saw what occurred, including some who knew Mitchell, but the accounts about what was seen varied and many people did not

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[79] Metro Trains Melbourne Incident Investigation Final Report, CB 714-715.
[80] Depicted in CCTV footage, Metro Trains Melbourne Incident Investigation Final Report, CB 716.
[81] Statement of Harry McCallum, CB 23; statement of Harrisson Brettell, CB 34; statement of Tom Ruffy, CB 124; statement of Tenielle Bulmer, CB 141.
[82] Statement of Finn Astle, CB 71.
[83] Metro Trains Melbourne Incident Investigation Final Report, CB 742.
[84] Statement of James Mulcahy, CB 12; statement of Anders Torcello, CB 26; statement of Harrison Brettell, CB 34; statement of Amy Plunkett, CB 92; statement of Aisling Leonard, CB 97; statement of Simon McMahon, CB 101; statement of Tom Ruffy, CB 124; statement of Tenielle Bulmer, CB 141.
[85] Statement of Tom Ruffy, CB 124-125; statement of Andrew Copolov, CB 114; statement of Emily Stribley, CB 121; statement of Georgia Sze-Tho, CB 131; statement of Tenielle Bulmer, CB 141; statement of Alexandra Medaglia, CB 148.
[86] Statement of James Mulcahy, CB 13.

have a clear view. Some witnesses were very distressed as they feared that Mitchell had impacted the side of the train and fallen under it, whilst others thought he had fallen back onto the platform, or they had heard something but were uncertain about what had occurred.[87] Three of Mitchell's friends got off the train at the next stop at Burnley Station and sprinted back to Heyington Station, extremely concerned about Mitchell's welfare and uncertain what had happened.

76. When the members of the group who were following behind Mitchell arrived at the platform, they immediately jumped down onto the train tracks to provide assistance to him, and calls were made without delay to 000 for an ambulance. It was observed that Mitchell was non-responsive, but that he was initially still breathing. One of Mitchell's friends checked his vital signs and checked for injuries, and Mitchell was repositioned to assist his breathing. A jumper was wrapped around his head to stem the apparent bleeding, but on a further check, Mitchell was observed to be no longer breathing. One of the friends immediately commenced CPR and continued without stopping until the paramedics arrived,[88] aided by other members from the group.[89]

77. At 23:55, the emergency button on the platform was used to notify Metro Trains of what had occurred,[90] requesting that the trains be stopped as there were people on the tracks. During this time the three friends who had alighted at Burnley Station and run back to Heyington Station arrived.[91] It was an extremely distressing scene for everyone involved and I acknowledge that friends of Mitchell remained with him throughout this time doing everything they could to provide assistance.

78. Paramedics received the call to attend the incident at 23:57 and arrived at 00:12,[92] with police and Metro Trains staff also attending the scene. Mitchell was assessed by paramedics as unconscious with no breathing and no pulse. He was moved onto the

[87] Statement of James Mulcahy, CB 12; statement of Anders Torcello, CB 26; statement of Harrison Brettell, CB 34; statement of Finn Pedersen, CB 45; statement of Jonty Pedersen, CB 58; statement of Kathryn Welling, CB 68; statement of Vinodh Krishnan, CB 81-82; statement of Megan Dal-Ben, CB 87; statement of Amy Plunkett, CB 92; statement of Aisling Leonard, CB 97; Statement of Simon McMahon, CB 102; statement of Mitchell Smart, CB 105.

[88] Statement of Andrew Copolov, CB 114; statement of Emily Stribley, CB 119; statement of Georgia Sze-Tho, CB 132; statement of Alexandra Medaglia, CB 149.

[89] Statement of Riley Boyd, CB 136; statement of Tom Ruffy, CB 125; statement of Emily Stribley, CB 119-120; statement of Andrew Copolov, CB 114.

[90] Statement of Joe Mabilia, CB 193.

[91] Statement of Emily Stribley, CB 120.

[92] Statement of Gary Robertson, CB 203.

platform, but it was apparent that further medical intervention was of no utility and Mitchell had sadly passed away. He was pronounced deceased by attending paramedics.[93]

79. The train driver was unaware that an incident had occurred, and the train continued its journey to Flinders Street Station. As the train travelled away from Heyington Station, CCTV footage inside the carriage indicated that the open doors on carriage four were not closed until 23:53:55,[94] consistent with train telemetry data which recorded the door status as being closed at 23:53:56. At that time the train was recorded as travelling at 58 km/hr.[95] The door had remained open for 22 seconds after it left Heyington Station, during which time the train travelled approximately 245.7 metres.[96]

80. This evidence accords with the descriptions of various witnesses in carriage four who observed that the doors remained open and were not closed until after leaving Heyington Station. It was observed that the doors only closed after travelling 50-100 metres and when the train was halfway to Burnley Station. Witnesses also described the doors as being open for "awhile" and "for a dangerously long time", whilst the train was travelling at a fast rate of speed, and with people inside the carriage concerned about the open doors and yelling out for them to be closed.[97]

81. There was some discrepancy in the witness accounts of how precisely the doors were closed. Some witnesses observed that the doors appeared "loose" and had to be manually and forcibly closed, although the evidence was unclear about who did this.[98] There were other witness accounts which indicated that the doors closed by themselves.[99] Regardless of the manner in which they were closed, the doors were noted to be functioning normally when the train arrived at the next stop at Burnley Station,[100] and there were no issues reported in relation to the doors for the remainder of the journey. The passengers alighted from the train at Flinders Street Station on the right side of the carriage.[101] The driver was met on arrival at Flinders Street Station by a Metro Trains supervisor and informed that

[93] Ibid, CB 203.
[94] Metro Trains Melbourne Incident Investigation Final Report, CB 716.
[95] Metro Trains Melbourne Incident Investigation Final Report, CB 729.
[96] Metro Trains Melbourne Incident Investigation Final Report, CB 729.
[97] Statement of Kathryn Welling, CB 68; statement of Finn Astle, CB 72; statement of Sarah Holmes, CB 76; statement of Aisling Leonard, CB 98.
[98] Statement of Anders Torcello, CB 26; statement of Kathryn Welling, CB 68; statement of Amy Plunkett, CB 92.
[99] Statement of Harrison Brettell, CB 35; statement of Vinodh Krishnan, CB 81.
[100] Statement of Megan Dal-Ben, CB 88.
[101] Ibid, CB 88.

there had been an incident at Heyington Station, but was not informed that there had been a fatality.

82. Whilst there was initially a great deal of confusion and shock regarding what occurred amongst Mitchell's group who remained on the train, it was not long before most people who had been with him at the party became aware through the exchange of telephone calls and messages that he had passed away. This became known to other friends, who contacted Mitchell's parents prior to the formal notification being provided to them by police. I acknowledge the terrible distress of Mitchell's immediate family and all those known to Mitchell as they were notified of his unexpected passing.

INVESTIGATIONS

83. Both Metro Trains and Victoria Police commenced investigations into the fatality on the night it occurred, and an investigation was subsequently also commenced by the Australian Transport and Safety Bureau (**ATSB**).

A. Metro Trains Melbourne Incident Investigation Report

84. The internal investigation into the incident by Metro Trains Melbourne resulted in an "Incident Investigation Report" (**MTM Report**).[102] The MTM Report summarised the investigations which were conducted following the incident by Metro Trains and made several conclusions about what occurred.

85. Relevantly, the MTM Report confirmed that a train should not depart a station until the doors are proven closed.[103] To this end, strict operational procedures and policies applied to train drivers when opening and closing doors at a station. This included the requirements of drivers when departing a platform, and the process by which doors on the train are opened and closed by the driver. This evidence was critical to determining what occurred in relation to the departure of the train from Heyington Station.

Platform departure process and visibility

86. The requirements of train drivers when causing a train to depart a platform included the following:

[102] CB 704-747.
[103] Metro Trains Melbourne Incident Investigation Final Report, CB 746.

a) Look back along the length of the train, as far as practicable, for any hand signals or dangerous situation that may arise;

b) Close the doors using the "doors close" button when safe to do so, meaning no passengers are getting on or off the train;

c) Ensure the "doors close" light steadies immediately prior to requesting traction power;

d) Re-check the train to ensure passengers and articles are clear of the doors;

e) Sound a long whistle and depart; and

f) As the train departs the platform, look back along the train as far as practicable, for any hand signals or dangerous situation that may arise.[104]

87. Whilst stationary at a platform, if a driver for whatever reason cannot obtain a clear view of the train, the driver must go to a position, by leaving the cab if necessary, where customers exiting and entering the train can be clearly observed, which includes using "operational platform departure infrastructure".[105]

88. An example of such infrastructure includes the Single Person Operations Television (**SPOT**) monitors located about 1.3 metres from the end of platform 1 at Heyington Station.[106] This is a large, elevated monitor visible to the train driver when stopped at the correct position at the station. At the time of the incident, it showed four views of the platform from CCTV cameras along the train/platform length, as the driver was otherwise unable to view the length of the platform and train due to the curvature of the track and platform at Heyington Station.[107]

89. The interior of the carriage was also visible to the train driver from an on-board CCTV system which was displayed on a monitor in the driver's cab where the driver sat and operated the train controls. The system enabled the driver to select footage to view each carriage. The CCTV footage was available for the driver to view when the train was at a standstill, and cut out when the train travelled more than 8 km/h.[108]

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[104] Metro Trains Melbourne Incident Investigation Final Report, CB 740; Metro Trains Melbourne procedure 'L2-TSD-PRO-014(1) Platform Departure', CB 2127.
[105] Metro Trains Melbourne Incident Investigation Final Report, CB 740.
[106] ATSB Transport Safety Report, CB 328.
[107] Ibid, CB 330.
[108] Ibid, CB 333.

Door open procedure

90. The controls required to open and close the train doors and operate the train were on the driver's desk in the driver's cab of the train,[109] and door opening and closing on the train was controlled by the driver.

91. When a train arrived at a station, the driver pressed the left or right side luminous "doors open" push button on the driver's desk, depending on which side of the train the platform was on. The button was yellow and illuminated when pressed. The doors open button only worked if the train was travelling below 3 km/h. When pushed, it caused a sound signal to be emitted in the carriages for 1.5 seconds, and push buttons on the interior and exterior of the carriage doors illuminated for passenger use. The passengers could then open the carriage doors using the illuminated push buttons, for entry and exit from the train. Train traction was inhibited at this time, meaning the train couldn't be moved by the driver. Train traction was ordinarily initiated by the driver moving a lever on the driver's desk called the "master controller".[110]

Door close procedure

92. Once all the passengers boarded the train, the driver pressed the "doors close" push button on the driver's desk to close the train doors. The button was blue and illuminated as a flashing light when pressed until all the doors were closed. When activated, it extinguished the yellow "doors open" light. Pushing the "doors close" button triggered a 3-second sound signal being emitted in the carriage to warn the passengers of the imminent door closure. At the time of the incident, it also triggered a 60-second time delay for traction authorisation by the driver, meaning that if the driver tried to move the train using the master controller during that period, the train would not move unless all doors were closed.[111]

93. After the 3-second sound signal, the door closure control was activated, closing the doors in the carriages. If all doors were detected as closed and locked, the blue doors close button illuminated as a steady, "fixed" blue light on the driver's desk. However, if at least one door was detected as not closed and locked, the doors close button remained

[109] Metro Trains Melbourne Incident Investigation Final Report, CB 735-736.
[110] Metro Trains Melbourne Incident Investigation Final Report, CB 725-726, 736; ATSB Transport Safety Report, CB 330-331.
[111] Metro Trains Melbourne Incident Investigation Final Report, CB 726, 736; ATSB Transport Safety Report, CB 331-332.

illuminated in a "flashing mode" to alert the driver that a door was open and unlocked.[112] The yellow doors open button remained extinguished throughout the door closure procedure.[113]

94. If all the doors were detected as closed and locked either before or after the 60-second time delay period elapsed, the doors close push button appeared as a fixed blue light, and traction of the train was authorised, meaning that the driver could move the train using the master controller.[114]

95. However, at the time of the incident, after the 60-second time delay period elapsed, if the doors were not all detected as closed and locked, the doors close button would remain flashing, but traction became available and the driver could move even though not all the doors were closed.[115]

Obstacles in the doorway

96. The door closing procedure could be interrupted and the doors would not close when there was an obstacle detected preventing the doors from closing. Every carriage door was fitted with an "obstacle detection device". If an object was detected between the doors during the door closing sequence, the door closing sequence was stopped. The door then tried to close every three seconds, on three occasions, after which the door remained in position.[116] When this occurred, an intermittent sound signal was broadcast for 60 seconds, which stopped if the obstacle was removed within that time.[117] Whilst any door remained obstructed and open, the doors close light continued to flash on the driver's desk. Only if the obstruction was removed and the doors closed would the blue doors close button return to a steady blue light.[118]

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[112] Metro Trains Melbourne Incident Investigation Final Report, CB 726-727, 736; ATSB Transport Safety Report, CB 332.
[113] ATSB Transport Safety Report, CB 332.
[114] Metro Trains Melbourne Incident Investigation Final Report, CB 726-727.
[115] Metro Trains Melbourne Incident Investigation Final Report, CB 726-727, 736-737; ATSB Transport Safety Report, CB 332. The mechanism by which traction could be authorised despite a door being indicated as open after 60 seconds was described by Metro Trains as "imperative", because "otherwise any reported door faults would strand the train at a station, with obvious flow on effects for other trains on the line": CB 737.
[116] Metro Trains Melbourne Incident Investigation Final Report, CB 727.
[117] Ibid.
[118] Ibid, 726-727; ATSB Transport Safety Report, CB 332.

97. Drivers were provided specific instruction on the procedure to be adopted to deal with a flashing blue doors close light. As part of that instruction, Metro Trains identified the relevant risk being addressed by the procedure as follows:

> Drivers must be aware of the risks involved should they detect a Flashing Door Closed Light whilst in running, the danger that it could impose on our customers. Therefore it is vital that all procedures are adhered to, to ensure the safe running of trains.[119]

98. Additionally, it was Metro Trains policy that the driver of the train was "responsible for the condition of the passenger doors, and when they fail to close or open must make attempts to locate the fault".[120]

99. According to Metro Trains procedures, drivers were directed that if the doors close light continued to flash after the door closure sequence, the driver was required to make a PA announcement telling the passengers to remove any obstructions from the doors/cease trying to force the doors open.[121] If the doors close light continued to flash, the driver was required to advise the Train Controller, carry out the "cab unattended procedure" and "walk along the train to ascertain which door is causing the problem and/or which cab a [circuit breaker] may have tripped in".[122] When the driver walked along the train, they ascertained which door was causing the problem by doing a visual check that each door has closed, and by listening for the audible door warning tones. The procedure specifically noted that "Under no circumstance must a Driver depart a station with a [flashing door close light] unless passengers have been detrained".[123]

100. There was also a Metro Trains policy that drivers must be "vigilant to detect incidents or criminal or antisocial behaviour, and to report them quickly".[124] A common example given was "Repeatedly holding open saloon doors". Drivers aware of such activity were required to notify the Train Controller at Metrol,[125] who would decide what further action should be taken.[126]

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[119] Metro Trains Melbourne 'Module 88 Session 04: Saloon Door Defects': Learner's Notes', CB 829.
[120] Ibid, CB 830.
[121] Metro Trains Melbourne Incident Investigation Final Report, CB 737.
[122] Ibid; transcript of committal, 25 January 2016, CB 1668.
[123] Metro Trains Melbourne Incident Investigation Final Report, CB 738.
[124] Ibid.
[125] The control centre for train operations on Melbourne's metropolitan rail network.
[126] Ibid, CB 739; Metro Trains Melbourne procedure 'Unruly passengers and unauthorised persons in cabs', CB 841.

Metro Train testing pre and post incident

101. As part of the Metro Trains investigation, testing was undertaken to determine whether there were any faults in the X'Trapolis train involved in the incident and, in particular, the operation of the door closure system including the doors open and doors close lights. The investigations concluded as follows:

    a) The door status indication on the train was working in the fourth carriage and the driver cab. This meant that if a door was open on the train, it would have been displayed on the dash of the driver cab and evident to a person in the driver's seat.[127]

    b) The traction delay system was functioning normally when the train driver attempted to depart and the system detected a train door was not closed.[128]

    c) In post incident testing, no defects were found with the train or the infrastructure.[129]

102. Overall, the Metro Trains investigation found that:

    a) There were no faults reported in relation to carriage four or the driver cab either before or after the incident;

    b) There were no reported faults with the SPOT monitor on platform 1 of Heyington Station, and the monitor captured the view of the middle door of the fourth carriage at the platform;

    c) Once the train was in motion, the driver lost vision of the SPOT monitors;

    d) Post incident checks did not reveal any faults with the train, including the doors and the flashing doors close light, which were specifically tested;[130]

    e) There was no evidence that the driver contacted Metrol to report any fault or incident; and

[127] Metro Trains Melbourne Incident Investigation Final Report, CB 745.
[128] Ibid.
[129] Ibid, CB 746.
[130] Ibid, CB 743-744, 745.

f) There was no activation of the Emergency Door Release (**EDR**) or automatic Passenger Emergency Intercom (**PEI**) system.[131]

103. With regard to the platform itself, the MTM Report noted that there was an inspection of its condition on 20 February 2014. This recorded the condition as "Fair", with no defects noted, although it was observed that the surface was rough and undulating, with cracks beginning to spread. The track and platform 1 were noted to be curved, not straight,[132] and with regard to the size of the gap between the train and the platform, it was documented that standard clearance requirements (**the standards**) did not apply as the station was constructed in 1890, prior to the implementation of the standards. However, at the location where the incident occurred, the platform was out of standard between 5 mm to 20 mm.[133] The investigation also found that the horizontal distance between an X'Trapolis type train and the edge of platform 1 was measured as being between 390 mm at the station entrance and 320 mm near where the incident occurred.[134]

104. The Metro Trains investigator noted that the train driver refused to provide an account of what occurred, and concluded that he was unable to comment on whether the driver saw that the doors close light was flashing, indicating a train door was open, or if it showed a steady blue light indicating all doors were closed.[135] The investigator was unable to comment on the status of the doors close light immediately prior to the train departing as there was no data available to verify the status of the light.[136] However, the investigator concluded that the driver "did not reinitiate the door closure process" immediately prior to departure.[137]

B. Australian Transport and Safety Bureau Report

105. The ATSB conducted an investigation into the incident in collaboration with the office of the Chief Investigator, Transport Safety (Victoria), and produced a "Transport Safety Report" dated 27 April 2016.[138]

106. The ATSB found that the operation of the traction interlocking system which permitted the train to move with the doors open, "increased risk and was contributory to this

[131] Ibid, CB 737.
[132] Ibid, CB 733.
[133] Ibid, CB 735.
[134] Metro Trains Melbourne Incident Investigation Final Report, CB 710.
[135] Ibid, CB 744.
[136] Ibid, CB 744.
[137] Ibid, CB 745.
[138] CB 322-348.

accident".[139] The ATSB further found that post incident testing by Metro Trains established that the doors close light functioned as designed and only changed from "flashing" to "steady" when the doors were closed. The ATSB noted that whilst this mechanism identified for the driver that the door may be open, it did not warn the driver when the traction interlock control had deactivated despite a flashing blue doors close light.[140]

107. According to the ATSB, in this case where there was no guard assisting with passenger boarding and exiting, the driver was solely responsible for "the safe operation of the train" as well as attending to security issues and passenger safety.[141]

108. As referred to in the outline of the procedural history, as part of the investigation, the ATSB utilised legislated compulsory powers to interview Mr Dickson after the committal proceedings were completed. At that time, Mr Dickson provided a version of events which were summarised in the ATSB report as follows:

    a) He made an announcement to passengers to move away from the doors, but the passengers holding the doors didn't comply.

    b) He checked the CCTV and SPOT monitors. He was trying to see the door but the vision was unclear due to the number of people standing near the door.

    c) He was about to make a call to Metrol to inform them, after which he intended to leave the driver cab to speak to the passengers and close the door.

    d) He did not make the call or leave the driver cab, as he observed a steady blue light indicating the door had closed. He applied traction power and departed the station.

    e) It was his understanding that the traction interlock would not allow the train to move if the doors were open, and he was unaware of the design feature that allowed the train to move with doors open after 60 seconds.[142]

109. The ATSB referred to the absence of any identified faults in post incident testing and concluded that the display available to the driver, including the doors open and doors close buttons, was functioning correctly.[143] It was theorised in the ATSB report that the

[139] ATSB Transport Safety Report, CB 334.
[140] Ibid.
[141] Ibid.
[142] Ibid, CB 335.
[143] Ibid.

driver's belief that he saw the steady light was influenced by his inaccurate understanding of the interlock system,[144] and his limited visibility of the platform. It was noted that when the train moved, he lost access to the SPOT monitors, and the CCTV would also cut out. Consequently, the ATSB concluded that driver would not have been able to see the platform or the attempts by persons including Mitchell to board the moving train.[145]

110. In performance of its statutory function, the ATSB identified two safety issues which contributed to the fatality which increased safety risk, namely, the operation of the traction interlock deactivation design, which allowed the train to depart with carriage doors open, and the wide gap between the platform and the train due to the curvature of the track, which posed a risk to passengers.

111. Another factor which was noted to increase risk was that the train door open/close indicator on the driver's console was inadequate when the traction interlock had deactivated.[146] The attempt to board the moving train, and the passengers holding the doors open were both also identified by the ATSB as factors which contributed to the incident.[147]

THE EVIDENCE OF RUSSELL DICKSON

Training, knowledge and experience

112. Mr Dickson qualified as a train driver for Metro Trains in July 2012 and he was fully qualified to drive the X'Trapolis train.[148] No deficiency in his training or experience was identified during the Metro Trains investigation, nor were any concerns raised about his work performance prior to the incident. Notably, Mr Dickson's driving skills were assessed on several occasions by Metro Trains during the "Train Driver Safety Audit" procedure, and prior to the incident he was last audited in January 2014, with no issues reported.[149] The audit reports establish that Mr Dickson performed his role as a train driver to a high standard. He was assessed as demonstrating continued adherence to Metro Trains

[144] Ibid.
[145] Ibid.
[146] Ibid, CB 340.
[147] Ibid.
[148] ATSB Transport Safety Report, CB 333; Metro Trains Melbourne Incident Investigation Final Report, CB 746; Transcript of Inquest hearing, 3 December 2024 (**'T'**), page 2, lines 14-15.
[149] ATSB Transport Safety Report, 333; Metro Trains Melbourne Incident Investigation Final Report, CB 724.

operating procedures, and demonstrated safety awareness, responsibility and professionalism.[150]

113. During his evidence at the inquest, Mr Dickson confirmed that he knew the procedure to be followed when arriving at and departing the station platform,[151] and that he also knew the door open and door close procedures. He knew the procedure to be followed when there was a flashing blue doors close light which signified that a door was open, and he stated that he had undertaken that procedure on many occasions.[152]

114. Specifically, Mr Dickson knew that prior to requesting traction he had to ensure that the doors close light had stopped flashing, and when the doors had all closed, the light would be "steady".[153] He was aware of the requirement that the driver must not depart the station with a flashing doors close light.[154] He agreed that if the light was flashing, at least one door was open,[155] and that the most obvious assumption was someone might be holding the doors, or there was something in the doors.[156] Mr Dickson agreed that it was "drummed into" him during his training that he should never apply traction if the blue light was flashing.[157] He stated he would never drive off with a flashing light.[158]

115. However, Mr Dickson claimed to be unaware that activating the doors close button on the X'Trapolis train initiated a 60-second traction delay function, despite agreeing that a document used at the time Mr Dickson was trained referred to the 60-second time delay for traction authorisation. He did not recall reading or being aware of that information in relation to the X'Trapolis train type.[159] Specifically, he had no recollection of being informed that there was a 60-second delay during which he couldn't get traction if the blue light was flashing for the X'Trapolis train type,[160] but he was aware that this was a feature on the Comeng type train which he also drove.[161] It was his consistent evidence that he was unaware that the traction would work after 60 seconds, with the blue flashing

[150] Train Driver Safety Audit records, CB 863-981.
[151] T 9:4-17; T 11:15-17.
[152] T 12:17-26; T 13:20 - 14:1.
[153] T 10:24-26.
[154] T 14:30 - 15:3.
[155] T 20:11-12; T 94:11-14.
[156] T 14:8-11.
[157] T 94:21-23.
[158] T 94:15-16.
[159] T 91:1 - 92:3.
[160] T 23:3-11.
[161] T 32:2-11.

doors close light present, and at least one door open.[162] He maintained that he thought it was not possible to drive the X'Trapolis train if the blue light was not steady.[163]

116. Mr Dickson gave an account of his usual implementation of the door closure and departure procedures. He explained that it was ordinarily about 5 seconds between pushing the doors close light and the blue light going steady. If it was longer, it was the flashing blue light that indicated to him in the first instance that there was an issue, and he would not have cause to look at the CCTV from the carriages unless he was first made aware of a problem in this manner. Once aware that there was an issue with door closure, he would take the steps set out in the relevant procedure.[164]

117. Mr Dickson stated that he would make a PA announcement, allow "a little bit of time" for people to move on and off, make another PA announcement, and if that did not work he would contact Train Control to let them know about the delay "after a few minutes". Whether or not he went to have a look would depend on the situation.[165] Whilst he was not familiar with the documented policy regarding anti-social and criminal behaviour (which included holding of carriage doors), he was aware of the expectations to report it.[166]

118. Once he obtained traction, he understood that his training required a second look and if he didn't see anything, he continued. At that point he looked in the train mirrors when he had passed a SPOT monitor, meaning he could only see a short section of the platform.[167] He gave evidence there would never be a situation where he would try and get traction to leave while there were still people getting on and off the train.[168]

119. Regarding the nature of his responsibility as a train driver, Mr Dickson understood the condition of the passenger doors was the driver's responsibility, and that this included taking steps to investigate any issues.[169] He also agreed that as a train driver he was responsible for the safety of his passengers.[170] He was aware of the risks involved in driving a train with an open door, and particularly in a crowded train with passengers in

[162] T 38:29 - 39:14.
[163] T 21:4-6; T 38:18-21.
[164] T 23:31 - 24:12; T 12:27 - 13:14.
[165] T 23:23-30.
[166] T 16:22-23; Metro Trains Melbourne procedure, 'Train driver dealing with Criminal Offences', CB 824.
[167] T 103:25 - 104:3.
[168] T 27:10-12.
[169] T 12:27 - 13:4.
[170] T 98:8-13.

the doorway.[171] He was therefore well aware of the risks involved in not following the relevant procedures.[172]

Earlier accounts

120. Prior to the inquest hearing, Mr Dickson provided two accounts of what occurred on the night of the incident.

121. The only contemporaneous account available is contained in the "Train Driver Incident Report" (**Incident Report**) completed by Mr Dickson. His evidence at the inquest was that after arriving at Flinders Street Station he was met by someone from Metro Trains and advised that there had been an incident at Heyington Station. This accords with an entry in Mr Dickson's "Train Driver Profile" that he was met on arrival by a Depot Manager. He was then breath tested, which recorded a negative result, and he authored and submitted an Incident Report.[173] This recorded that the incident occurred on 22 February 2014 at Heyington, and the description provided was "group of men holding rear car door open made announcement to stand clear. Couldn't see anyone near train platform. Departed train".[174]

122. Whilst the initial copy of the Incident Report provided to the Court was missing the word "open" in that narrative,[175] a different copy of the document was subsequently provided by Metro Trains which included it.[176] Having compared the two documents, it is apparent that the word "open" was redacted from the initial copy provided to the Court. The redaction is clear on the face of the document from the absence of lines from that section of the lined page, and the appearance of part of the letter "p" from "open" visible in the redacted copy. Mr Dickson confirmed in evidence that it appeared to be his handwriting.[177] It is not known how or why that redaction occurred, but I am satisfied that they are the same document and the word "open" was included by Mr Dickson.

123. During his evidence, Mr Dickson agreed he wrote an Incident Report, and that the Incident Report on the brief had his handwriting and signature. However, he also gave evidence that he remembered writing a different document on the night and he didn't know if that

[171] T 98:14-17.
[172] T 98:18-22.
[173] Train Driver Incident Report, CB 1147; Train Driver Profile, CB 860; T 6:17-22.
[174] Train Driver Incident Report, CB 1147.
[175] CB 539.
[176] CB 1147.
[177] T 108:16.

was the document on the coronial brief. Mr Dickson also gave evidence that he authored an Incident Report in which he wrote that people were holding the doors, which is consistent with the information provided in the Incident Report on the coronial brief. He did not deny authoring the Incident Report contained in the brief.[178] I am therefore satisfied that the Incident Report contained in the coronial brief was authored by Mr Dickson on the night, and that the version that he authored is the document which included the word "open".

124. When questioned about the description in the Incident Report describing what occurred, Mr Dickson explained that he could see people in the carriage when he viewed the CCTV footage, and he drew an assumption that they were standing in the doorway.[179] He couldn't recall why he included the detail about not seeing anyone on the train platform.[180]

125. Mr Dickson only provided a more detailed account of what occurred when he was interviewed by the ATSB. By that time, he had access to the criminal brief of evidence and had been in attendance at court during the evidence of the committal witnesses. Whilst the transcript of the ATSB interview was not made available to the coronial investigation, Mr Dickson gave evidence at the inquest that the answers he gave to the ATSB were true, and he did not take issue with the summary disclosed by the ATSB report regarding what was said by him during the interview. I note that information was consistent with his original account in the Incident Report, insofar as he stated that he was aware that people were holding the doors. It was during the ATSB interview that Mr Dickson stated that he had a steady blue light when he pulled away from the station. As the transcript of that interview was not available, it remains unknown whether any further details were provided by him to the investigators.

Inquest evidence

126. There was no further account available from Mr Dickson concerning his actions and observations on the night of the incident until his viva voce evidence at the inquest when he was questioned extensively about his operation of the train doors, and his observations about what was occurring inside and outside the train carriage.

[178] T 53:27 - 54:23.
[179] T 52:4-19.
[180] T 52:29 - 53:7.

127. Mr Dickson explained that he had no visibility at Heyington Station of people running down the stairs towards the platform. He only had a very narrow field of view to look down the train for a couple of metres.[181] Because of the curve at the station, he relied on the SPOT monitor to see what was happening along the length of the train and he would always need to look at the SPOT monitor at Heyington Station.[182] It was otherwise impossible for him to see the rear of the train using the train mirrors. He further explained that the SPOT monitor was primarily used to see that people on the platform had finished boarding and alighting, so that he could start the departure sequence. He agreed that he needed to be able to see the platform to know when it was safe to depart.[183]

128. It was not in dispute that Mr Dickson pressed the blue doors close button in preparation for departure from the station, nor that it became apparent to him that there was a problem with the procedure, which caused him to take further actions.

129. However, Mr Dickson denied that he had actual knowledge that people were holding the doors as he couldn't see that occurring in the CCTV or SPOT monitors.[184] He stated that it was only because he observed the flashing blue light that he was able to conclude someone was holding the doors.[185] He stated that he couldn't use the CCTV in the driver cab which showed views of the carriage to identify the problem with the doors, as the view on the monitor in the driver's cab was too small and there were too many people crowding the doors. However, he agreed he was able to move between the various CCTV camera views of the carriages if he wanted to.[186]

130. Mr Dickson was aware that trains recorded data which could be retrieved.[187] He was specifically asked about the train telemetry data which recorded a request for traction power on two occasions within seconds of him pressing the doors close button and blowing the whistle. He initially accepted the accuracy of the data, which showed that he sought traction on two occasions when it was not available,[188] and he agreed that he was

[181] T 27:22-31.
[182] T 26:29 - 27:4.
[183] T 26:3-27.
[184] T 34:10-16.
[185] T 34:17-19.
[186] T 18:15-17.
[187] T 30:20-26.
[188] T 80:11-15.

aware at the time that no traction power was available.[189] He confirmed that the whistle was blown to let everyone know that the train was departing.[190]

131. At first, Mr Dickson stated he had a recollection that the blue doors close light was steady when he first requested traction power.[191] He was asked if he recalled trying to 'go for power' twice and that on both occasions it didn't work, and he responded that he did, but he also stated that he couldn't recall the exact events on the night, explaining, "I might have attempted, you know, initially after 30 seconds and then realised something was wrong, that was when I made my announcements and stuff, but um look I – I wouldn't go for power without that steady light, like, it was steady".[192]

132. Regarding the announcement he made, Mr Dickson recalled saying "keep clear of the doors, or something" but couldn't recall exactly what he said. He thought he made only one announcement, as he was about to call Train Control to request police and let them know he was running late.[193] He indicated that if the blue light kept flashing, he would sometimes go back to look, but on the night in question he would have requested police or PSOs to attend.[194] He confirmed that he thought he might be running late at that time because "at one point or other I had a flashing blue door light".[195] He indicated the light was steady the first time he requested traction, and then it started to flash.[196] He recalled that it stopped flashing again[197] and he stated the light was solid blue for a few seconds prior to him requesting traction a final (third) time.[198]

133. As Mr Dickson continued to be questioned about the requests for traction and his observations regarding the blue doors close light, his evidence became confused. Whilst he initially stated that on the first request for traction he had a steady blue light, he also gave evidence that on the first and second occasion when he applied for traction power, the blue light was probably flashing.[199] Ultimately, Mr Dickson accepted that on the first occasion when he applied for traction there was a flashing blue light and his actions were therefore in contravention of his training.[200] He explained that on the first occasion when

[189] T 80:22-25.
[190] T 32:16-17.
[191] T 32:25 - 33:6.
[192] T 33:15-23.
[193] T 33:30 - 34:5.
[194] T 24:13-17.
[195] T 34:6-9.
[196] T 34:20-23.
[197] T 35:23.
[198] T 36:6-11.
[199] T 84:20 - 85:2.
[200] T 95:25-27.

he applied for traction when the blue light was flashing, it was due to "muscle memory" and "a bit of an instinct".[201] He indicated that the reference to "muscle memory" was related to him responding to the sounds of the doors when they closed in the carriage behind him in the driver's cab, which were audible to him.[202] He maintained that on the second occasion he sought traction, he thought the light steadied before it started flashing again.[203]

134. He disagreed with the proposition put to him that on the third occasion he applied for traction power, the blue light was flashing indicating a door was open.[204] Mr Dickson was adamant that when he departed the station he believed that the doors were shut.[205] He stated that he did not see anyone on the platform when he moved the master controller, nor as the train moved, and he did not see anyone running on the platform at any time after the train moved.[206] Mr Dickson explained that when the train travelled past the SPOT monitor, his focus shifted to the signals and the track in front of the train.[207]

135. He denied that an explanation for seeking traction power on the first and second occasions when the blue light was flashing was because he knew it would override after 60 seconds. Yet he also agreed that applying for traction with a blue light flashing was pointless.[208]

136. Mr Dickson rejected the suggestion that when he applied traction on the third occasion, he knew the doors were not closed, but was tired of waiting and the disruption, and he decided to proceed with the blue light still flashing.[209]

137. Mr Dickson agreed that the evidence of the eyewitnesses and telemetry data that the door was open for 22 seconds after leaving Heyington Station was inconsistent with his own recollection that he had a steady blue light indicating the doors were closed. However, he denied that he was mistaken and denied that the blue doors close light was flashing when he obtained traction and drove the train from the platform.[210] He maintained this denial when it was put to him that post incident testing did not identify any faults with the doors

[201] T 85:15-22; T 94:24-29.
[202] T 98:26 - 99:13.
[203] T 85:15-22.
[204] T 85:3-5.
[205] T 102:29-31.
[206] T 103:1-15.
[207] T 103:17-24.
[208] T 85:6-13.
[209] T 85:23 - 86:4.
[210] T 37:1-20.

or door close button, and it was therefore more likely than not that the blue light was flashing when the train started to move off.[211]

138. When asked if he knew of any possible explanation for the discrepancy between his evidence and other evidence, Mr Dickson suggested that it was possible people were physically forcing the doors open and closed.[212] Whilst he agreed that the doors close button caused the doors to close and lock so that they couldn't be opened again by a passenger pressing the button in the carriage, he stated it was his belief that the doors could still be forced open.[213] As another possibility, he thought that there might have been some fault with the train.[214] He denied a possible explanation for what occurred was that he assumed the doors were closed and left without looking at the blue light because he was able to get traction after 60 seconds, and he didn't know that the train could move if the blue light was flashing and a door remained open.[215]

139. Although Mr Dickson at one time accepted that the telemetry data was accurate, he also gave evidence that the telemetry data must be wrong, and that the eyewitness accounts that the door was held open continuously must also be incorrect. His basis for this assertion was that in such circumstances there would have been a flashing blue light, and yet he saw he had a steady blue light.[216]

140. Mr Dickson also did not accept that because of the manner in which Mitchell's death occurred, the doors must have been open, and he continued to assert that the doors were closed.[217] However, he was unaware of evidence that the male friend had jumped on the train while the train pulled away with doors open.[218] He also stated he did not recall the evidence of the witnesses at the committal who gave evidence that the doors were open.[219] He stated he had not read any of the evidence in preparation for giving evidence at the inquest.

141. According to Mr Dickson, he was not aware of the allegation that the doors were open when the train moved off until a year or more after the incident.[220] However, he explained

[211] T 37:23-31.
[212] T 38:1-9.
[213] T 40:8-29.
[214] T 68:14-22.
[215] T 39:11-14.
[216] T 43:23 - 44:9.
[217] T 44:18-21.
[218] T 44:22-27.
[219] T 45:13-16.
[220] T 64:7-9.

that he turned his mind to the status of the blue light earlier than that point in time because he spoke to his union about it. He was also aware the incident was under investigation when he was stood down from his duties by Metro Trains, which caused him to think about the status of the blue light.[221]

142. During his evidence, there were clear indications that Mr Dickson's memory of the events was affected by the passage of time, which was unsurprising. The evidence from Metro Trains showed that there was no traction override switch in the driver cab on the X'Trapolis when the incident occurred, but Mr Dickson maintained that his memory was that such a switch was present at the time of the incident. There were also significant aspects of the committal evidence which he was present for, but which he did not recall. Most strikingly, he did not recall the evidence of the overwhelming majority of the witnesses called who described that the train doors were open on departure.

143. There was also evidence that Mr Dickson's memory may have been contaminated by his knowledge of other evidence about the case. He stated that since the incident, he had thought about whether his memory of seeing a steady blue light immediately before departing Heyington Station could have been wrong. However, he recalled that at the committal he heard evidence from the one witness who said the door was closed when the train moved off. Mr Dickson described the effect of this evidence upon him as follows, "It cast all doubt out of my mind. You know, I knew exactly that I departed with the steady blue light".[222] It was therefore apparent that the strength of Mr Dickson's belief in what occurred had been reinforced by reference to this evidence from another witness, and this was despite the overwhelming evidence of the witnesses at the committal that the door was open.

FINDINGS REGARDING CONTESTED FACTS

144. In addition to the findings outlined above regarding the circumstances in which the death occurred, there were a number of unresolved contested factual issues which were the focus of the questioning of Mr Dickson and the submissions which were filed following the inquest. These are addressed below.

[221] T 64:10-30.
[222] T 101:22 - 102:28.

A. The status of the carriage doors

145. It was the evidence of Mr Dickson that the carriage doors must all have been closed when he departed from Heyington Station. This was contrary to the consistent evidence of the majority of witnesses that the middle doors of carriage four remained open at that time, including the evidence of persons who were holding the doors open.

146. Many of the witnesses who provided evidence that the doors remained open also made observations of the doors being held open by members of the group at an earlier point in time whilst the train was stationary at the platform. The witness accounts convey that the doors were "still" being held open as the train departed as a continuous act. Significantly, the carriage doors were not described by any witness as being closed in this period leading up to the train moving away from the platform. The weight of this body of evidence conveys that the middle doors of carriage four remained continuously open from the time members of the group commenced holding them open, up to, and including, the time that the train commenced pulling away from Heyington Station.[223]

147. The observations of the witnesses who observed that the doors were open were all tested in cross-examination during the committal proceedings, and there was extensive questioning of the witnesses regarding their observations. This included cross-examination of witnesses who described their involvement in holding the doors open. I have considered not only the statements of these witnesses but also their committal evidence, and note that the witnesses generally did not resile from their assertions that the doors were open when the train departed from Heyington Station.[224]

148. One exception to the otherwise consistent accounts of the witnesses that the doors were open was provided by a witness who was inside the carriage making observations of the group of people near the middle door of carriage four. In a statement made shortly following the incident, the witness described that she saw the doors "in the process of

[223] Statement of James Mulcahy, CB 12; statement of Harry McCallum, CB 22-23; statement of Anders Torcello, CB 25-26; statement of Harrison Brettell, CB 34; statement of Finn Pedersen, CB 44; statement of Jonty Pedersen, CB 58; statement of Kathryn Wellings, CB 68; statement of Sarah Holmes, CB 76; statement of Vinodh Krishnan, CB 81; statement of Megan Dal-Ben, CB 87; statement of Amy Plunkett, CB 92; statement of Simon McMahon, CB 101; statement of Mitchell Smart, CB 105; statement of Andrew Copolov, CB 114; statement of Tom Ruffy, CB 124; statement of Georgia Sze-Tho, CB 131; statement of Tenielle Bulmer, CB 141; statement of Alexandra Medaglia, CB 148.

[224] Evidence at committal of: James Mulcahy, CB 1284; Anders Torcello, CB 1305; Harrison Brettell, CB 1319; Finn Pedersen, CB 1338; Jonty Pedersen, CB 1350; Kathryn Wellings, CB 1358; Sarah Holmes, CB 1374; Vinodh Krishnan, CB 1523; Megan Dal-Ben, CB 1454; Amy Plunkett, CB 1468; Simon McMahon, CB 1247; Mitchell Smart, CB 1560; Andrew Copolov, CB 1550; Thomas Ruffy, CB 1491; Tenielle Bulmer, CB 1504; Alexandra Medaglia, CB 1446.

closing" as the train pulled away from the station.[225] However, during her committal evidence a markedly different version was provided. In evidence, the witness described that at a time very close to when the train moved away, the doors had fully closed and were then pried open again by members of the group who were standing in the doorway using their fingers. This was said to have occurred as the train was moving and the doors were opened wider to permit someone to jump into the train.[226] I do not accept this evidence for several reasons.

149. The veracity of the later version of events by the witness is questionable as it differs substantially from the initial account provided by the witness in their statement made at a time much closer to the incident, whereas the committal evidence was given more than 22 months later. It is also contrary to the evidence in the coronial brief from Metro Trains regarding the operation of the doors on the X'Trapolis type train to the effect that the train doors mechanically lock when closed and cannot be forced open when the train is in motion. The only means by which the train doors can be opened when they have been closed by the driver is by use of the emergency door release (**EDR**) lever within the carriage.[227] However, when the EDR is used, it alerts the driver and there is train data recorded that this has occurred. The Metro Trains investigation found no such data recorded. It was only through the use of the EDR that closed doors on the X'Trapolis train could have been re-opened, but use of the EDR is also inconsistent with the description by the witness that the doors were being forced open using fingers and hands from a completely closed position. Moreover, the train telemetry data and the CCTV footage indicate that the doors were not recorded as being closed until 22 seconds after it left Heyington Station.

150. The uncontroverted evidence is that it was not possible to manually pry open the carriage doors of the X'Trapolis train type after they had closed. This is consistent with the evidence of the remaining majority of the witnesses that the doors remained open when the train moved away from the platform and did not close for a significant period following the train's departure. It is also consistent with the uncontroverted evidence that both Mitchell and his friend ran for the train as they saw the doors were open from the top of the stairs of the station. It was nighttime and the carriage with their friends was lit up inside and clearly visible to them both.[228] It is inconceivable that either of them would

[225] Statement of Aislin Leonard, CB 97.
[226] Committal transcript of 14 December 2015, CB 1245-1246.
[227] Statement on behalf of Metro Trains Melbourne, CB 988; statement of Robert Duvel, CB 1739.
[228] Witness statements at CB 131 and CB 71.

have commenced to run at speed and continued running to board the train if the doors had been closed at any time, noting that it was mere seconds between their observation that the doors were open and the attempt to board the train. There was no opportunity for the doors to have closed and been re-opened during that brief period. Self-evidently, the doors were open when the friend was able to board the train, which was within seconds of it moving away from the station. Further corroboration is provided by the train telemetry data and CCTV evidence indicating that the doors closed after the train moved away from the station. The veracity of that evidence is confirmed by its consistency with the majority of the witness accounts. I am therefore comfortably satisfied that the middle doors of carriage four remained open as the train moved away from the station and, furthermore, that the doors had been held open continuously, only closing after the train left the station.

151. In arriving at this conclusion, I have considered Mr Dickson's belief that the doors could not have been open because he observed a steady blue light. However, that evidence is of little probative value. Mr Dickson made no actual observation that the doors were closed at any time, and his evidence instead relied upon a pathway of reasoning dependent upon the accuracy of his recollection of seeing a steady blue light, which was also a factual issue in dispute.

B. The status of the blue doors close light

152. A critical factual issue to be resolved in the coronial investigation was how the train departed Heyington Station with the middle doors of carriage four still open. This was contrary to the policy and procedures of Metro Trains and should not have occurred if those policies and procedures were adhered to by Mr Dickson. The issue was central to the findings to be made regarding the circumstances in which the death occurred because Mitchell's death could not have eventuated if the train did not depart Heyington Station at the time he ran to catch it.

153. I am satisfied that the relevant training, procedure and policy for Metro Train drivers prohibited a train driver from requesting traction when there was a flashing blue doors close light. It was a clear requirement that a train driver not request traction unless the doors were first proven to be closed by observing a steady blue doors close light. I am satisfied that this was known to Mr Dickson. I am also satisfied that Mr Dickson

understood the relevant policies and procedures which were applicable to his employment and the operation of an X'Trapolis train.

154. The evidence establishes that ordinarily the blue doors close light would continuously flash until all the doors were closed and locked, at which time it became a fixed blue light. It is uncontroversial that at the time of the incident, after a 60 second delay, the train could be moved despite the continuation of the flashing blue door close light and this enabled the train to be moved even if a door remained open.

155. As I am satisfied that the doors to carriage four were open when the train departed, there are two possible explanations available for the actions of Mr Dickson. Either Mr Dickson departed Heyington Station with a flashing blue doors close light contrary to his training and the required procedure, or Mr Dickson observed a steady blue light despite the presence of the open doors, meaning there was a fault in the operation of the train which led him into error. For the reasons outlined below, I have ultimately determined that Mr Dickson must have departed the station with the presence of a flashing blue light indicting that there was at least one door which remained open.

156. During testing conducted by Metro Trains before and after the incident, no faults with the doors or door operating system were identified. Specifically, no fault was identified with the operation of the blue doors close light. The veracity of this testing was accepted and relied upon during the ATSB investigation, and in my view was corroborated by a substantial body of other probative evidence.

157. It was significant that no faults with the doors or the door operating system were observed by Mr Dickson in his operation of the train at any other time during the journey, either before or after the departure from Heyington Station. If the interference with the doors at Heyington Station had caused an unexpected fault to occur with the doors close light, such that it remained steady despite an open door, it is inexplicable that the fault would not have been observable in subsequent testing, or in the subsequent operation of the train prior to arrival at Flinders Street Station.

158. I accept that the testing conducted by employees of Metro Trains did not exactly replicate the duration and manner in which the doors were held open. However, the expected operation of the door operating system was tested by employees of Metro Trains who

were experienced in maintaining, fixing and testing the door operating system.[229] They conducted the testing of the carriage four doors by means of obstructing the relevant door. It was documented that the system operated as expected, and resulted in the blue doors close light flashing on the desk of the driver's cab. There is no evidence before me which indicates that conducting that door testing in some other manner would have produced a different result and revealed a fault.

159. It is also clear from Mr Dickson's own account that he observed the blue doors close light to be working correctly on the night in question after the doors were held open. Mr Dickson's evidence was that he formed a belief that the doors were being held open while at Heyington Station. This was also documented in the record he made in the Incident Report when he arrived at Flinders Street Station, which recorded that a group of men were holding a rear car door open and that he made an announcement to stand clear. The evidence from Mr Dickson and the other witnesses regarding the general content of that announcement is further evidence of his belief that persons were obstructing the doors, noting that the use of the announcement was in accordance with the procedure to be used when an issue with the door closure procedure was apparent to a driver.

160. Mr Dickson was also alerted to an issue with the doors closing by the failure of his initial attempt to request traction after he pressed the doors close button. He accepted in his evidence that the doors close light was flashing at that time. Mr Dickson conceded that when he initially requested traction the doors close light was flashing and he therefore acted contrary to his training and the required procedure. I am satisfied that the doors were open at the time Mr Dickson observed that the blue doors close button was flashing and he believed that the doors were open. As such, the flashing doors close button is demonstrated to have been operating correctly when the doors were open at Heyington Station. This is consistent with the subsequent test results which did not detect any fault.

161. Mr Dickson gave evidence that the blue light subsequently steadied and was at least momentarily fixed prior to his second and third applications for traction. However, he also accepted that the doors close light remained flashing up until just before he applied for traction on the third occasion when it steadied. If accepted, the effect of Mr Dickson's evidence would be that the blue doors close light operated correctly when he first

[229] Statement of David Anderson and attachments DPA-1, DPA-2, CB 252-274. Committal evidence of: David Anderson, CB 1387; Zivko Gorgievski, CB 1572.

requested traction, but inexplicably malfunctioned on the second and third occasions, such that a steady blue light occurred despite the doors remaining open. I do not accept that is what occurred as it is inherently unlikely having regard to the weight of the available evidence.

162. There is no available explanation as to how the blue doors close light could have been steady while a door remained open, and the reliability of Mr Dickson's recollection is questionable having regard to the time which has passed since the incident. Unsurprisingly, there were demonstrated issues with his memory, and it has likely been contaminated by his acceptance of the evidence from the one witness at committal who recounted that the doors were closed. In my view, Mr Dickson regarded that account as confirming his own belief that this would have caused the blue doors close light to steady, eradicating any doubts he may have had about what he observed. This was despite the overwhelming evidence from the other committal witnesses that the doors remained open, which evidence he had no memory of.

163. The credibility of Mr Dickson's recollection was also adversely affected by his failure to follow the proper procedure before departing the platform. Accepting that he initially applied for traction despite a flashing blue doors close light, this was contrary to the strict procedure in place and all his training and experience. His only explanation was that he made a mistake due to "muscle memory". However, Mr Dickson also failed to follow procedure after this point.

164. Having regard to the extended time that the doors were obstructed, he should have informed Metrol of the delay and reported the behaviour, performed the "cab unattended procedure" and walked along the train to ascertain which door was causing the problem. If he had concerns for his safety, he should have alerted Metrol. Prior to departure, Mr Dickson was required to re-check the train to ensure that passengers and articles were clear of the door, and to sound a long whistle prior to departing. If Mr Dickson thought he had a steady blue light, he did not reinitiate the door closure process and did not sound the whistle again prior to departing.[230] This non-compliance casts doubt upon the accuracy of Mr Dickson's subsequent account that he complied with the relevant procedure and had a steady blue light, when the weight of the evidence demonstrates that could not have been the case.

[230] Metro Trains Melbourne Incident Investigation Final Report, CB 745.

165. Another unsatisfactory aspect of Mr Dickson's evidence concerned his understanding of the 60-second time delay on X'Trapolis and Comeng type trains. The way in which this design feature operated formed part of Mr Dickson's training, and it was identical for both types of train. Yet, Mr Dickson's evidence was that he understood the feature applied to Comeng trains, but not to the X'Trapolis train that he was driving. He maintained that this was his understanding and that it did not affect his actions on the night.

166. It therefore remains unexplained what Mr Dickson believed was occurring when he applied for traction on two occasions and was unsuccessful. The only possible explanation available to him was that there was an override of the traction power in place, in accordance with the design feature that had formed part of his training. It must have been the case that Mr Dickson was aware that the traction power was delayed due to the doors being open, and it is difficult to accept his explanation that he still remained unaware that it would become available after 60 seconds as it did with the Comeng trains.

167. I note also that there was some uncertainty about whether Mr Dickson accepted that the telemetry data was accurate because it contradicted his evidence that the doors must have been closed with a steady blue doors close light displayed. However, I am comfortably satisfied that the train telemetry data is correct and that Mr Dickson applied for traction on three occasions whilst the doors close light must have been flashing. There was no dispute regarding the accuracy of most of the telemetry data recordings regarding the time that the train arrived and departed Heyington Station, or the time that the doors close button was activated and the whistle sounded. The data is consistent with the eyewitness evidence which I have accepted, as well as the evidence from the Metro Trains investigation regarding the CCTV footage and the subsequent testing of the door operating system.

168. Whilst Mr Dickson found it difficult to accept that the data demonstrated that the doors were open when he departed, his evidence did not dispute that the data recorded his application for traction on three separate occasions, and he provided evidence of a recollection in accordance with that sequence of events. The timing of those occurrences as recorded by the data also generally accords with Mr Dickson's own account of what occurred regarding his initiation of the door closure procedure, his realisation that the doors were obstructed, and his utilisation of a PA announcement, followed by a period of time during which he was delayed at the station before he again applied for traction.

169. In arriving at my conclusions regarding Mr Dickson's evidence, I have had regard to the genuine difficulty faced by him giving evidence about the details of an incident which occurred in 2014. I have also had regard to the potential impact on Mr Dickson from giving evidence about his conduct in connection to the traumatic death of a young man, and the context of a procedural history where he was criminally charged and suffered significant stress during those proceedings. As the contents of his ATSB interview are unknown, the occasion of Mr Dickson giving viva voce evidence at the inquest on 3 December 2024 is the first known occasion on which he provided a full account of his actions. However, even allowing for these difficulties, I have determined that his evidence that he saw a fixed blue light prior to departing Heyington Station is unreliable.

170. There are demonstrated defects with Mr Dickson's memory. He was non-compliant with relevant procedure, and the train departed with the middle doors of carriage four open. There were no identified faults with the door operating system, and the account Mr Dickson provided about his observations and actions was inherently unlikely. I therefore do not accept that Mr Dickson observed a steady blue light prior to applying traction and departing Heyington Station.

171. I am comfortably satisfied that there was a flashing blue doors close light displayed on the driver's desk due to the middle doors of carriage four remaining open. This should have alerted Mr Dickson to there being at least one door open, and he should not have caused the train to depart Heyington Station.

C. The ability to observe the platform

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172. I am satisfied that Mr Dickson would not have seen either Mitchell or his friend running for the train, and that he was not aware of what occurred. The curve of the platform was such that Mr Dickson was dependent upon the view from the SPOT monitors. The successful traction request and commencement of the train moving away from the platform occurred prior to the time at which Mr Mitchell and the male friend entered onto the platform. Mr Dickson needed to check the train prior to requesting traction, and if he did so, the platform would have been empty at that time. It is likely that he had passed the SPOT monitor by the time the young men would have been visible running alongside the train, and Mr Dickson would have been unable to see them as he departed the station.

D. The decision to depart Heyington Station

173. It is unclear why Mr Dickson departed Heyington Station with a flashing blue doors close light. I have had regard to the submissions made on this specific issue by Counsel Assisting, counsel on behalf of Mitchell's family and counsel for Mr Dickson.

174. On behalf of the family, it was submitted that Mr Dickson was untruthful in his evidence and his lies ought be treated as an implied admission that he disregarded procedure and departed Heyington Station knowing that a door was open, and knowing that there was a flashing blue doors close light. I do not accept these submissions. Whilst I have found that Mr Dickson was an unreliable witness and incorrect in his recollection regarding what occurred, I am not satisfied that his account was dishonest.

175. On behalf of Mr Dickson, it was submitted that I ought accept Mr Dickson's evidence that he saw that the blue doors close light was fixed when he departed Heyington Station and that his evidence was credible in that regard. It was further submitted that findings could not be made that a door on the train was open when traction was obtained, that the blue light was flashing when traction was obtained, that Mr Dickson saw the light and proceeded regardless, or that Mr Dickson knew a door on the train was open when he sought traction. It was submitted that no adverse comments or findings were available in relation to Mr Dickson's conduct. For the reasons outlined above, I have not accepted these submissions.

176. In the alternative, it was submitted on behalf of Mr Dickson that if I am satisfied that the blue doors close light was flashing, there were several possibilities which explained what occurred, and that it was not possible to prefer one over any other as being more likely on the balance of probabilities. The possibilities submitted were as follows:

    a) Mr Dickson believed that the doors were closed when he sought traction and obtained it, consistent with his (incorrect) belief that traction was not available on the X'Trapolis train if the doors were open;

    b) Mr Dickson was misled into believing the doors were closed due to hearing the front door of the carriage close, which was the "muscle memory" explanation offered by Mr Dickson in his evidence;

    c) There was momentary inattention by Mr Dickson whilst performing a routine task;

d) Mr Dickson was careless, namely, he did not closely check the status of the light before engaging traction, in the context of operating a system with a "design flaw" which created the opportunity for a driver to move the train with at least one door open.

177. Having considered the totality of the available evidence, despite being satisfied that the doors were open and that the flashing blue doors close light was operating correctly, I am unable to determine why Mr Dickson departed the train from Heyington Station. I am similarly unable to determine what his state of knowledge was regarding the flashing blue doors close light at that time.

178. I accept the submission made that I cannot explain why Mr Dickson departed the train from Heyington Station contrary to his training and the relevant procedure. Accepting that this is so, I am unable to rule out any reasonable possible explanation. This includes the possibility that Mr Dickson was aware of the flashing doors close light but requested traction regardless to end the delay to the train's departure, assuming that if those persons in the doorway promptly moved away from the doors, they would close automatically.

179. I accept that such an action would be out of character having regard to Mr Dickson's known competency as a train driver who complied with the relevant procedures, but the other possibilities are also predicated on Mr Dickson uncharacteristically failing to comply with his training and the procedure which was known to him. It also remains unsatisfactorily unclear why Mr Dickson requested traction on three occasions when the blue doors close light was flashing, clearly indicating that a door remained open and that the train should therefore not depart the station.

CAUSATION

180. Having regard to the totality of the evidence, the accident occurred because of a collection of factors which combined in a matter of mere seconds to produce a tragic outcome.

181. Mitchell and his friend both made a split-second decision to attempt to board a train which in their observation had the doors open and which was near to stationary or which had barely commenced moving. It is therefore not clear that there was any appreciation at that time by either of them that what was being undertaken posed any serious risk. It is likely that they both assumed that they would be boarding a train that was near to stationary. Mitchell could not have known how quickly the train would gain speed when he made that ill-fated decision. Everything changed without warning in a mere moment, and the

result could not have been anticipated. While Micthell would not have run and attempted to board the train if the doors were not open, those inside the train who were holding the doors are not responsible for this split-second decision having been made by Mitchell.

182. The design of the 60-second traction delay which enabled the train to depart the platform with an open door was also a contributing factor. Whilst Mitchell made a decision to run for the train because the door was held open, the open door did not present as a hazard or risk unless the train was moving.

183. The train should not have departed the platform with an open door and the Metro Trains policies and procedures which existed at that time were sufficient to guard against that risk when complied with. Although, I note the ATSB findings that there was inadequate warning to the driver of the deactivation of the traction lock after 60 seconds, Mr Dickson departed the station despite a flashing blue doors close light which indicated that a door was open and traction should not have been requested in those circumstances. It remains unclear why this occurred, as it was contrary to Mr Dickson's training and knowledge of the applicable procedure. Mr Dickson was unaware that persons were running for the train and attempting to board it, and he is not responsible for that momentary decision making. However, the moving train with open doors was a known risk and it created a hazard which was the precondition for the tragic events which occurred. The train with open doors should have remained stationary, and the death would not have occurred if it had done so.

184. The unusually large gap which existed at Heyington Station between the curved platform and the train was also a contributing factor. The width of the gap was not in accordance with the relevant standards, noting that those standards did not apply to Heyington Station. Whilst Mitchell fell attempting to board a moving train, it was only because of the width of gap between the platform and train that he came into contact with the train in a manner which caused fatal injuries. The death would not have occurred if the gap complied with the standards applicable at other train stations.

POST INCIDENT CHANGES

185. Following Mitchell's death, his family and friends campaigned for changes to be made to the infrastructure at Heyington Station. From the outset of the coronial investigation, they expressed alarm at the prospect that another life could be lost in a similar manner if such changes were not made.

186. Significant changes were subsequently made to the infrastructure at Heyington Station and the operation of the X'Trapolis trains and construction standards, through the combined actions of the Department of Transport and Planning (**the Department**), under the public-facing brand Public Transport Victoria (**PTV**), and Metro Trains Melbourne. These changes included actions taken in response to the ATSB safety recommendations which were made as part of the "Transport Safety Report" regarding Mitchell's death.[231] Due to the nature of these changes, it is unlikely that such a fatality could occur again at Heyington Station.

187. At the time of the fatality, it was the responsibility or Metro Trains to maintain the rail infrastructure and ensure it was safe for use, and the changes and modifications could only be made with approval by PTV, subject to government funding.[232]

188. The track at Heyington Station was realigned and a rubber finger coping was installed along the entire edge of the platform to minimise the gap between the platform and the train. LED lighting was also installed to improve visibility, and a barrier was constructed at the platform entrance to deter passengers from running for the train.[233]

189. In addition to Heyington Station, it was identified by Metro Trains that there were 20 other priority platforms where there was a safety risk posed by the gap between the platform and the train. The list of affected stations was finalised by PTV in August 2017 and funding was approved to address those platform gaps as part of a "Platform Gap Mitigation Project". Mitigation works were completed to address this risk at all platforms except for Flinders Street and Southern Cross Stations, as a cost-benefit analysis led to a conclusion that the cost of the works was exceptional, and not commensurate with the risk posed. The risks identified at those locations also related to the number of passengers, and not necessarily the condition of the assets.[234] Considering that the risk has been acknowledged, such funding decisions are ultimately a matter for the relevant authorities and the government.

190. Metro Trains also modified the traction interlock system to remove the automatic functionality that restored traction availability after a 60-second delay. The modification

[231] See statement on behalf of Metro Trains Melbourne, CB 982-989.
[232] Submissions by the Department of Transport and Planning (22 April 2025), [7].
[233] Ibid, [8(a)].
[234] Submissions by the Department of Transport and Planning (22 April 2025), [8(d)]; statement on behalf of Metro Trains Melbourne, CB 986.

to both the X'Trapolis and Comeng fleets was completed by 17 June 2021[235] and all train fleets now require a deliberate action by the driver to enable traction power in the event of a door malfunction.[236] As a result of the changes, the train can no longer be operated in the manner that it was on the night of the incident.[237]

191. A "Design Practice Note" was also implemented to provide guidance on the permissible construction tolerances for platform renewal works, to reduce the risk to passengers by achieving an optimal gap between trains and platforms. These were incorporated into the "MTM Standard A 1530 Stations and Public Precincts", setting out specific requirements for track alignment to railway platforms.[238] No new stations are being built with a curved platform.[239]

192. The ATSB accepted that the actions taken by Metro Trains and PTV were sufficient to comply with the safety recommendations it had made.

193. As part of the submissions filed by counsel for Mitchell's family, it was proposed that a recommendation should be directed to the Department and the ATSB that "in-cab" cameras be installed in all trains in Victoria. In reply submissions, the Department outlined that such cameras have been a requirement for new Victorian trains since 2016. They have also been retrofitted to the Siemens fleet of trains which currently make up 35% of the metropolitan train fleet. It is intended that the cameras will also be fitted on new X'Trapolis trains that will replace the Comeng train fleet, which are being retired in 2029. There remains an existing fleet of X'Trapolis trains which are not fitted with in-cab cameras, comprising 52% of the metropolitan train fleet.[240]

194. I note that the Office of the National Safety Regulator (**ONSR**) has created a policy proposal that mandates in-cab audio and video of passenger and freight trains, which was endorsed by the federal and state transport ministers in late 2021. The policy has yet to be implemented due to ongoing industrial relations issues. If the policy comes into force, the Department will be required to retrofit the X'Trapolis train fleet with in-cab cameras.[241] I

[235] Statement on behalf of Metro Trains Melbourne, CB 983.
[236] Ibid, CB 987.
[237] Submissions by Metro Trains Melbourne (22 April 2025), [6].
[238] Ibid, [8].
[239] Statement on behalf of Metro Trains Melbourne, CB 986; Submissions by the Department of Transport and Planning (22 April 2025), [8(c)].
[240] Reply submissions by the Department of Transport and Planning (29 July 2025).
[241] Reply submissions by the Department of Transport and Planning (29 July 2025).

therefore accept the submission made by the Department that a recommendation regarding in-cab cameras is not necessary.

195. Having regard to the changes made by both Metro Trains and PTV, and the proposed ONSR policy, I have not identified any further prevention opportunities arising from this case.

196. By way of comment, I observe that the primary difficulty encountered by both the criminal prosecution and the coronial investigation was the absence of any recording of what occurred in the driver's cab. If there had been in-cab camera footage, there would have been no contested factual issues regarding the actions and observations of the train driver relating to the operation of the blue doors close light and the operation of the train controls from the driver's cab. It is likely that the necessity for an inquest to examine the actions of Mr Dickson would have been avoided. Mitchell's loved ones would also have been provided additional clarity about the circumstance of his death from the earliest stages of the investigations, and the investigative burden for Metro Trains, Victoria Police, the ATSB and the coronial investigation would have been substantially reduced.

FINDINGS AND CONCLUSION

197. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was Mitchell Luke Callaghan, born 10 July 1995;

b) the death occurred on 23 February 2014 at Heyington Railway Station, off Heyington Road, Toorak, Victoria 3142;

c) the cause of death was 1(a) head and neck injury in a train incident; and

d) the death occurred in the circumstances described above.

CORONIAL IMPACT STATEMENTS

198. Mitchell is survived by his parents, Mark and Belinda, and his brother Thomas. He was part of a close-knit extended family and a very large circle of friends. Following the inquest, members of Mitchell's family and friends generously prepared and submitted coronial impact statements which I have had the opportunity of reading.

199. The statements are deeply personal in nature, and I am aware that many of the writers found it difficult to relive what occurred and to explain the full impact of it. They provide

insights into Mitchell's life and what he meant to those who loved him, as a counterbalance to the focus which has been placed to date on the tragic circumstances of his death.

200. By all accounts, Mitchell was an exceptional young man who was greatly loved and will be dearly missed forever. He was an accomplished musician, a talented composer, a gifted debater and artist. Those who knew him spoke of his kindness, his sense of humour, his commitment to his friends and family, his commitment to justice and his sense of what was right. Mitchell was only 18 years old and had just finished his Year 12 studies. He was planning to attend university and undertake degrees in Arts and Law. Mitchell had many plans for his future which were unrealised. I am unable to adequately convey the depth of emotion from those who recalled Mitchell's positive attributes and all the fond anecdotes and memories that they have of him.

201. The statements also provide a harrowing account of the raw and enduring grief and sense of personal loss experienced by Mitchell's family and friends since his death. The impact of this has reverberated throughout all aspects of his loved ones' lives. I also acknowledge that they speak with one voice regarding the detrimental impact and the compounding of their grief that occurred because of the extended procedural history of the case. This has clearly taken its toll on Mitchell's family and friends, and shaken their faith in the justice system. The nature of Mitchell's unexpected death has altered their view of the world in many ways, and they remain grief stricken.

202. The coronial impact statements honour Mitchell's memory and are a testament to how loved he was. I acknowledge that his family and friends have suffered deeply due to his death, and I again convey my sincere condolences to Mitchell's family and friends for their loss.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Belinda & Mark Callaghan, Senior Next of Kin (c/- Alessi Legal)

Metro Trains Melbourne (c/- Herbert Smith Freehills)

Russell Dickson (c/- HWL Ebsworth)

The Department of Transport and Planning (c/- MinterEllison)

Safe Transport Victoria

Detective Sergeant Gemma Etherington, Coronial Investigator

Signature:

Catherine Fitzgerald
Coroner

Date: 31 August 2026

NOTE: Under section 83 of the *Coroners Act 2008* (**the Act**), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.