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

Dear Andrew,

RAIB Report: Near miss between a train and a track worker at Shawford on 24 June 2016

I write to provide an update[1] on the action taken in respect of recommendation 3 addressed to ORR in the above report, published on 23 March 2017.

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 3 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 19 April 2021.

Yours sincerely,

Oliver Stewart

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

Recommendation 3

The intent of this recommendation is to reduce the risk to staff working on or near the line by improving compliance with the requirements for such working.

Network Rail should:

a. Investigate why management arrangements within Wessex Route did not detect and/or rectify gross non-compliances within the rail testing and lubrication section at the former Eastleigh (now Wessex Outer) delivery unit with the processes for managing the safety of people working on or near the line. The investigation should include consideration of:
    - why its audit and self-assurance processes did not identify the full extent of the non-compliances with planning and implementing safe systems of work found by the RAIB;
    - why its monitoring and reporting processes did not trigger earlier action by senior management within the Wessex Route to resolve the way in which safe systems of work were being planned and delivered;
    - how the availability of, and time pressures on, staff in roles within the work planning process affected the way in which safe systems of work packs were being produced, reviewed, signed off and used;
    - whether there are other delivery units, with persistent non-compliances to processes that can affect the safety of its staff when on or near the line; and
    - the effect that any other factors have had in contributing to the gross non-compliances with planning and implementing safe systems of work.
b. Based on the findings of its investigation, take action to improve the management arrangements at Route level for monitoring the performance of the delivery units, with respect to planning and implementing safe systems of work (paragraph 98a). This recommendation may also apply to other Routes within Network Rail.

ORR decision

1. Network Rail has investigated why management arrangements within Wessex Route did not identify non-compliances within the rail testing and lubrication section at the former Eastleigh delivery unit. The investigation was comprehensive and identified a number of improvements around resource allocation, assurance of safe systems of work and identification of good practice and non-compliances. We are satisfied that these findings have been addressed locally.

2. ORR delayed reporting to RAIB that the recommendation had been implemented whilst we considered the degree to which we should expect Network Rail to take account of the final point about the applicability of the recommendation to other routes. We concluded that there was limited value in requiring a replication of the approach adopted in Wessex – but this is only because of what we have learnt during our own separate work on wider considerations of assurance. Based on what we know from regular meetings over the last two years, and of the further work that

Network Rail is undertaking in relation to the Margam recommendations, we are content to consider this recommendation implemented.

3. 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

4. On 22 March 2018 ORR reported that Network Rail had not formally responded to the recommendation.

Update

5. On 29 October 2019 Network Rail sent the following update:
Following the incident our Route WHSEA undertook a Level 2 investigation and the underlying causes were identified as detailed in investigation summary below:

An investigation took place into the circumstances of this incident that resulted in identified failures in management arrangements to detect and/or rectify gross non-compliances within the rail testing and lubrication section at the former Eastleigh (now Wessex Outer) delivery unit with the processes for managing the safety of people working on or near the line. The investigation took into consideration; the audit and self assurance processes, monitoring and reporting processes, resourcing and resilience within the sections, consideration of similar situations throughout the route and other relevant factors.

The investigation took into consideration changes in working practises in this arena resulting from the implementation of the national Planning and Delivery of Safe Work (PDSW) project and associated changes in the NR/L2/OHS/019 standard. Consequently the following improvement actions have been taken;
1) A review of the appropriate allocation of resources considering the workload of planning staff,
2) Comprehensive briefing programme delivered which included specific areas of focus identified as necessary during the investigation, including what line managers need to check when reviewing a used safe system of work document.
3)Processes requiring enhanced monitoring and review of safe systems of work provision and application and enhanced L1 assurance requirements,
4)Improved periodic compliance reporting and assurance of safe system of work activities utilising the C.M.O. software system which provides greater visibility of assurance activities ,
5) Implementation of a rolling 2 year audit programme focussed on NR/L2/OHS/019 to identify non-compliances and areas of good practise.

Investigation Summary

There was no evidence to confirm a formal 'safe system of work' had been set up by the COSS (Controller Of Site Safety) when he and the Team leader, who had been nominated as site lookout for the shift, entered the infrastructure.
There was lack of formality and instruction from the COSS to the Team leader as to the next action to be taken once they had reached a position in the down cess closer to the mileage of the 'suspect' fault.

The Team Leader (also a COSS) failed to follow the instructions of the COSS to remain in the Down Cess.
He had been briefed earlier in the shift that he was the site lookout for the full shift and had acted as such in the previous locations.
Once inside the infrastructure he quickly walked away from the COSS and started to use his phone to find the 'suspect' fault with the GPS tracker.
As he was the designated site lookout for the shift he should not have been working.
This was the last job of the last shift before he went on holiday that evening.
His personal circumstances were further complicated because he was fatigued having slept in his car all week because he had moved to Essex in preparation for his transfer to a Section in Hither Green, South East Route and failed to inform his supervisors.

The Safe System of Work Pack (SSOWPS) provided to the COSS was not fit for purpose.

It was supplied for use in several different locations throughout the shift of the 24th June; it contained numerous errors outlined in the body of this report.
This was not an unusual occurrence, a state of continual supply of sub-standard SSOWPS to COSSs within the RT&L section over many years had prevailed.
As a consequence a culture of poor custom and practise associated with the responsibilities of the role of the COSS (as outlined in NR/L2/OHS/019) had manifested, this including the depreciation of on-site formality associated with COSS briefing and on site discipline

The Section Planner had a history of poor attendance and poor performance in the core role activity of the provision of 'fit for purpose' SSOWPS.
There was a consistent failing by consecutive DU line management to the RME, and the RT&L Section Manager, to provide suitable / sufficient resources to enable them to supply the RT&L staff with fit for purpose SSOWPS.

A - Why its audit and self-assurance processes did not identify the full extent of the non-compliances with planning and implementing safe systems of work found by the RAIB;

RT&L Section Manager had diligently completed the Assurance checks on SSOWPS returned by his teams after use.
He had checked all details entered by the COSS during its use including but not limited to; correct calculation of sighting distances, nomination of lookouts and signatures for COSS briefings received and found them to be correct.

He did not at that stage check the information supplied on the SSOWPS to all the COSS's, due to the fact that he had come from a department where the majority of

work tasks are delivered inside T3 'Possession Engineering Worksites' and consequently had limited knowledge of what is an acceptable standard of information to be contained in a SSOWPS for Red Zone working

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Previous Functional Audit have picked up issues with the quality of completion in elements of the SWP but had not highlighted any systematic failings to deliver Safe Working plans within the sections audited

- ***Why its monitoring and reporting processes did not trigger earlier action by senior management within the Wessex Route to resolve the way in which safe systems of work were being planned and delivered;***

As a result of this incident the DU WHSEA conducted a fact finding activity involving all the Ultrasonic Team Leaders in this section, this is a summary of the findings;

a) Upon checking 500 plans produced by the Ultrasonic planner he found that 440 of the plans had been produced in the wrong format, having been generated as 'Cyclic' rather than as new work, and contained many errors and excessive mileages without actually relating to the work to be carried out.

b) Cyclic plans do not automatically produce the necessary Appendix C form which carries the same number and description of work as the SSOWP, therefore the planner issued a photocopy of a blank Appendix C, which showed no reference to the work plan issued, and when signed by the COSS did not indicate what he had accepted.

c) The one exception to this was the COSS involved in this incident who completed the necessary information required on the form to cross reference it to the issued SSOWP.

d) This was discussed with all the Ultrasonic COSS's and it was found that none of them had sufficient understanding of SSOWPs and that the plans given to them did not help them in any way regarding their safety, the location of the work, or the nature of the work.

e) As the information on the SSOWPs is too generic, and the mileages too great, they did not feel the SSOWPs supplied were of benefit, consequently they do not read them. Completing sections by rote as required, and returning a signed Appendix C with no information shown on it.

f) They believe that as long as the COSS gives a formal brief at the beginning of the day no further formal briefs are required but a recap brief is necessary at the access gate of each job. They accept that they aren't able to record this or obtain signatures for each time they go to a new site at a different location.

g) None of the staff are aware of the component sections on the new SSOWP's system, despite all having received a brief delivered when the new system came in.

h) The Planner does not understand the SSOWPs 2 planning system or the meaning of 'Cyclic' maintenance, and believes that 'cyclic' SSOWPs are to allow him to recall a previous SSOWP and re-date to save time.

i) The result is that COSS's receive a SSOWP which sometimes covers 20 plus miles and is not fit for purpose. It has been confirmed by other Team Leader/COSS's that this isn't unusual and that as errors were never rectified they stopped reporting them and ignored the information on their issued SSOWPs, going through the motions of completing and returning issued SSOWPs to the planner.

What the above assessment demonstrates is an insular section of Team Leaders who have accepted sub-standard SSOWPS over many years and lowered their expectations accordingly. One of the consequences of this is the depreciation of the formality

The management self-assurance submission did not flag up these issues as the Section Manager was effectively not aware of the level of non-compliance to process

We have now implemented PDSW utilising the changes in the 019 standard. This ensures that skilled persons, who have been identified as Persons In Charge, are involved in the planning process and sign off the SSOWP prior to being used. Given the safety risks we have encountered and the environment our teams work in we have spent time with our teams communicating the change as well as ensuring the changes have been successfully embedded.

This has been achieved by a singular person undertaking the briefings to all teams and re visiting teams prior to implementation. This allowed issues to be raised and shared amongst teams. Further teams have been revisited to capture any post implementation challenges to resolve and share these too. The singular brief has been important to ensure that there was a consistent message.

As part of the 019 roll out we are rolling out an internal audit process.
This will see each section manager have two audits over two years – a full and light audit. The full audit will be undertaken by an independent person outside of the depot, whilst the light audit will be completed by delivery unit representatives from outside of the section to be audited

- ***How the availability of, and time pressures on, staff in roles within the work planning process affected the way in which safe systems of work packs were being produced, reviewed, signed off and used;***

The Planner suffered with poor mental health conditions for several years, including anxiety and depression.
He was regularly absent from work for quite long durations, the longest being of four months with depression. The efficiency of the RME dept. and RT&L Section was affected by this absence.

The effects of the constant absenteeism of the Planner have been difficult to cope with and invariably this has resulted in both Managers seeking assistance from other departments Planners to provide SSOWPS.

The RME obtained the SSOWP Planner Competence last year to enable him to access and amend pre-existing SSOWPS plans within the system to try and resolve some of these issues.

Additional Planning resource has been obtained, in several sections, to remove the system and management pressure when periods of absence are encountered. Further, additional support function resources have been recruited for both Delivery Units, such as HR, to remove workload from particularly section managers

- ***Whether there are other delivery units, with persistent non compliances to processes that can affect the safety of its staff when on or near the line;***

In August 2017, Wessex commissioned an investigation to understand section manager perception over self-assurance activities undertaken by our Maintenance Compliance and Assurance Advisor (MCAA). This was completed in August 2017 and extended across both Inner and Outer Delivery Unit as well as across disciplines at a section manager level. The section manager level was chosen as they authorise SSOWP and put teams out to work, as well as undertaking self-assurance activities.

The report highlighted inconsistencies over the perception of self-assurance, with there being a lack of understanding why it was being undertaken. Given this lack of appreciation self-assurance activities were either given lip service or missed. Being a paper based format made it hard to track and monitor completion status and quality of the each Periods activities.

Outside of the investigation it was also noted that there was a gap in communication between the MCAA, and the Performance and Assurance Engineers (P&A Eng.) for each depot, which may have added to the inconsistencies.

This had been exacerbated by the fact that there had been no full time MCAA for the previous 18months and as the role had been covered by various secondments. These secondments have now ceased

Managers self-assurance has been migrated into CMO (Compliance Management On-Line)
This system allows the Route to have a weekly/period update on status across the route for Self-Assurance activities and the associated actions resulting from these reviews

These monitoring processes are being developed in line with National recommendations

The MCAA now holds regular meetings with the Performance and Assurance Engineers from each Delivery Unit to review emergent trends and shortfalls in quality of management self-assurance checks

The MCAA attends the National Compliance & Assurance meetings to review developments and issues found in the other Routes and to share suggestions for improvement, such as improved question sets and monitoring processes

We have recruited an independent auditor to implement a rolling 2 year audit programme focussed on NR/L2/OHS/019, aligned with RM3 to identify non-compliances and allow areas of good practise to be shared.

Previously reported to RAIB

Recommendation 3

The intent of this recommendation is to reduce the risk to staff working on or near the line by improving compliance with the requirements for such working.

Network Rail should:

c. Investigate why management arrangements within Wessex Route did not detect and/or rectify gross non-compliances within the rail testing and lubrication section at the former Eastleigh (now Wessex Outer) delivery unit with the processes for managing the safety of people working on or near the line. The investigation should include consideration of:
    - why its audit and self-assurance processes did not identify the full extent of the non-compliances with planning and implementing safe systems of work found by the RAIB;
    - why its monitoring and reporting processes did not trigger earlier action by senior management within the Wessex Route to resolve the way in which safe systems of work were being planned and delivered;
    - how the availability of, and time pressures on, staff in roles within the work planning process affected the way in which safe systems of work packs were being produced, reviewed, signed off and used;
    - whether there are other delivery units, with persistent non-compliances to processes that can affect the safety of its staff when on or near the line; and
    - the effect that any other factors have had in contributing to the gross non-compliances with planning and implementing safe systems of work.
d. Based on the findings of its investigation, take action to improve the management arrangements at Route level for monitoring the performance of the delivery units, with respect to planning and implementing safe systems of work (paragraph 98a). This recommendation may also apply to other Routes within Network Rail.

ORR decision

1. Network Rail have not formally responded to the recommendation.

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

- not provided a response setting out how the recommendation will be delivered.

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

Information in support of ORR decision

3. No information provided by end implementer.