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OFFICE OF RAIL AND ROAD

11 January 2017

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

Dear Andrew,

RAIB Report: Collision between a stone-blower and ballast regulator near Arley, Warwickshire, 10 August 2012

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 8 August 2013.
The annex to this letter provides details of the action taken regarding this recommendation, the status of which is now '**Implemented**'. We do not propose to take any further action in respect of this recommendation, unless we become aware that any of the information provided becomes inaccurate, in which case I will write to you again.

We will publish this response on the ORR website on 12 January 2017.

Yours sincerely,

Oliver Stewart

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

Recommendation 3

The purpose of this recommendation is to gain assurance from Network Rail that it understands why the managerial arrangements in place at Saltley Infrastructure Maintenance Delivery Unit have not prevented a recurrence of non-compliant behaviour and to ensure that any measures put in place to address these issues will be effective in the long term.

Network Rail should review why the measures taken to implement Recommendation 2 from RAIB report 01/2011 to achieve improved management surveillance and supervision at Saltley Infrastructure Maintenance Delivery Unit, did not detect or prevent unauthorised changes being made to a plan of work and instances of non-compliance with its company standards for possession management. It should then implement any measures identified to bring about a sustained behavioural change.

ORR decision

1. The recommendation was reopened by Network Rail following the Logan derailment, where two engineering trains collided in similar circumstances to Arley. Recommendation 3 directs Network Rail to carry out assurance work to ensure that communication between those managing engineering possessions and train drivers in those possessions (recommendation 2 of the Arley report) has been properly implemented at a specific location (Saltley Infrastructure Maintenance Delivery Unit). Following a review by Network Rail, the action they took to initially close the recommendation remains valid.

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 8 January 2014 we reported that Network Rail's *S&SD safety culture change team proposed to work collaboratively with LNW and the Saltley Delivery Unit management team to address the potential safety culture issues identified by:*

> *1) Undertaking a full review of the current safety culture and producing a summary report of the findings.*
>
> *2) Undertaking a Safe Teams workshop, to enable management and workers to come together to look at the learning gained by action 1 and to understand*

the real blockers that prevent compliance/effective management of change, which perhaps sometimes leads to cutting corners where safety is concerned.

3) An action plan to be developed around the outcomes from the one-day workshop, the issues identified by the team, and the local skills and ownership needed to make a change.

Network Rail gave a timescale of 31 December 2014. We reported the recommendation as 'In progress'.

Update

4. On 7 May 2015 Network Rail asked for a timescale extension to 30 November 2015 (following a previous extension from 31 December 2014 to 20 March 2015). They stated that the extension was required to check that the arrangements have embedded following significant management staff changes in the depot.

5. Network Rail were chased for an update on 12 February 2016 and on 18 March 2016 ORR received an e-mail stating that a closure statement was currently being written for Arley Rec 3. The work to address the recommendation was complete and there was just some re-working of the closure wording needed to fully demonstrate what had been done.

6. Network Rail provided a closure statement on 25 July 2016 containing the following information:

A review was undertaken, led by the route safety improvement manager and supported by a Safety Leadership and Culture Change Consultant.

This review identified that in response to the Washwood Heath incident an internal review was held. The internal review led jointly by STE and the local depot management focussed on what happened during and in the run up to the incident and by whom. Those involved were interviewed as part of the review but did not determine how the review was completed or its findings. The review resulted in training being identified for those involved. The overall effect was that the review and the training was therefore identified for them and done to them.

Following the post Arley review a different approach was taken. Those involved were engaged in identifying and understanding the root causes themselves and then in planning and implementing the resultant changes, developments and learning activities. As a result there are on-going activities to challenge themselves about safety including their own and colleague's behaviours.

The objectives of the review were to:

- *Understand why despite proactive action by the route in the 18 months between these two incidents (Washwood Heath 06/032010 and Arley*

10/08/2012), there was a continuation of unsafe behaviours and a lack of compliance, at Saltley Delivery Unit.

- *To identify areas that support/are a barrier to safe behaviours*
- *Inform the design of an action plan*

The post Arley review at Saltley Delivery Unit and the Associated Depots considered 3 key factors in the incident:

1. *Individual A (who undertook role of PICOP/ES during the Arley Incident);*
2. *The local Whittacre Heath Depot team and management;*
3. *The wider Saltley Delivery Unit team and management*

The review extended beyond the Arley incident to understand wider potential behavioural contributors and cultural impact. This was to ensure understanding of the limitations of previous responses and to ensure all cultural issues were considered and managed. The review methodology was

1. *Structured Confidential Safety Conversations;*
2. *Factual evidence, used from the original RAIB Investigation reports;*
3. *Close Call Reporting Data for Saltley Depot;*
4. *Safety Climate Survey and Focus Group information from March 2013.*

The Learning from this review was that the behaviours of managers, teams and across team contributed to the continuation of unsafe behaviours and

risk was managed reactively not proactively.

Appendix 1

Findings:

1. *<u>Listening and communication skills:</u>*

Individual A:

- *Individual A is observed to be someone who 'listens to speak' - thinking about what to say next, rather than 'listening to understand'.*
- *Individual A did admit to having previously been a bully and to having changed his ways during the 9 months he was fully seconded to shadow a Workforce Health and Safety Advisor (WHSA). The secondment was an action taken following the Washwood Heath incident of 06/03/2010*
- *Workforce Health and Safety Advisors and TU Safety Reps reported to have seen a difference in the behaviour displayed by Individual A, and to have seen him challenge others around health and safety issues.*

Team:

Following the secondment no measures were taken to reintegrate Individual A back into the Whittacre Heath Depot, The local teams and managers were not provided with support or prepared in order to receive Individual A back into the team. This appears to have undermined the work done in arranging the secondment and the wider Saltley Management Safety Conference arranged following the Washwood Heath Incident.

2. *Risk Perception*

Individual A:

Individual A does not demonstrate an adequate risk perception nor does he appear to link his risk assessments with aligned safety measures. As a result his control and mitigation when undertaking key safety critical roles is incomplete. This may indicate rote learning rather than personal thinking and engagements with deep understanding of risk.

Team:

Lack of challenge from others within the team, possibly as a result of Individual A's attitude towards them and/or custom and practice to blindly trust the person in charge, added to the overall risk.

3. *Challenge and trust*

- *There is a feeling within the Whittacre team that they are unable to challenge when Individual A is in a position of authority (COSS/PICOP/ES).*

Team:

- *During the investigation, it was evident that safety rules are not always followed at Whittacre Depot,*
- *There is a clear lack of communication between Individual A and his immediate line manager, with no evidence of performance management, coaching support, or one to one meetings.*

In summary the review of the actions taken after Saltley showed that a lack of ownership and design of changes locally allowed non-compliant behaviour to go uncorrected.

Following the Arley incident the approach was to create local ownership and recent review (these are on-going) has shown that even with a significant change in staff, the processes, systems and different ways of working are maintaining. NR has however decided given the churn of staff that the

Central safety team will continue to monitor and support the local team for a longer period.

The outcome of this review led to the development of an action plan which is managed by the depot occupational safety advisor together with staff at the depot.

Actions resulting from this review – both closed and on-going – can be seen in the following table:

What did we do	*Why*	*What impact has it had*	*Further action*		*If yes- what and why*
Interviews	*To help all concerned to understand the issues leading to the incident and to collaboratively plan/implement response*	• *Underlying issues of relationships between staff identified* • *Conflicting perception of roles eg ES PICOP addressed* • *Some staff have been moved* • *Review of relationship between WHSEA's & TU Safety Reps, jointly with TU's. Focus on increasing risk perception.* • *Set joint objectives for safety (WHSEA/TU)* • *Red zone working has reduced*	*Yes* *X*	*No*	• *Workstream at reps meeting for more engagement and site specific risk perception* • *More joint walkouts* • *Joint objectives for safety reps*
Workshops- designed specifically for area and rolled-out elsewhere in business *(eg safer teams and safety leadership for*	• *Promote value of Reporting and communicate examples of learning from incidents*	• *Safety awareness and expertise is now promoted/recognised as positive* • *Fair culture believed and reporting of issues increasing* • *Increased conscious risk assessment*	*X*	*X*	*Training completed* *Learning roll-out and improved practice continuing*

front-line)	• *Scenario testing as part of Team interactive scenarios. Reiterate as part of Safer Teams and Managing Safety Conversations*	*(reduced complacency)* • *Issues of group think highlighted and minimised*			
Increased use of appropriately focussed safety conversations by TME Line Managers. *Section Managers have been through training in Safety Conversations.*	*Up-skill of safety critical frontline leaders to have effective safety conversations*	*All staff are undergoing safety conversations though use of mission room, visualisation rooms and on-site safety conversations. This is increasing risk awareness, reporting, local solution to safety issues and challenge* *Learning is shared more efficiently and owned*	*X*	*X*	*Training completed* *Resultant actions on-going*
Shadowing and mentoring including greater management visibility		*As above* *Support given to South-East route to implement LOWS*	*X*	*X*	*Supported SE route* *Shadowing and mentoring routine*
Development of fair culture tool kit	*The development of a tool to support*	*It will include analysis and development of managers' skills, the individual's skill and*	*X*		*Toolkit under-development*

	managers in assessing and supporting individuals in returning to work after safety incidents is ongoing.	*behaviour and work with the individual and their teams to rebuild trust*			

As NR understood that many of these issues will be wider spread this style of engagement for improving safety behaviours has been embedded in various leadership courses (Rail Industry Leaders; Senior Leaders, Leadership Essentials in Network Rail and is part of the Safe Work Leader training which trains SWL to :

- *Listen for Collaborative solution*
- *Think differently about risk*
- *Effectively challenge and give feedback*

This is delivered through interactive sessions, personal learning plans and feedback.

With the pause in PDSW this is being embedded within several of the Integrated Safety Plan projects (Home safe)

In summary the review of the actions taken after the Washwood Heath incident showed that a lack of ownership and design of changes locally allowed non-compliant behaviour to go uncorrected. Following Arley the identification of issues and causal factors was supported locally and the action plan was locally owned. This is evidenced by the on-going commitment to it after a considerable time lapse. However given that many of these behaviours are deeply embedded NR is providing on-going local support post closure of this recommendation and is developing necessary behavioural changes through embedding skills and competency development in on-going training courses.

Appendix 1:

Close out of RAIB recommendation 3 – Overview of follow-up review

1 Promote value of Reporting and communicate examples of learning from incidents

- *Every RIDDOR accident or incident on the DU has comprehensive investigation and lessons learnt produced. Cascaded to workforce through team meetings / IME PDR's*

- *Sharing and learning of national incidents from learning from incidents working group run by Corporate Investigation and Assurance Manager*

2 Increased use of appropriately focussed safety conversations by TME Line Managers. Up-skill of safety critical frontline leaders to have effective safety conversations

- *Section Managers are included in Safety Leadership for frontline managers programme to up-skill*
- *Safety conversations have been encouraged as part of planned general inspections*

3 IMDM and wider team to base at/shadow Whitacre Depot to increase visibility and learning

- *Increased coverage of senior team at Whitacre depot to understand issues and follow through with individuals areas of concern*

4 Review relationship between WHSEA's & TU Safety Reps, jointly with TU's. Focus on increasing risk perception. Set joint objectives for safety

- *Workstream at reps meeting for more engagement and site specific risk perception*
- *More joint walkouts*
- *Joint objectives for safety reps*

5 Scenario testing as part of Team interactive scenarios. Reiterate as part of Safer Teams and Managing Safety Conversations

- *Scenario days with reps*
- *Scenario days with frontline staff*

6 Shadowing and mentoring process over range of real life situations, in other depots and Whitacre

- *LOWs teams*
- *Development of Mission Rooms*