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Mr Andrew Hall
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Dear Andrew,

RAIB's 2015 Annual Report




At ORR's most recent Recommendation Review Committee (RRC) meeting we discussed our position regarding Norwich Station recommendation 3 in the light of press interest in relation to the concern expressed by RAIB in its 2015 annual report.





Whilst RRC was content with the response already provided to RAIB on this matter, and with our reporting of the recommendation as 'Implemented', it felt that it was important to publish this on our website as a means of providing a full picture on the status of the recommendations highlighted in your report. The annex to this letter therefore provides our formal response to each of your 2015 points of concern and this letter will be published on our website on 16 June 2016.

Yours sincerely,

Andrew Eyles

RAIB 2015 Annual Report – ORR responses to points of concern

Report Title	Rec No	Recommendation Text	Triangle Colour	ORR Recommendation Status	RAIB Concern	ORR comment
Fatal accident at James Street station, Liverpool	3	The Office of Rail Regulation should, in conjunction with railway industry parties, ensure that the findings of this report are taken into account in published guidance on the types of measures that promote the safe movement of trains from platforms through the adequate control of risk. The areas that should be the subject of particular consideration in such guidance are: a. equipment and methods which enable the person responsible for dispatch to observe the platform/train interface without interruption for as long as possible, ideally until the train has left the platform; b. equipment and methods which enable the person responsible for dispatch to stop a train quickly in an emergency; and c. adaptation of trains and infrastructure to reduce the size of the platform edge gap when this is possible and appropriate, for example in connection with investment in new trains and infrastructure.	White 	Implemented	More evidence is needed to consider whether the PTI strategy, and associated research, will lead to delivering the recommendation's intent effectively.	ORR notes RAIB's comments. However, the recommendation requires that the findings of this report are taken into account in published guidance that promote the safe movement of trains from platforms through the adequate control of risk. ORR considers that RSSB PTI strategy and the revised RIS-3703-TOM (along with plans to develop these areas further) delivers this requirement. ORR also notes and commends the further work that the industry is undertaking to address associated risks.
Fatal accident at Athelney level crossing, near Taunton, Somerset	2	Network Rail in conjunction with RSSB should review past and current research into level crossing signage and emergency communication with signallers and consider means of improving the presentation of public emergency telephones for non-emergency use at automatic level crossings (paragraph 85c). This might include changes to signage or to the location of telephones, and should take account of Rule 34 of the Highway Code.	Blue 	Implemented	RAIB believes that actions taken have not met the intent of giving motorists an obvious way of contacting the signaller if AHBs are down for what may seem to be an abnormally long time.	The intent of this recommendation was to identify how to improve public awareness of the availability of telephones to contact the signaller in non-emergency situations, and not to provide a means for motorists to contact signallers under non-emergency conditions. ORR responded to RAIB on 22 October 2015: 'Recommendation 2 required Network Rail to review research into level crossing signage and emergency communications with signallers, and consider means of improving the presentation of public emergency telephones for non-emergency use. Telephones at these locations already provide a means to communicate with the signaller if necessary. The issue was about how to enhance the message to the users that it's also available for them in a non-emergency situation. Whilst Network Rail's conclusion from the review was that adding even more signage to that which is already there was not a good idea and potentially confusing (as the attached photograph shows), drivers still have the ability to communicate with the railway if the barriers are down for a long period. The existence of the large or slow vehicle signs also indicates that the telephone is not just for use in an emergency.' ORR considers that this recommendation has been addressed appropriately.
Passenger train collision at Norwich	3	Greater Anglia should review and make any necessary changes to the application of the audit procedure, including any locally pre-defined question sets, to ensure that it allows for consideration of compliance with all safety related elements of the operational procedures (paragraph 123c.iii).	Blue 	Implemented	RAIB is concerned that the audit process allows for consideration of compliance with some (not all) safety related aspects of the operational procedure. RAIB considers that the audit process should be re-examined.	As there is no evidence in the report of a potential weakness throughout the audit system it seemed clear to both ORR and Greater Anglia (GA) that the intention of the recommendation was ensure that NTS was embedded not only in the CMS and the investigation process, but to complete the loop and ensure that it is embedded in the audit process to pick up any missed opportunities relating to behavioural issues. Paragraph 123 of the report, to which the recommendation is referenced, is focused on the possibility 'that the driver had a lapse in concentration' with sub paras a), b) and c) setting out potential factors for this, with c) iii highlighting the 'missed opportunities - for identifying such lapses – were not identified by internal audits (paragraph 93, Recommendation 3)'. ORR therefore considers that the recommendation – in clearly referencing paragraph 123.c.iii - could have clarified that its scope was wider than NTS. ORR sought the further views of GA which responded as follows:

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						<p>'GA did understand the purpose of the recommendation and audit protocols were updated by the Operations Standards Team. This was to ensure that the application of NTS was taking place and that could be checked during audits of competence files and process.</p> <p>To provide explanation about the NTS reference.</p> <p>During the feedback by the lead inspector for this investigation there was much debate about NTS. This was because the driver was involved in incidents over his driving career and plans had been put in place, however, the link between them to consider the potential underlying concentration issue had not been identified. Our Driver Manager, Audit Team or Driver would not have had NTS awareness or training from the start of this driver's career. This new learning and use of NTS has since been introduced into our SMS. This was in reference to the report clause 123 ciii as the auditors may have been able to identify an NTS deficiency if the Driver Manager had not. The explanation given by the inspector about the missed opportunity by our Driver Manager and audit team to identify this NTS issue was well explained using Figure 8. The lack of an SPR being triggered for the driver was an oversight in CMS application but not a fundamental flaw in our audit regime.</p>
Derailment at Primrose Hill/Camden Road West Junction	1	Network Rail should provide specific guidance to managers with responsibility for track maintenance on the action to be taken to confirm that track quality remains acceptable should a planned run of a track geometry measurement train over a section of line be cancelled (paragraph 128a). This should include the criteria for whether it is necessary to conduct additional track geometry measurements, as well as the timescales for any such measurements to be completed.	White 	Implemented	In order to consider this recommendation to have been addressed, further action (which has already been proposed) is required.	<p>Whilst Network Rail concluded that its current standards adequately addressed the requirements, it has taken action to enhance their clarity through the BCR programme, MOCs and supporting guidance, and the provision of a TME course to enhance the capability of its TME community.</p> <p>ORR continues to monitor the progress of the BCR programme generally, and supporting role based capability and skills assessment scheme.</p>
	2	<p>Freightliner and Network Rail should jointly request that RSSB:</p> <p>a) researches the factors that may increase the probability of derailment when container wagons are asymmetrically loaded, and in particular:</p> <p>i. sensitivity to combinations of longitudinal and lateral offsets in loads that can reasonably be encountered in service;</p> <p>ii. the predicted performance of wagons with high torsional stiffness along their length (using the FEA type as an example); and</p> <p>iii. the effect of multiple twist faults, track twist over distances other than 3 metres (as commonly specified and measured by Network Rail) and lateral track irregularities.</p> <p>b) updates and amends as necessary the risk assessment contained within the RSSB and Transport Research Laboratory joint report ('Potential risks to road and rail transport associated with asymmetric loading of containers'); this should take into account the results from the research referred to in a) and additional evidence presented in this investigation report; and</p> <p>c) works with industry stakeholders to use the outputs of a) and b) to identify, evaluate and promote adoption of any additional reasonably practicable mitigations⁴⁶ capable of reducing the risk from asymmetric loading of wagons (paragraphs 128c, 130a, 130b and 131b).</p>	Blue 	Implemented	Although some positive steps have been taken, (ie the establishment of the cross-industry working group) the findings of the group have not yet been delivered or fully considered.	<p>ORR wrote to RAIB on 10 February 2016 confirming tis view that the wording of this recommendation had been implemented appropriately.</p> <p> Primrose Hill Camden Road Recommendation 2 .msg</p> <p>Subsequent to this:</p> <ul style="list-style-type: none"> the XIFDWG interim report has been published on the RSSB website @ http://www.rsb.co.uk/risk-analysis-and-safety-reporting/accident-investigation-and-learning/tackling-freight-derailments. ORR has written to the XIFDWG on 15 February 2016 regarding the concerns RAIB had and emphasising the need to deliver the intent of the recommendation. ORR has written to the XIFDWG on 16 February 2016 regarding future reporting arrangements for the XIFDWG to which RSSB have responded positively. <p>ORR considers that this recommendation has been addressed appropriately and continues to monitor the work and output of the XIFDWG,</p>
Passenger train collision with trolley at Bridgeway UWC	2	Network Rail should review work planning practices and processes at Shrewsbury Maintenance Delivery Unit and optimise the distribution of information for both planners and track workers to carry out their jobs effectively (paragraph 96). This review should consider:	White 	Implemented	RAIB remain concerned that the applicability to other maintenance delivery units of safety issues (raised in this recommendation) have not been determined or acted upon.	<p>ORR's response confirmed that:</p> <p>The review of the incident completed by the Delivery Unit considered the RAIB's concern that similar issues that resulted in the Bridgeway UWC incident could exist at other Delivery Units within Network Rail.</p>

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		<p>a. workload and resourcing to enable more strategic and proactive approaches to work planning;</p> <p>b. information available to the planner and the COSS in producing and checking SSOWP documentation, including details of the work to be undertaken; and</p> <p>c. local practices and assumptions about planning parallel line blockages with respect to national procedures and processes, particularly concerning the designation of 'working' lines and the inferred level of protection on the part of the planner and the COSS.</p> <p>Network Rail should also determine whether such issues are applicable at other maintenance delivery units and take action as necessary to address any problems identified.</p>				<p>and</p> <p>...these deficiencies on the day were discrete to the Shrewsbury Delivery Unit it is the view that no further action is required in this regard.</p> <p>ORR considers that this recommendation has been addressed appropriately.</p>
	3	<p>Network Rail should, as part of its review of Assessment in The Line:</p> <p>a. clarify the management arrangements for seconded staff so that it is clear which part of the organisation is responsible for each element of an individual's competence and knowledge; and</p> <p>b. revise its criteria for refresher training following periods of extended absence, particularly where significant changes to work patterns, practices or infrastructure arrangements have occurred during the absence (paragraph 97a).</p>	Blue ▲	Implemented	The response fails to fully implement the intent of the recommendation. RAIB is concerned that the same circumstances that applied at Bridgeway could still occur.	<p>ORR response identified that:</p> <p>'Establishing individual and team competence requirements</p> <p>Line Managers are accountable for identifying each individual within their teams for whom they take responsibility in terms of initial and ongoing training, assessment and development activities.</p> <p><i>This includes:</i></p> <ul style="list-style-type: none"> • Permanent team members; • Seconded team members; • Temporary staff (such as those on fixed term contracts etc.)' <p>ORR considers that this recommendation has been addressed appropriately.</p>
Dangerous occurrence at Lindridge Farm UWC near Bagworth, Leics.	1	Network Rail should revise its project management processes and company standards to require that signalling re-control projects (ie projects transferring the control of signalling from one location to another when the interlocking, trackside signalling equipment and infrastructure are unchanged) identify the signalling source records that are needed for the design, checking and testing of these works. These projects should then be required to include activities within their scope of work to obtain these signalling source records, including correlating, updating or producing records as necessary (paragraphs 144a, 144c and 145).	White △	Implemented	No substantial change has been made as Network Rail believes its standards already cover this. RAIB has notified ORR that it disagrees. ORR has sought further clarification from the end implementer.	ORR has sought additional information from Network Rail.
	3	Network Rail should revise its design processes so as to specifically require that the position of fixed infrastructure, shown on any new signaller's display being installed by a project, is correlated to its position as shown on the existing signaller's display that is being replaced. This work should be carried out by staff who are qualified as competent to do correlation, and when a discrepancy is found between the new and existing signaller displays, they should record it and investigate the reason for it. Such an investigation should include a check of the accuracy of associated records, such as signalling or scheme plans, and result in the necessary corrections being made to the design or to the records to resolve the discrepancy (paragraphs 144g, 144h and 146b).	Blue ▲	In progress	The response fails to fully address the intent of the recommendation. RAIB is concerned that the same circumstances that applied at Lindridge Farm could still occur. ORR has asked the end implementer to reconsider its position.	ORR has asked Network Rail to reconsider its position.
Derailment of a freight train at Barrow-upon-Soar, Leicestershire	1	Network Rail should amend its company standards so that track maintenance staff are required to notify the Route geotechnical team if the foot of an embankment is saturated, flooded or has recently been flooded, and a track geometry defect or loss of ballast is found on top of	Blue ▲	Implemented by alternative means	It is not clear to RAIB how existing processes and proposed changes will address the intent of the recommendation.	The intent of this recommendation is to reduce the risk of an embankment failure due to flooding by providing the Route geotechnical team with information that will trigger an earthwork evaluation.

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		the embankment (paragraphs 114b, 114c, 114d.i, 114d.ii, 114d.iii and 115b).				<p>ORR's formal response confirmed that:</p> <p><i>Network Rail's closure statement states that the Chief Track & Lineside Engineer (CTLE) is satisfied that track engineers do liaise with geotechnical staff and exchange data; and in response to our challenge sampled the views of the geotechnical community. Although feedback was mixed, dependent on the extent and scale of geotechnical problems that are impacting track condition, the CTLE concluded that there was sufficient communication between TMEs and geotechnical engineers.</i></p> <p>ORR also made reference to Network Rail's update of 2 December 2015 from its geotechnical team:</p> <p><i>The bow tie for embankments shows the barriers against threats of scouring and adverse/extreme weather events. The main barriers against these threats are as follows:</i></p> <ol style="list-style-type: none"> <i>1. Earthwork management process. A suite of Network Rail standards address this earthwork management process. These are NR/L2/CIV/086 Management of Earthworks, NR/L3/CIV/065 Examination of Earthworks and NR/L3/CIV/071 Geotechnical Design. There is also drainage standard NR/L3/CIV/005 Drainage which specifies Drainage Management Plans which have been produced for each Route. The Business Process Documents referred to on the attached bow tie are currently being drafted.</i> <i>2. Weather – managing the operational risk. Earthworks have been risk assessed nationally for adverse/extreme weather. This was carried out by plotting earthworks on a risk matrix with axes of Earthwork Hazard Category (giving likelihood of failure) and Earthwork Asset Criticality Band (modified for drop-offs). Each Route has an adverse/extreme weather plan with actions to mitigate risks once rainfall trigger levels have been exceeded.</i> <p><i>The bow tie shows that reports from Network Rail staff (including TME) is one source of information that the RAM (Geotechnical) team get on scouring or adverse/extreme weather events. Track inspection staff report to Section Manager, via a TEF, in accordance with NR/L2/TRK/001. Notification of such issues to the RAM (Geotechnical) by TME is complementary to the stronger mitigation means of control provided by Earthwork management process.</i></p> <p>This confirms that Network Rail is not heavily reliant on information from track to manage its assets.</p> <p>In addition ORR is considering Network Rail's implementation of this recommendation as part of our investigation into the recent incident at Linsdale, where sharing of information between track and Geotech may have been a factor.</p>