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19 October 2020

Mr Andrew Hall
Deputy Chief Inspector of Rail Accidents
Cullen House
Berkshire Copse Rd
Aldershot
Hampshire GU11 2HP

Dear Andrew,

RAIB Report: Near miss with track workers and trolleys at South Hampstead, London on 11 March 2018

I write to provide an update[1] on the action taken in respect of recommendation 6 addressed to ORR in the above report, published on 18 December 2018.

The annex to this letter provides details of actions taken in response to the recommendation and the status decided by ORR. The status of recommendation 6 is **'Implemented'.**

We do not propose to take any further action in respect of the recommendation, unless we become aware that any of the information provided has become inaccurate, in which case I will write to you again.

We will publish this response on the ORR website on 20 October 2020.

Yours sincerely,

Oliver Stewart

[1] In accordance with Regulation 12(2)(b) of the Railways (Accident Investigation and Reporting) Regulations 2005

Recommendation 6

The intent of this recommendation is to understand how the revision of safety critical business processes can be improved.

Network Rail should undertake a review of how the change of NR/L2/OHS/019 from issue 8 to issue 9 was managed, in order to identify any areas for improvement in the management of change.

ORR decision

1. Network Rail have carried out a review of how the change of NR/L2/OHS/019 from issue 8 to issue 9 was managed and identified a number of corrective actions. We note that the review was paused in order to take into account the outcomes of the Margam review.

2. After reviewing the information provided ORR has concluded that, in accordance with the Railways (Accident Investigation and Reporting) Regulations 2005, Network Rail has:

- taken the recommendation into consideration; and
- has taken action to implement it

Status: Implemented.

Previously reported to RAIB

3. On 18 December 2019 ORR reported that Network Rail have committed to providing ORR with an overview of the post-implementation review of the change from 019 issue 8 to issue 9.

Update

4. On 10 September 2020 Network Rail provided the following closure statement:

[N178-04] South Hampstead Rec 6 Cl

5. Network Rail state the following:

Although work was started on these recommendations in 2019, following the fatalities at Margam in July 2019 the work was paused while the investigation took place as the themes being investigated were similar to those found at South Hampstead.

Following the publication of the Margam investigation in May 2020, the following recommendation was made:

Network Rail's Internal Audit completed two audits regarding 019 that Network Rail will propose closes both South Hampstead Rec 5 and 6, it also shows the actions that have been agreed from the audit.

In regard to Rec 6 the audit found the following actions were required to improve safety critical business processes. These will now be monitored via the Group Technical, Safety and Engineering Director, via the Head of Assurance and reporting weekly to the relevant lead manager.

Finding	Risk	Required actions	Action owner	Due date	Exit criteria
1	Failure to demonstrate that the Standard communication and review activities are completed could lead to its incorrect application and/or failure to take appropriate action, increasing the risk of workforce incidents / fatalities occurring and non-compliance with legislation.	1.1 Define and implement a document management process for Standards development, including (but not limited to) key elements, such as consultation, briefing (see action 1.3), PIR completion and follow up. The purpose of this action is to enable a more rigorous storage and record retention for future Standard developments.	*John Winnifrith, Acting Principal Rules, Standards & Controls Manager*	*30 October 2020*	• Documented evidence (e.g. Standard, guidance document) in place that clearly explains how Standard documents should be stored, backed up and organised including the key elements specified. • Repository set up with clear folder structure.
		1.2 Undertake a dedicated review of the evidence available associated to the NR/L2/OHS/019 Standard Temporary Variations (TVs). Based on the outcome, confirm TVs closure and / or define dedicated actions to address the causes for lack of completeness. Consideration to be given to possibly include TVs evidence within the document management process for Standards development (action 1.1).	*Rupert Lown, Chief Quality, Health, Safety & Environment Officer [to be reassigned to the Head of Corporate Workforce Safety once in post]*	*30 October 2020*	• Action plan to address the weaknesses identified following the TVs evidence review.
	adequacy, resulting in an increased risk of workforce incidents / fatalities occurring and non-compliance with legislation.	implementation, based on Level 1 and Level 2 assurance outcomes. This will be developed through the following steps: • Undertake a review and identify relevant Standards. • Identify any existing governance forums and reporting to present Level 1 and Level 2 assurance outcomes associated to the Standards identified. • Communicate the process to the relevant parties, including Standard Owners.			• Evidence of process being communicated to relevant parties involved, including Standard owners.

		1.3 Define a mechanism for Standard Owners to be able to demonstrate that records are held to confirm the briefing completion and that required front-line staff have been suitably briefed.	*John Winnifrith, Acting Principal Rules, Standards & Controls Manager*	*30 October 2020*	• Documented evidence (e.g. Standard, guidance document) in place that clearly explains how briefing completion is tracked and monitored.
2	A lack of understanding of requirements and responsibilities could lead to staff not applying the Standard requirements correctly, increasing the risk of workforce incidents / fatalities occurring and non-compliance with legislation.	2.1 Identify risk-based criteria to enable the Standard Owner to determine appropriate mechanisms to confirm understanding of Standard requirements and to assess the briefing process adequacy. The mechanisms to confirm understanding could consider specific training including a confirmation of understanding, or briefing. The above criteria should be defined based on technical guidance and solutions provided by the NR Training function.	*Rupert Lown, Chief Quality, Health, Safety & Environment Officer*	*22 January 2021*	• Evidence of guidance provided by NR Training on solutions on how to confirm understanding of Standard requirements and to assess the briefing process adequacy. The guidance should take into consideration: o Briefing materials o Briefers competence o Mechanisms available to confirm understanding. o Supporting mechanisms to provide clarifications. • Based on the guidance above, documented criteria to confirm approach to understanding of Standard requirements and to assess the adequacy of the briefing process.
3	Gaps in the assurance oversight may lead to failure to identify and take appropriate action on the Standard	3.1 Define a process for Standard Owners to identify management actions and improvements required on the Standards and their	*Cajetan Chukwulozie, Head of Risk Management*	15 July 2021	• Evidence of the review outcome including relevant Standards identified, associated governance forums and reporting of assurance activities.

Previously reported to RAIB

Recommendation 6

The intent of this recommendation is to understand how the revision of safety critical business processes can be improved.

Network Rail should undertake a review of how the change of NR/L2/OHS/019 from issue 8 to issue 9 was managed, in order to identify any areas for improvement in the management of change.

ORR decision

1. Network Rail have committed to providing ORR with an overview of the post-implementation review of the change from 019 issue 8 to issue 9.

2. After reviewing the information provided ORR has concluded that, in accordance with the Railways (Accident Investigation and Reporting) Regulations 2005, Network Rail has:
   - taken the recommendation into consideration; and
   - is taking action to implement it

Status: Progressing. **ORR will advise RAIB when further information is available regarding actions being taken to address this recommendation.**

Information in support of ORR decision

3. On 3 May 2019 Network Rail provided the following initial response:

   Action Plan

   Under the requirements laid out for standards change for Network Rail, all changes of standards are required to undertake a post implementation review. This has been undertaken at a route level as NR/L2/OHS/019 issue 9 was rolled out in this way.

   The reviews are complete and are being centrally collated by the workforce safety team to produce a holistic view of lessons learned and how this can be improved in future. This is due to be complete by the end of July.

4. On 2 August 2019 Network Rail advised us that it had extended RAIB Rec 6 for South Hampstead to Oct 2019 while they collate the evidence from the post implementation review.

5. On 14 November Network Rail advised us of a timescale extension for completion of the work to 29 February 2020.