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OFFICE OF RAIL REGULATION

30 May 2013

Ms Carolyn Griffiths
Chief Inspector of Rail Accidents
Rail Accident Investigation Branch
Block A, 2nd Floor
Dukes Court
Dukes Street
Woking GU21 5BH

Dear Carolyn

Safety Incident between Dock Junction and Kentish Town, on 26 May 2011

I write to report[1] on the consideration given and action taken in respect of the recommendations addressed to ORR in the above report, published on 23 May 2012.

The annexes to this letter provides details of the consideration given/action taken in respect of each recommendation where recommendations 1, 2 and 3 have been implemented[2].

We do not propose to take any further action in respect of these unless we become aware that any of the information provided becomes inaccurate, in which case I will write to you again[3].

We expect to publish this response on the ORR website on 13 June 2013.

Yours Sincerely

Chris O'Doherty

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

2 In accordance with Regulation 12(2)(b)(i)

3 In accordance with Regulation 12(2)(c)

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Initial Consideration by ORR

1. The recommendations from the report were addressed to ORR when the report was published on 23 May 2012. After considering the report and the recommendation ORR passed recommendations 1 and 3 to Network Rail and Train Operating Companies and recommendation 2 to First Capital Connect, asking those organisations to consider and where appropriate act upon them and advise ORR of its conclusions. The consideration given to the recommendation is outlined below.

Recommendation 1

The intent of this recommendation is to improve the way in which incidents involving stranded trains are currently handled across the network with a view to implementing good practice and with the objective of train operators reviewing existing protocols, or jointly developing and agreeing with Network Rail new protocols that can be applied to the management of all such events.

Train operating companies and Network Rail routes over which they operate, should review existing protocols, or jointly develop a new protocol, for stranded trains in accordance with the contents of ATOC / Network Rail Good Practice Guide GPD SP01 'Meeting the needs of passengers when trains are stranded'. The protocols should also consider:

- the key findings from this investigation;
- the different arrangements in place for the interface between Network Rail and train operators' control functions;
- the different approaches to managing incidents and good practice applied in different parts of the main-line and other railway networks;
- the need to identify who will take the lead role in managing the incident and how key decisions will be recorded and shared between the affected organisations;
- the need to provide on-site support to the train-crew of such trains in managing passengers' needs;
- the need to provide technical support to the train crew of stranded trains, with a particular focus on means of communicating and the need for coordinating the technical and operational response to such incidents;
- the need to recognise when minor operational occurrences have the potential to develop into major incidents unless decisions are taken in a timely and decisive manner;
- the views of passenger interest groups and emergency services: and
- the positive and negative role that can be played by social networking sites in the management of such incidents.

Summary

2. Responses, including additional information where required, were received from Network Rail and TOCs and can be found at Annex B. These responses demonstrate that all TOCs have reviewed their stranded trains' protocols against the ATOC/NR Good Practice Guide GPD SP01. Whilst the recommendation states that the views of passenger interest groups should be considered, some TOCs took this to mean canvassing the views of some of their own passenger groups. London

Travel Watch / Passenger Focus therefore wrote separately to all TOCs requesting additional information.

ORR decision

3. ORR in reviewing the response and considering the documents provided by Network Rail and TOCs has concluded that in accordance with the Railway (Accident Investigation and Reporting) Regulations 2005, they have:

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

ORR will monitor the application of the TOCs' stranded trains' protocols against the ATOC/NR Good Practice Guide GPD SP01.

Status: *Implemented*

Recommendation 2

The intent of this recommendation is to ensure that First Capital Connect safety related processes in relation to emergency preparedness are managed effectively.

First Capital Connect should carry out a review of its management processes referred to in this report to examine why it did not identify and address deficiencies in emergency preparedness prior to the incident. The lessons learnt from this review should lead to changes in management systems to provide confidence that all such deficiencies will be identified in the future.

Actions taken or being taken to address the recommendation

4. In its response dated 1 August 2012 First Capital Connect explained.

We have carried out a comprehensive review of our management processes making changes where necessary to ensure that any future incidents are managed effectively. Since this incident, there have been events with similar precursors which we have recognized, implemented our management processes and controlled before becoming significant.

We have also introduced a matrix which cross references group standards and Operations Procedures to enable a quick reference when altering a document - either Group Standard or one of the business procedures - to ensure other procedures referenced are altered as necessary.

The changes made to First Capital Connect procedures have been briefed out to all relevant staff and other organisations that could be effected such as Network Rail.

ORR decision

5. ORR in reviewing the response and considering the documents provided by First Capital Connect has concluded that in accordance with the Railway (Accident Investigation and Reporting) Regulations 2005, it has:

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

Status: *Implemented*

Recommendation 3

The intent of this recommendation is for safety related lessons learnt during Significant Performance Incident Reviews and other incident review processes to be effectively tracked, implemented and shared with other railway operators, as appropriate.

Network Rail and the train operators should amend their processes so that safety lessons identified during Significant Performance Incident Reviews and other incident review processes can be effectively monitored through to closure, and actions taken as appropriate. The process should also include a mechanism for advising other railway operators of safety lessons that may be relevant to them

Summary

6. Responses, including additional information where required, were received from Network Rail and TOCs and can be found at Annex C. The TOCs and Network Rail have demonstrated how they monitor safety lessons and share those lessons with other operators.

ORR decision

7. ORR in reviewing the response and considering the documents provided by Network Rail and TOCs has concluded that in accordance with the Railway (Accident Investigation and Reporting) Regulations 2005, they have:

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

Status: *Implemented*

Recommendation 1

Network Rail

The National Control Instruction relating to Stranded Trains was re-issued on 3 June 2012 taking into account the information contained within the stranded trains protocol that was developed by the East Midlands route, as well as the AcOP for Stranded Trains as issued by ATOC in March 2012.

Network Rail (High Speed) ltd

We would refer to recent correspondence between yourselves and Eurostar / Southeastern with regards to the above incident and in particular your request for a response to recommendations 1 and 3 as raised in the RAIB Rail Accident Report published in May 2012.

We have been and continue to be in regular dialogue with both train operating companies with regards to dealing with stranded trains. There is a regular programme of liaison meetings and exercises (both table top and live) that are held with the respective companies. A number of refinements have been made to our processes as a result of these.

With regards to the specific bullet points in this recommendation we would respond as follows

Key findings from the investigation
The investigation report has been studied and reviewed with both train operating companies. We are satisfied that the circumstances are adequately addressed within our existing processes and procedures.

Interface between Network Rail and the Train Operator's Control Functions
Arrangements for communications and interface arrangements with the respective controls are in place and are current. These were subject to particular testing through a number of concentrated exercises held immediately prior to the 2012 Olympics. We consider these arrangements to be suitable and sufficient.

Differing approaches to managing incidents and good practice applied in different parts of the mainline and other railway networks
HS1 is a relatively unique railway in the UK. During construction of the two sections, cognisance was given to European (and in particular French) high speed practice as well as that adopted within the Channel Tunnel.

Due to the international nature of the Eurostar operation in particular, the opportunity has been taken where possible to align incident management with that applied within the Channel Tunnel.

The differing type characteristics of infrastructure between NRIL and NR(HS) has meant that some of the process for managing incidents involving Southeastern trains on HS1 is specific to the high speed operation. We will continue to refine our processes in agreement with the train operators in line with changing circumstance and emerging good practice.

The need to identify who will take the lead role in managing the incident and how key decisions will be recorded and shared between the affected organisations.

As Infrastructure Manager, Network Rail (High Speed) will take the lead role in managing incidents on NR(HS) managed infrastructure. This has been agreed with the respective train operators and the mechanisms for this are coordinated within the respective incident response manuals. We are satisfied that the processes for recording and sharing key decisions have been adequately covered.

The need to provide on-site support to the train-crew of such trains in managing passengers' needs

Whilst acknowledging that this is primarily a train operator function, NR (HS have an agreed protocol with them and will dispatch staff to the scene to assist. In particular, we have mobile security teams who patrol the railway and are available for rapid deployment to provide on-site assistance within very short timescales. A 20 minute failure window has been agreed with both train operators. If it is not possible to rectify a defect within this time, the train will be declared a failure and an appropriate recovery operation will be implemented.

The views of passenger interest groups and emergency services

Both of these groups are invited to and do attend both joint planning meetings and exercises.

The positive and negative role that can be played by social networking sites in the management of such incidents

All communications with the media is dealt with by the NRIL and HS1 Ltd Press Offices on our behalf. The Emergency Plans identify the command and communications structure that will be set up to deal with the various types of incident. This is intended to make sure that the respective Press Offices are kept appraised of the situation. In addition the NRIL Press Office now actively monitor and use social networking sites to post incident information.

Cross Country

Cross Country will commence joint review with NR of the contents of ATOC / Network Rail Good Practice Guide GPD SP01 'Meeting the needs of passengers when trains are stranded'. This will take place at the 8 weekly level 2 operational safety meetings between Cross Country Trains and Network Rail. This review will be completed by January 2013 with any changes being required to Cross Country's emergency handbook or train operator contingency plan being amended by this time.

Cross Country has reviewed the key findings from this investigation and believe the RAIB report to be lacking in technical information as to the cause of the incident. The report does not fully explain or provide sufficient technical evidence relating to why the presence of foliage in the vicinity of the rear pantograph caused the ADD to operate to lower the pantograph; our understanding is that the ADD only drops the pantograph if the pantograph itself exceeds the maximum or minimum height levels, or if carbons are displaced from the pantograph head.

There is insufficient evidence in the report to allow the reader to understand fully why the OLE tripped again after the train departed Kings Cross given that the rear pantograph was lowered at this point. The reader may assume that the foliage on the rear pantograph came into contact again with the OLE. However, this then makes it unclear as to why the driver was unable to leave the front pantograph raised which led to the complete failure of the train, given that there is no relationship between the front and rear pantographs and their provision of power to their respective portions of

the train. This logic is borne out of the fact that the driver was able to leave Kings Cross in this mode i.e. front pantograph raised and rear pan lowered. The report does not make it clear whether the train was stranded without power due to the OLE remaining isolated or whether it was because both pantographs were lowered. If it was due to the OLE remaining isolated then the report does not investigate fully the reasoning why between the driver , signaller and controls that the OLE was not re-instated for the provision of power to the front set.

The report does not mention at what point the OLE was re energised for the assisting train to enter the section, and it is difficult to understand (and almost frustrating) why the front unit of 1W95 could not take power from the OLE. If the reason for the tripping was the foliage on the rear unit pantograph, what changed to allow the OLE to be reset at some point given that no action was taken to remove the foliage? It is therefore hard to understand why the front unit of 1W95 could not take power from the OLE and have simply assumed the role as the assisting unit.

There is in effect no difference between the front unit being present at the front of the train with the pantograph up, and the assisting unit that eventually arrived. To this end we feel that the RAIB investigation could have examined closely why this was not undertaken or why / if it was not possible to be technically undertaken in a 'cut and run' scenario.

To this end Crosscountry feels that key findings from this investigation may have been overlooked and that a lack of detail makes it difficult for the reader to evaluate whether there were failings in the local management of this specific incident or whether there are lessons to be learnt across the industry.

CrossCountry does not have a co-located control with Network Rail. It was previously co-located with NR LNW(S) zone in Birmingham until 2008 when it was re-established within the Crosscountry headquarters. Given the nature of the CrossCountry geography and the need to communicate with many NR zone controls, there was little perceived advantage over the way in which operational performance was either enhanced or inhibited when comparing the co-location at Birmingham with LNW(S) zone and other zone controls, hence the re location of the CrossCountry control into headquarters.

CrossCountry recognises that different approaches exist in managing incidents with customers on stranded trains. It will review its Emergency Handbook taking cognisance of ATOC / Network Rail Good Practice Guide GPD SP01 'Meeting the needs of passengers when trains are stranded' by December 2012 to consider amongst other things:-

- *The differences between failures of diesel and electric trains and the impact on customers e.g. ambient conditions within the train (XC only operates diesel trains).*
- *The staffing levels on trains, CrossCountry do not operate DOO passenger services (certain trains have lower staff numbers dependant on catering levels).*
- *The demographic of customers travelling and the journeys they make.*
- *The elapsed time prior to evacuating a stranded train (XC currently applies a 2 hour criteria).*

CrossCountry's Control Duty Managers assume the lead role in managing incidents, supported by level on call for Operations, Customer Service and senior duty office on call. This structure has worked well and was subject to review within the Emergency Response Handbook by ORR during 2010 with satisfactory results.

On-site support is always provided when a train becomes stranded, with level 1 on call staff and Technical Service Engineers being despatched to site within 20 minutes of an incident occurring should it be considered to be going to last in excess of 60 minutes. Network Rail and other agency staff will be requested to attend as appropriate. All on board staff are trained in evacuation procedures.

Technical support to crew and on call staff on site is provided by maintenance providers via the CrossCounty Control maintenance controller.

Recognition of the potential for a minor incident to escalate into a major incident is undertaken immediately by issuing a 'Code Red' alert and procedure as defined within the Emergency Handbook unless there is a high degree of confidence that the incident will be resolved within 60 minutes.

The views of passenger interest groups and other agencies will be considered as part of the joint CrossCounty / Network Rail review of the ATOC / Network Rail Good Practice Guide GPD SP01 'Meeting the needs of passengers when trains are stranded' and be completed by Jan 2013

CrossCounty currently uses social networking in its customer relations and public relations activities. It has not as yet had occasion to use it for the purpose of advising customers on a stranded train as information has been available via on board crew.

Arriva Trains Wales

ATW have reviewed our current process to deal with Stranded Trains. Our process shall be enhanced that considers the key learning points listed in the RAIB report 07/2012 and the ATOC Good Practice Guide – Responding to Stranded Trains.

Our plan is to finalise the amended Stranded Trains Procedure at an ATW Internal OPSRAM meeting on 24 September 2012.

We shall brief train crew on the requirements of the ATW Stranded Trains Procedure during a combined Driver and Conductor Safety Training Update Day (STUD). This shall commence on 05 November 2012.

c2c

c2c have reviewed existing company procedures against ATOC GPG SP01 and the 9 bullet points in the recommendation and as a result we have identified the need for new procedures or the revision of existing procedures as listed below:

- *New process for the use of social networks including Twitter and Facebook*
- *Emergency plan to be revised to include more detail on assessment times for all critical on-train equipment, this includes heating/air conditioning.*

These procedures are currently being developed and revised for approval and circulation.

The c2c Service Delivery Centre (SDC) is located at Upminster in shared accommodation with Network Rail (signallers), this enables face to face contact

between the two organisations. This facility has direct communication channels with the Anglia Integrated Control Centre (AICC) for both c2c and Network Rail.

c2c is represented at various industry groups at which subjects including emergency planning are discussed and good practice shared between operators. In addition any good practices identified in investigations etc. including RAIB reports are considered as part of the c2c investigations review process.

The c2c emergency plan provided details of the control and command structures for the different levels of incident including the information channels and the recording critical information and, the Service Contingency Plan (produced in conjunction with Network Rail) also provides details of the different organisations involved in communication in the event of an incident.

The control manual provides details of the support provided to train-crew including assistance from other staff on-board the train (travelling as passengers) and technical help direct from the on call technical engineer. There is also comprehensive guidance on the failure and effects of critical train borne equipment for control staff to refer to and liaise with train crew direct.

Chiltern

Existing ad hoc and official protocols have been reviewed. From this and including the RAIB recommendations, ATOC good practice guide and all other information available at the time a new stranded trains procedure has been developed and issued 27 July 2012.

East Coast

Network Rail has issued a 'National Control Instruction' on Train Evacuation (Instruction 4.5, Issue 2, 2 June 2012). We are led to believe that this has been produced in response to the 1W95 incident. However, East Coast has not been involved in the consultation process for the 'new' Instruction and, on its review, do not consider it to fit well with our rolling stock or indeed our current processes for managing a stranded train in hot or cold weather. As such we are engaging with Network Rail at local (i.e. Route) level to review our current protocols, ensure these remain fit for purpose and take fully into account the contents of GPG SP01. Timescales for review and where necessary production of revised protocols is envisaged to be end November 2012.

East Midlands Trains

EMT Emergency and Security Manager has produced a stranded trains document as guidance for the business.

On 16 November 2012 East Midlands Trains provided further information, below:

East Midlands Trains developed and implemented its Stranded Trains Guidance in July 2012. Rather than being developed as a direct result of the RAIB recommendation, it was developed as a proactive measure to address one of the potential hazards identified during one of the Hazard Identification (HAZID) workshops that we used in preparation for delivering the train service over the Olympic period. We also recognised the importance of providing a consistent and

proportionate response to stranded train incidents based on our awareness of similar incidents across the national network.

The standard was developed using a cross functional group of managers, the Emergency Planning Passenger Information and Contingencies Group (EPPIC) who are responsible managing and developing the standards, guidance and training for EMT emergency response.

In November 2011, EPPIC delivered a live training exercise with a scenario focussing specifically on the humanitarian response to an incident. The exercise gave all response related roles of EMT (Control, Customer Services, Ops, Engineering, Media etc.) the first-hand experience of a stranded train scenario, having to manage distressed members of the public and how quickly an incident in a confined space of a train can escalate. The exercise was delivered with the assistance of the British Transport Police and Network Rail, training over 120 responders.

The feedback from our on call managers who took part in this exercise was used, alongside information gained from other TOCs, to increase the effectiveness of the Stranded Trains Guidance.

EMT is currently reviewing its Stranded Trains Guidance as a direct result of the newly issued ATOC guidance note GN015 and the publication of the RAIB report into the Kentish Town safety incident. The Emergency Planning and Security Manager participated in the publication of the ATOC/GN015 and GPG SP01 through the ORAS: Emergency Planning Group and is already working closely with FCC and network Rail to assist in improving the emergency response to stranded FCC services.

As part of this review we have examined the 9 points in the recommendation of the RAIB report. We believe that we comply with all of the recommendations and go above and beyond them in a number of areas. The following points may be useful to note:

- *The relationship between EMT and Network Rail is very effective. The control teams are co-located within the East Midlands Control Centre. Both organisations work proactively together to plan for forthcoming events that may have detrimental implications to the railway to train/exercise together and to consult and share emergency response documents to ensure both organisations are aware of current practices.*
- *The EMT standards that identify the core elements of emergency response are combined into an operational A5 'My response Handbook' issued to all on call managers. The 'My response Handbook' is created and reviewed by EPPIC, thus keeping the change and development of EMT documents constant. Every on call manager is briefed on the document prior to issue and they take part in an annual training exercise to refresh their knowledge base of existing practices, brief changes and developments allow them to experience situations in a safe environment, and allow for networking between EMT response staff and other stakeholders.*
- *EMT control are issued with a communication matrix of on call managers, prioritised based on the potential incident. This is used in conjunction with*

colour thresholds which act as an immediate guide to identify the severity of the incident to the whole business.

- *EMT work closely with the Local Resilience Forums, British Transport Police and Network Rail for multi-agency event planning, joint emergency response and exercises. EMT are represented in the Rail Personnel Security Group and Community Safety Partnership Groups where key stakeholders including passenger interest groups work together.*
- *EMT proactively used social networking sites to communicate with passengers during the Olympics. On a daily basis, EMT respond to comments received on social networking sites and endeavour to respond in real time with existing resources.*

Greater Anglia

Greater Anglia already have a number of processes in place which are discharged by competent persons to deal with emergency and out of course situation. However to look to further improve those we will review the relevant sections of our SMS related to emergency planning, emergency response and train evacuation arrangements. This will take into account the specific findings of RAIB's investigation into this incident and the updated advice contained within ATOC / Network Rail Good Practice Guide GPG SP01.

The following additional information was provided by Greater Anglia on 22 November 2012

We can confirm that Greater Anglia have reviewed the processes which we have in place and our SMS to take into account the learning points identified from RAIB's investigation in to the incident which occurred near Kentish Town in May 2011. We have also considered the content of the Good Practice Guide referenced in RAIB's report.

Greater Anglia's SMS process for dealing with incidents of this nature are managed through our control manual, on call arrangements, our emergency plan and the way in which we manage interface risk with Network Rail through our AICC.

Eurostar

Work has been conducted between Network Rail and Eurostar associated with the opening of HS1, planning for the Olympic and Paralympic games and as a result of the independent review of train failures within the Channel tunnel in December 2009. This work involved both review of existing process and a series of exercises to prove that the processes developed are effective. As a result there is a close relationship between the two organisations in the planning and implementation of emergency plans associated with train failures.

In response to the particular bullet points

- *The key findings from this investigation.*

The report was studied and reviewed jointly with Network Rail and we are satisfied the circumstances are addressed within the company's protocols.

- *The different arrangements in place for the interface between Network Rail and train operator's control functions.*

Arrangements for communication and interface arrangements between Network Rail and Eurostar controls are established, current and we are satisfied these are adequate.

- *The different approaches to managing incidents and good practice applied in different parts of the main line and other railway networks.*

Eurostar is unique among UK passenger operators in that we operate international passenger services requiring interface arrangements to be in place and effective for our operations in the UK, France, and Belgium and through the Channel Tunnel. As a result of this our approach to managing incidents takes account of French and Belgian practices as well as those within the UK. Additionally there is close liaison with Eurotunnel's Control Centre including direct video links with our Centre Operationalle d'Eurostar (COE) in Lille as well as our Crisis Command centre in the UK. Additional visits have been made to other organisations outside the rail industry to review best practice.

- *The need to identify who will take the lead role in managing the incident and how key decisions will be recorded and shared between the affected organisations.*

We are satisfied that there are adequate decision making and information sharing arrangements in place. In terms of lead role, this would be Network Rail for incidents on the infrastructure.

- *The need to provide on-site support to the train-crew of such trains in managing passenger' needs*

For operations through the Channel Tunnel Eurostar trains carry a minimum of 5 crew, consisting of a driver, 2 train managers and two members of the catering crew who have additional safety and evacuation responsibility in the Channel Tunnel. More generally additional catering crew are available on the train. All of these crew can be co-ordinated by the lead train manager (designated TM1 on the train – the person who undertakes the role of the guard in the UK) to provide information and assistance to passengers on the train. Additionally each train is equipped with an emergency supply of food and water should extended delays be required and protocols exist for opening of doors etc. on Network Rail HS1 Infrastructure to provide additional ventilation should there be a loss of power. In the event of greater assistance being required Network Rail HS1 staff or contractors can be asked to assist, something which was implemented effectively where a detrainment on the line was necessary as a result of a train becoming divided in February 2010.

- *The need to provide technical support to the train crew of stranded trains with a particular focus on means of communication and the need for coordinating the technical and operational response to such incidents.*
- *The need to recognise when minor operational occurrences have the potential to develop into major incidents unless decisions are taken in a timely and decisive manner.*

Eurostar policy dictates that where a technical solution to a failure cannot be reached within 20 minutes the train will be declared a failure and a recovery operation will be implemented. Once this decision has been made resources will continue to mobilise even if the train manages to subsequently restart. Such mobilisation will only cease

when the train arrives at the next suitable location to deal with the incident effectively (generally at destination, or at Ashford or Ebbsfleet stations where transbordement can be effectively managed).

- *The views of passenger interest groups and emergency services*

Emergency services have been involved in joint planning and exercises, with post incident reviews conducted, most recently following a fatality near Folkestone in October 2011. The views of passenger interest groups (specifically London Travel Watch and Passenger Focus) were included in the incident review following the failures in the Channel Tunnel in December 2009.

- *The positive and negative role that can be played by social networking sites in the management of such incidents.*

Eurostar has previously experienced situations where social media have played a significant part in the management of operational incidents, particularly during snowfall incidents and during the Ash Cloud incident where aircraft were grounded in European airspace resulting in a particularly busy period for the company. As a result we have reviewed processes to both use media as a means of communication and to react to social media comment on a real time basis where possible.

First Capital Connect

We have with Network Rail Thameslink Route produced / implemented and briefed out to staff the document TLP/FCC/SE "Core Route Response and Communication Plan. This document outlines the roles / responsibilities, timescales in respect of management of rolling stock incidents through the 'core' section, and how key decisions will be recorded.

We have also revised and re briefed all relevant staff on FCC/SM 7.17 Dealing with Stranded Trains and Controlled evacuation of Passengers. FCC/SM 7.17 Dealing with Stranded Trains and Controlled evacuation of Passengers and TLP/FCC/SE "Core" Route Response and Communication plan both cover the potential of a minor operational incident developing into a major incident. The timescales also incorporated in both the mentioned documents, and also state how to provide support to train crew.

Our Safety Performance Investigation Review meetings (SPIR) are tracked and briefed out to relevant staff (please read in conjunction to recommendation 3)

We have introduced additional phone lines at West Hampstead and East Croydon to enable Control and technical support (fleet) to give timely advice to drivers of stranded trains.

With respect to Passenger focus groups and emergency services, our Managing Director and Executive members attend "Meet the Manager" planned events which enables the customers to inform the managers on good bad and indifferent experiences of travelling with us. On Train and stations "Meet the Manager" sessions from the Managing Director to local level managers, are also undertaken per period and we hold Directors online forums every three months.

We liaise with passenger group forums, such as London Travel Watch and Passenger Focus and have had a number of communications with regards to this event.

Our Customer Relation Department upon receiving passenger complaints and plaudits forward these to the relevant departments for address.

Our Station Managers liaise with local emergency services and other station stakeholders to ensure Emergency arrangements are in place and everyone is aware of them.

We have reviewed the use of social media during disruption to ensure Control Centres are kept advised of safety issues and customer behaviour, and implemented a full time disruption centre in Hertford House to support this

First Great Western

The management of stranded trains within First Great Western is currently mandated by Control Centre Procedure 'Stranded Trains Protocol'. We also have a Safety Management Standard which mandates the management of trains which incidents where on train air-conditioning or ventilation fails. We are currently undergoing a complete review of our Safety Management System in preparation for our application in 2013 for a new Safety Certificate. This standard forms part of that review process.

We have agreed with Network Rail to complete a joint review of our arrangements using the good practice in FCC which followed this incident and also ensuring we meet the requirements of the Rail Good Practice Guide GPD SP01.

In the interim period we have identified that our Senior Controllers did require additional briefing / training on the application of our existing processes in this area. We have completed that briefing/training of these colleagues. We have recently reviewed our Controller Competence System and have taken the opportunity to enhance our requirements to assess competence for the management of stranded trains.

On 10 December 2012 First Great Western confirmed

A review of the arrangements with Network Rail are now complete. We have agreed that we will test our arrangements using a live exercise that we will film and then use for briefing

First ScotRail

First ScotRail has in conjunction with Network Rail fully reviewed our policy document for managing stranded trains and produced a new document entitled;

Meeting the Needs of Passengers When Trains Are Stranded: Guidance for NR and FSR Control Staff.

This document fully enshrines the contents of the ATOC / Network Rail Good Practice Guide GPD SP01 Document.

This document has been published and also briefed to the relevant staff within our Control Office.

We have been provided with a copy of First Capital Connect's actions matrix devised from the various internal enquiries that were undertaken and have reviewed this fully to enable us to identify any actions and the learning points that could possibly apply to our operations.

An action tracker detailing the areas that are applicable to ScotRail has been compiled and will be fully reviewed at a meeting led by my Head of Service Delivery to take place on Wednesday 27th June.

Thereafter we will identify an appropriate Champion and timescale for each action that is applicable to the Company and these will be tracked fully to completion.

Grand Central

Following a level 2 Joint Safety Meeting between Grand Central, Network Rail and First Hull Trains on 16 July 2012, it was agreed that the effectiveness of the emergency plans of both operators would be most suitably tested at a desktop exercise. Network Rail agreed to progress this with their Emergency Planning Department (York). Participation at the exercise will be sought from other train operating companies, and other stakeholders such as passenger groups. It is anticipated to conduct the exercise by the end of December 2012. Any outputs from the exercise will be considered in future updates to Grand Central's plans.

However, it is unlikely that a Grand Central service will be involved in an incident as severe as Dock Junction, owing to the characteristics of the fleets operated. High Speed Trains operated by Grand Central have droplight vestibule windows. In the event of a train being stood for any considerable length of time, the windows can be dropped to enable air into the coaches. Additionally Grand Central Class 43s are all buffer-fitted, allowing easier coupling to a rescue locomotive, in the event of a train failure.

Class 180 Diesel Multiple units have five engines and it is extremely unlikely that all of them will fail. Therefore, air conditioning will be available in at least part of the train. Should a Class 180 be identified as becoming under-powered whilst in service, and there being an evident risk of total failure, arrangements may be made to detrain passengers at the next suitable location, including stations at which Grand Central does not normally call.

Unlike the train involved in the Dock Junction incident, all Grand Central services have a number of on-board staff, in addition to the driver. During disruption, train-crew can proactively monitor on board conditions and passenger welfare, as well as communicating with passengers face to face should the public address system fail. Supplies of emergency drinking water are carried on all services.

Heathrow Express

In the event of a significant incident involving a Heathrow Express operated train service which will result in considerable delay / disruption;
We currently have a comprehensive suite of documented procedures for addressing

- *Communications between our control room (HECR) and Network Rail*
- *Providing support to stranded trains (TOLO's Emergency support teams on both NR and BAA infrastructure)*
- *Customer support / service recovery*
- *Disruption handling*
- *Technical assistance / Movement of defective trains (Cut and Run) as necessary*
- *Detrainment / Evacuation of trains both above ground and within the tunnel environments.*

All documents have been discussed and agreed with Network Rail, a recent review was undertaken earlier this year to assess the suitability of the procedures, however we would as part of our internal review process following any incident discuss the event with Network Rail and would where necessary produce a report (a copy of which would be forwarded onto Network Rail).

In addition Heathrow Express takes part in regular table top exercises with Network Rail and periodically with the emergency services and neighbouring TOC's to communicate our response policies and to assess their suitability / practicality.

However we would welcome any request or opportunity to meet with Network Rail to standardise the response process for stranded trains, particularly in the event of a loss of OHLE supply which will affect Heathrow Express / Heathrow Connect services acutely and we will progress this issue appropriately.

The following additional information was provided by Heathrow Express on 14 November 2012.

We have reviewed our current suite of operating procedures and support documents and believe that we have a robust and practical strategy for dealing with defective/stranded trains. Heathrow Express operates over a relatively short section of railway which fortunately allows for a high degree of operational flexibility with bi-directional/reversible sections and numerous crossovers and stations. We have a comprehensive suite of operating and contingency procedures which address the impact of disrupted degraded and emergency working and promote the welfare and safety of our customers.

Recently we have been in communication with Network Rail concerning the development of a coherent procedure concerning the response to stranded trains on the region and in particular the impact of the loss of OHLE supply will have on our services. In addition we have now developed a comprehensive competence management system for our train drivers, on board staff and control room operators which recognise the importance of maintaining communication with customers during delays and disruption and ensuring vulnerable /special needs customers are recognised and their needs prioritised. In addition we are actively progressing the use of social networking/communication strategies to assist in ensuring that our customers are aware of what is taking place and that the incident is being managed.

We have also considered the ATOC good practice guide (GPG SP01) and below we detail our response to the criteria/issues raised for consideration.

1: Journey Duration

With the typical journey time between London Paddington and Heathrow being 13-15 minutes unless environmental conditions required a more urgent response, as a rule we would seek to initiate the detrainment of customers after no more than 60 minutes, we have reaffirmed this with Network Rail during the review of their stranded train policy proposal. As to the number of trains likely to be involved, current timetabling and availability of stations and OHLE sectioning suggest that the most adverse effects of either damaged equipment or a defective train will be limited to one service train as we will have the ability to divert / re-route or de train at a station any other trains in service.

2: Type of passenger (Customer involved)

We recognise that the typical Heathrow Express customer is likely to be very time conscious and our service recovery strategy reflects the likelihood of customers being anxious or concerned considerably earlier than some other rail customers. We are currently developing and enhancing our communication policies to include the use of social media and website updates. We also ensure that our on board staff are able to receive advice / information concerning the incident from the driver and via our control room in order that we can keep the customers advised of the on-going delay and the progression of any incident response strategy.

3: Staffing of trains

Currently all Heathrow Express (including the suburban Heathrow Connect) train services are staffed by a driver and at least one member of on train staff per unit (as our class 332's do not have end vestibule doors allowing transfer between units when class 332s work in multiple there will be at least one member of on train staff provided per unit). All on board staff are trained in managing customer's expectations and identifying those with special requirements/needs and ensuring that all practical and reasonable precautions are taken to ensure customer comfort and safety in the event of a prolonged delay. All train drivers and on board staff are also trained in detrainment and evacuation procedures and this competence has been recognised and prioritised by the relevant competence management systems. All our customer facing staff are trained in conflict avoidance and in the unfortunate event of a colleague suffering verbal / physical abuse we have a comprehensive support process and we are able to call on BTP resources at both Paddington and at the airport.

4. Train types/On board systems

Heathrow Express services are provided by the Siemens / Cakk class 332 electric multiple units. Trains maintain their internal environmental conditions via an AC fed HVAC system which actively regulates local vehicle temperature/humidity to ensure customer comfort (we accept however that the HVAC system is only available whilst the train is drawing current from the OHLE system and as such will prioritise the recovery / detrainment of any train which for any reason is not capable or able to maintain it's traction current supply).

In addition the trains are equipped with both visual and audible customer information systems and a CET type toilet which is configured for disabled access. If needed trains carry emergency First Aid kits and equipment to facilitate an evacuation. On board staff receive training in recognising and assisting customers with special needs and are trained in first aid (Lifesaving skills). All trains also currently carry a mobile phone which would be available to a customer should they need to convey a message to another party.

Heathrow Connect services are provided by The Siemens 360/2 Desiro Electric Multiple Units which for the purpose of this document are virtually identical in equipment provision.

5. Degrades Working (Trains)

In the event of a loss of the OHLE supply the trains HVAC system will cease to function and the auxiliary loads will initially be supported by the train's 110V DC battery supplies, the train will sequentially shut down systems using a risk based formula eventually leaving emergency lighting / PA / Comms systems only. Train drivers are trained on managing train failures and how to prolong on train systems

where necessary (e.g. by shutting down the lighting in certain vehicles and transferring customers to adjoining vehicles in order to prolong the battery life of the train).

6. Availability of assisting locomotives/trains

At present Heathrow Express is the only operator of AC type electric trains on the Western Region and as such there are a number of compatibility issues between our rolling stock and other vehicle types operating alongside our services. Currently Class 332s carry a Schaffenberg to draw hook emergency adaptor coupling, a similar Deliner adaptor for the class 360 is also available from the train care facility at Old Oak Common. However, historically we have never used the couplers as we have always recovered any failure with one of our own trains as it has been the most practical and expeditious solution.

First Hull Trains

We have carried out a review of our plans and are working with Network Rail and other TOCs, to hold a joint table top exercise to test these. The date of the exercise has not been confirmed yet.

The Kentish Town scenario for First Hull Trains, is extremely unlikely due to the Class 180 trains having 5 diesel engines, the probability of more than 2 failing at any one time is reasonably low, therefore some cooling would be available. During periods of hot weather we also consider removing trains from service, if air conditioning problems are causing significant discomfort. Stocks of water are also carried and the trains have at least 3 crew on board, plus the driver to communicate with passengers. As a final mitigation we also carry door guards which could be deployed if required and staff have been trained in their use.

First Hull Trains provided the additional information below on 12 November 2013

To reiterate we believe that the complete failure of a train, during very hot conditions as experienced by FCC is remote, however discussions are still on-going with Network Rail and other TOCs regarding holding a table top exercise based loosely around this scenario. Given the busy calendar of their Emergency Planning person, it is proving difficult either to meet either to meet for a sufficient time to plan an exercise, and then diary an exercise. However, this remains an aspiration on our part and also of a similar interfacing TOC and remains on the agenda for our Joint Safety Improvement Plan Meetings with Network Rail.

London Midland

London Midland have reviewed National Control Instruction NR/L3/OCS/043/4.6 which our Control work to, along with our Network Rail Co-located Control colleagues, and believe the contents provide sufficient framework, and guidance, for our Controllers to effectively manage an evacuation incident.

Both Controls work to this instruction and London Midland believe this provides a joint approach to management, understanding and recording of the incident. We believe this was proven during the evacuation of a London Midland train, after a de-wirement, at Rickerscote during autumn 2011.

London Midland Control also use Standard OPS-005 'Management of Disabled or Stranded Trains when Air-Conditioning Systems Fail to Operate.' Section 8, dealing with Train Evacuation.

Train evacuation is also underpinned by Train Crews Competency Assessment, including reference to GE/RT8000/M1/6 'Evacuating a train.'

As a result of the Dock Junction incident, London Midland's Control Manager is currently re-briefing all Control staff on the above documents as part of their quarterly safety brief.

London Midland's Emergency Plan OCC-510, identifies when an incident has escalated from minor to major, and the necessity to send a Train Operations Liaison Officer (TOLO) to site and, where necessary, a Fleet Incident Manager to provide technical expertise.

In addition London Midland's TOLOs have received a briefing, as part of their recent re-assessment cycle, on the need to immediately request further assistance to site should a train evacuation be necessary.

London Midland agree with the recommendation regarding the use of social media and it is now an integral part of our process during any incident.

On 16 November 2012 London Midland confirmed it had considered ATOC/Network Rail Good Practice Guide SP01 and the nine points listed in the RAIB recommendation.

London Overground Rail Operations Ltd

The risks associated with stranded trains have always been recognised by LOROL as a key area of risk for the company. This reflects the 'metro' nature of LOROL's operations and the recognition that passenger's will start to de train themselves in an uncontrolled way much sooner on LOROL's network than on an intercity service for example. In April 2011 LOROL's Head of Safety Quality and Environment chaired a risk workshop for a Stranded Trains Working Group which was set up to review current arrangements and identify ways of improving LOROL's response to stranded trains. The group had cross departmental and senior representation, including LOROL's Managing Director. As a result of this workshop and a number of follow up meetings a series of actions were identified and an action plan implemented.

Many of the actions have addressed issues raised by the RAIB report. They include:

- *Agreement of an improved joint response protocol with Network Rail which includes a phone conference no later than 15 minutes after the train becomes stranded and a clear understanding of who takes the lead in managing the incident;*
- *Improved briefing to train crews of evacuation arrangements and the importance of providing Control with key information when a train becomes stranded (e.g. passenger numbers, vulnerable passengers, additional assistance on board the train).*
- *Production of a stranded trains plan for control which provides prompts and encourages a prompt and effective response to a stranded train*

- *Improved arrangements for arranging on-site technical support to train crew although LOROL already has robust arrangements in place to provide support by phone.*
- *Development and implementation of training to managers and supervisors in personal track safety and stranded trains to provide improved support on site for stranded trains.*
- *Provision of supplies of water and thermal blankets at key locations for passengers on stranded trains.*
- *Production of a stranded trains manual that includes good practice from the ACOP Good practice Guide. The manual is currently in the consultation period and when approved will be issued to all staff who have a role to play in dealing with stranded trains.*

Whilst we believe that we have already adopted good practice and the key findings of the RAIB report it will be formally reviewed by LOROL's Standards Review Group at the September meeting and will be formally reviewed jointly with network Rail at the next Strategic Safety Meeting after the Olympics and Paralympics. The meeting with Network Rail will focus particularly on ensuring that our plans and protocols meet the needs of the emergency services. In addition LOROL's Passenger Board's meeting in October will include a presentation to passenger interest groups on the Board on our arrangements for dealing with stranded trains so that we can get feedback from them.

Merseyrail

We have been in contact with Network Rail locally, who advise that this recommendation was accepted by the National Recommendations Review Panel on 24 June 2013.

The recommendation must now go to the Network Rail Safety & Sustainability (S&SD) for approval prior to any Network Rail, the next S&SD meeting is taking place on 3 September 2012.

We have agreed in principle with Network Rail that any protocols agreed will be tested in a joint table top later in the year. We will keep you updated on progress made against this recommendation as and when Network Rail contact me regarding closing out this recommendation.

Merseyrail confirmed on 1 November 2013 that the desk top exercise with Network Rail was due to take place in December 2012.

Northern Rail

Northern already have in place a specific guidance document describing the requirements for stranded trains and dealing with passengers on stranded trains and this was briefed to our Operations Control team in 2011 and refreshed earlier in 2012. This document is being reviewed by the working group and will be re-issued and briefed upon completion. This review will take into account the recently published Network Rail document NL_L3_OCS_043 National Control Instructions – Train Evacuation, June 2012. This review will be completed by end of September 2012.

Northern are working with Network Rail and other Train Operators in the attempt to gain a national agreement for specific evacuation ramps to be placed within Network Rail on-call vehicles to assist with that process. We aim to have these in place by the end of the year.

Integrated Control centres at York and Manchester already assist with key interfacing between ourselves, Network Rail and other TOCs, and decisions made during incidents of this type and this work will continue to evolve and improve.

The Northern internal Train Operators Liaison Officer (TOLO) course is being reviewed to ensure that lines of responsibilities are highlighted. The command & control structure for Network Rail and the emergency services are already detailed within the training course and we have planned to put all Duty Control Managers through the TOLO course by the end of 2012.

Northern's on-call structure allows for the support of train-crew and other front line staff through a network of bronze on-call managers competent to assist in all incidents. Bronze on call managers are usually mobilised to site as soon as the need for this becomes apparent. We also have an area silver on-call to assist with managing the more serious incidents and disruption. Duty Control Managers work off an on-call matrix within the control manual that describes who needs to be informed of various incidents and stranded trains over a specific timescale. Current documentation also states that no decisions are to be made during evacuation of stranded trains without authorisation from Northern Control and Network Rail.

Northern have a bronze and silver level engineering on-call structure that would assist in all incidents of this type when required, with bronze level resources being mobilised to site and silver level generally providing support, but attending site in the event of a serious incident.

Northern has already recognised the potential value of social media and has already established a project team who are driving forward the following changes in our business:

- *Establishing a dedicated Twitter service disruption account to enable us to respond efficiently and effectively to customer queries during times of disruption*
- *Setting up a Northern Facebook page to improve our media coverage and to highlight positive service messages as well as respond to queries during disruption.*
- *Developing more proactive use of social media to highlight routes with good service.*

Funding has been agreed for establishing and staffing these services, which are hoped to be up and running by the end of October 2012.

South West Trains

Following the incident on 9 June 2011, when an attempted cable theft at Sturt Lane sub-station (near Farnborough) caused serious disruption resulting in a significant number of trapped trains on the approaches to Woking, both SSWT and Network Rail commissioned an independent review into the management of that incident and already taken considerable steps to introduce measures to avoid a repeat. This has included:

- *Being directly involved in the working group that reviewed existing ATOC good practice and guidance notes culminating in the publication of the new Good Practice Guide SP01 – Meeting the Needs of Passengers when Trains are Stranded, and applying the processes therein through our Wessex Integrated Control Centre operational procedures - this has included prioritising responses to trapped or stranded trains based on feedback provided by the train-crew on a) passenger profiles and b) on board conditions.*
- *Undertaking a complete review of the command and control structure for the Wessex Route to ensure that the wider picture of incidents is always captured and managed accordingly.*
- *Proactively applying the requirement for signallers to ensure that whenever practicable, trains are held in or moved into station platforms where potential for substantial delays has been identified.*
- *Immediately identifying trains that are either trapped or stranded, and ensuring that personal contact is made by managers with the train-crew in order for on board conditions to be constantly monitored for the duration of the incident.*
- *Deploying train crew management to trains that are stranded in order to provide practical support to the train crew, including the appointment of an operations manager to undertake the role of Train Operator Liaison Officer (TOLO) in accordance with the circumstances.*
- *Identifying, in order of preference, the most appropriate means of evacuating passengers from trapped or stranded trains with the first preference being end to end transfer using a rescue train.*

SSWT already has a well-established process for train drivers to obtain appropriate technical support and advice. This process, known as 'Phone a friend', is applied on a regular basis and includes the 'Cut and Run' policy by which drivers are advised to take a defective train out of service at the earliest opportunity rather than risk the potential for being trapped or stranded through subsequent failure and the 'knock on' effect on following train services.

In addition SSWT have also procured ten train to train bridging ramps (as used by FCC AND Southern) to be provided at strategic locations for deployment by the management response team on rescue teams where a side to side evacuation has been identified as the most viable option. These ramps are currently undergoing a modification for them to be used with the Class 158/159 diesel multiple fleet and will be in full use by the end of September 2012.

Southeastern

Southeastern in conjunction with Network Rail issued a Stranded Train Brief and Protocol in October 2011. This document is supported with various procedures which specify the arrangements to manage trains; these include the Southeastern Service Disruption Procedure, a joint booklet (NRHS and Southeastern) specifically about 'Managing a Train Failure in Long Tunnels' and the Southeastern Controlled Evacuation of Passenger Trains procedure.

Following a review of the RAIB report, Southeastern decided to carry out an internal review of all our procedures, documents, instructions and guidance relating to

management of stranded trains. The review identified that, although we had guidance in place and this followed ATOC and Network Rail good practice, some publications were wordy and could be confusing to follow. The conclusion of the review was that a more collaborative approach was required.

We have agreed that following the Olympic and Paralympic Games period, a joint workshop with NR and NR High Speed will take place. This will identify all procedures, documents, work instructions, ATOC guidance, investigation findings and Railway Group Standards that relate to the management of stranded trains and carry out a gap analysis against our current arrangements. This will ensure that the different approaches to managing stranded trains have been identified and that there are supporting documents to put this into practice. The first workshop is scheduled for October 2012.

Southern

Following our own incident in 2011, when trains became stranded on the evening of the Epsom Derby day, we conducted a joint review of our management of stranded trains. This review involved our partners in Network Rail, British Transport Police and other 'blue light' services and looked to ensure, so far as we were able to address very similar issues that had arisen or may arise from such an incident.

This review resulted in a guidance document being produced that was ratified in 2011 by our Environment, Safety, Security Board and this is held in our joint Southern, Network Rail control room.

This work was formally shared with our ORR inspector in 2011 to help ensure that we were providing suitable and sufficient measures.

The industry guidance that existed was used to inform the process and on production of the Dock Junction report we have revisited our work in this area.

In addition to the pre-Olympic planning and preparations, this year has resulted in some further developments of our processes in respect of stranded trains and these have been reviewed independently and we have been given positive feedback. Network rail has been an active partner in all aspects of this approach on the Sussex Route.

First Transpennine Express (FTPE)

FTPE have produced an action tracker that is considering all the recommendations in the report. All recommendations relevant to FTPE and all those not considered directly applicable have been documented and recorded with action or consideration required, who is responsible and timescales for completion. The action tracker is monitored at the FTPE Health and Safety Management Group meeting which is attended by the Managing Director and other members of the Executive Team, this meeting is held every four weeks. This tracker is available to view should that request be made by you or other applicable regulatory functions.

Processes relating to Incident Management in FTPE have been reviewed against the following publications:

- *ATOC ACOP 015 Passenger Information During Disruption (PIDD).*

- *ATOC/Network Rail Good Practice Guide GPG SP01 'Meeting the needs of passengers when trains are stranded'.*
- *National Control Instruction 4.6 issued on 2 June 2012.*

However in particular:

- *OM 5.5 On-Call Arrangement – has been completely re-written in line with ATOC ACOP 015 PIDD REQUIREMENTS TO PROVIDE FOCUS IN FTPE Control on who they should communicate with during incidents. The matrix of events was split into Operations and Retail and ordered from serious incidents to those of less importance. With this it emphasises to those within the on call structure who they should contact.*
- *Yellow 08 – the Management of Train Fires and Failures including 'Cut AND Run' policy has been amended. The last review was completed against the ATOC / Network Rail Good practice Guide GPG SP01 'meeting the needs of passengers when trains are stranded' and the stranded trains document and applies to large Network Rail incidents as well. The emphasis within the control is deal with stranded trains and its customers first over all others.*
- *FTPE is also reviewing the Network Rail Control Instruction 4.6 issued on 2 June 2012 to ensure the interworking requirements contained within are reflected in our processes and will be used to construct scenarios during our stranded train exercises.*

The FTPE emergency procedures are currently being reviewed against these new standards and will consider the results of a number of train stranded/evacuation desk top exercises planned to take place by October 2012.

Disruption Management Process and Strategic Leadership – FTPE has documented the Command structure within EM 002 Processes and Emergency Weather Action Team (EWAT) as defined in OM5.5A.

A training and Development plan has been introduced in FTPE Control which enables familiarity with other functions in order to assist in emergency situations.

Engagement with Network Rail re: Incidents – The FTPE Service Delivery Manager has an objective to develop improved communications with Network rail Operations Managers. This process commenced on 19 July 2012, communication is a critical element of this project.

Train crew have been briefed on the requirement to ensure customers are regularly updated with information during disruption or incidents (in accordance with PIDD requirements), this is also monitored via management tours and service quality checks.

FTPE are actively seeking examples of best practice in relation to the management of disruption.

Social Media – FTPE have a dedicated resource which is currently developing the use of social media networks and this will be considered as part of the above desk top exercises.

FTPE were required to evacuate a train during 2011 at Conisborough, although this evacuation went exactly as planned FTPE reviewed the incident to establish if there were any further learning points.

Virgin Trains

Virgin trains undertake to carry out the following actions to address the content of the recommendation.

a) Review of the existing Virgin Trains Managing Service Disruption Policy

Virgin Trains currently has a policy document on managing service disruption, which has been developed to mirror the principles of the ATOC/Network Rail Good Practice Guide, and contains detailed instructions for Control Staff and other On Call Personnel on the actions to be taken in relation to stranded trains

A review process, led by Virgin Trains Control Operations Manager and involving Network Rail LNW, will take place to ensure that any lessons learned from the RAIB report are incorporated into an updated version of this policy.

Lead Manager: Virgin Trains Control Operations Manager.

Target for completion 31 August 2012.

b) Re-issue of Virgin Trains on board Evacuation policy

Virgin Trains currently has a policy document on actions to be taken in order to evacuate a stranded train. The content of this policy has been revised, in view of observations contained in the RAIB report, to clearly document the criteria to be considered and the process to be adopted when deciding whether to enable train to train transfer of passengers from a stranded train utilising on board ramps.

A revised version of the On Board Evacuation Policy will be briefed and distributed to all relevant staff who may be involved in the decision making processes or the practical application of carrying out a train to train evacuation of passengers utilising the on board ramps.

Recommendation 3

Network Rail

A review of the Performance Manual for reference to safety information has been undertaken and changes are proposed to capture safety reporting requirements.

Section 6 of Performance Manual is to be amended and re-issued to require safety lessons from Significant Performance Incident Reviews to be reported to the Safety Reporting team.

A communications brief will be undertaken to inform relevant personnel of the update.

The Safety Reporting team will input safety lessons into the Safety Information Management System (SMIS) against the incident.

As regards the means of advising other railway operators of safety lessons that may be relevant, this is currently via SMIS and it is not considered that any changes are therefore required.

Monitoring the closure of safety lessons will be the same as for any other incident in SMIS.

Network Rail (High Speed)

Safety related lessons learnt during Significant Performance Incident Reviews (SPIRs) and other incident review processes to be effectively tracked, implemented and shared with other railway operators as appropriate.

A SPIR, chaired by ourselves will be held following a significant incident. Appropriate train operators' representatives will be invited to attend same. A documented record is kept of each SPIR together with agreed actions. A tracking spread sheet is maintained of all actions which are monitored through to completion.

Cross Country

Cross Country has reviewed and amended its significant Performance Incident reviews (SPIR) process undertaken by the Performance team within the company. Upon completion and review of XC led SPIRs safety related issues identified will be further reviewed by the Safety team and input into SMIS where relevant to other industry members. Network Rail will be invited to attend any XC led internal SPIRs. The 8 weekly level 2 operational safety meetings between XC and Network Rail will review any XC generated SPIRs and record committed actions by Network Rail. Safety related aspect of SPIRs will be reviewed at the 4 weekly XC safety security and environmental group meeting chaired by the XC MD.

Arriva Trains Wales

Our functions are expected to contribute to identifying and delivering improvement actions through the Significant Performance Incident Reviews (SPIR) process. These actions will be recorded within the SPIR Action Tracker, which is reviewed on a monthly basis at Performance Improvement Group.

SPIR purpose is: -

- *Identify the root cause and contributing factors*
- *Improvement plans to prevent or reduce occurrence*
- *Improve the customer impact*
- *Reduce the cost to the business*
- *Ensure the management of disruption is most effective*
- *Lessons learnt are communicated across the industry*
- *Prevent recurrence of safety related issues.*

c2c

Lessons learnt from Significant Performance Incident Reviews and other incident review processes are discussed and recorded at the Joint Performance Review (JPR) attended by c2c representatives and the Network Rail Anglia Performance Manager. Safety lessons to be shared are recorded and circulated by Network Rail.

On 14 November 2012 c2c confirmed it had established a working group that has been reviewing and updating its existing standards/processes as a result of the incident.

Chiltern

All recommendations are tracked via performance or safety related meetings dependent upon the recommendation. These recommendations are input into an action tracker for the meeting until the recommendation has been concluded.

East Coast

East Coast in conjunction with Network Rail has undertaken a review of our current processes for undertaking SPIRs. From which we have decided that the current process needs amending to ensure that there is appropriate representation (from East Coast Safety Department) at SPIRs which involve, or might involve, safety-related issues. The role of the safety representative (which normally will be East Coast's Emergency Planning Manager) will be to ensure safety 'lessons learnt' are identified and actions taken as appropriate (including tracking these to closure and advising other railway operators as appropriate).

East Midlands Trains

SPIR are not there to look at safety incidents. In the event this becomes a safety incident (i.e. unauthorized detrain or incorrect isolation of safety system) then a safety investigation should be triggered. The SPIR should not track any safety recommendations, only performance improvement issues.

Additional information below was provided by EMT on 16 November 2012

Any safety incident identified through a SPIR will be passed on to the relevant safety team. The normal process for sharing and tracking safety issues between train operators is through NIRs for fleet issues and the Rail Notices website (NIR 3350) for all other information. Adding a tracking layer in the SPIR process creates duplication and unnecessary risk.

EMT constantly tracks and reviews its safety processes. A new process has been developed via document control to ensure that we capture any external recommendations which are issued and decide as a business if they are applicable

to us; we then ensure the applicable function is aware and track the progress they make in implementing the recommendations.

Greater Anglia

Greater Anglia already undertake joint SPIRs with Network Rail following every major incident. The SPIRs are recorded using a template document which includes prompts to instigate information being passed to other train operators or other areas of Network Rail where relevant. Greater Anglia already have a process in place for monitoring actions identified from SPIRs which includes any joint actions with Network Rail. This process ensures that progress against any identified action is monitored to completion or implementation.

This process is further strengthened by the fact that Greater Anglia and Network Rail staff work alongside each other in the fully integrated control centre.

Eurostar

Where a review is undertaken it is agreed that resulting recommendations will be categorised as to their importance, Eurostar will implement this recommendation and will actively track recommendations by 30 November 2012.

Two other actions were agreed to improve incident management – 1) Eurostar will provide controlled issue copies of key contingency management documentation to Network Rail HS1 by 30 September 2012 and 2) An invitation will be made to Network Rail HS1 for incident response staff (in particular Mobile Operations Managers) to visit Eurostar control for familiarisation purposes. This invite will be formally extended by 31 October 2012 and visits will be arranged after this date.

Further information (below) was provided by Eurostar on 15 November 2013

Where significant incidents result in the publication of formal investigation reports these are reported via the Safety Management Information System (SMIS) administered by RSSB and used by all operators within the UK. Additionally Eurostar complies with the requirements of Railway Group Standards GO/RT3350 'Communication of Urgent Operating Advice' and with Railway Group Standard GE/RT8250 'Reporting High Risk Defects' relating to engineering defects on rail vehicles.

First Capital Connect

We have undertaken a thorough review into how we undertake Significant *Performance Incident Reviews (SPIRs) with a primary focus on how these are tracked and recommendations followed up to closure. This includes implementing an expanded process on closure. All recommendations are now subject to audit to assure the recommendations address the original issue.*

All outputs from the SPIR's are reviewed in the Performance Steering Group which has direct governance to the Business Executive through sponsorship from Director level.

All SPIR's now have a Safety Lessons section with any Safety lessons learnt in the SPIR's circulated and shared with all other relevant railway operators as identified during the SPIR.

In summary we have reviewed the recommendations issues and acted upon them alongside the recommendations that we made well in advance of the report's publication as detailed in the RAIB .These actions should be taken into consideration when reading the response to the RAIB recommendations.

We feel that other events with similar precursor's that we have had since the event have been identified, acted upon and suitably managed, testament to the organisation's learning from this event.

First Great Western

Currently Significant Performance Incident Reviews (SPIR) are held jointly with Network Rail when there is a performance incident which exceeds 1000 minute delay. These are completed to a Network Rail National template. We also undertake internal reviews on incidents which are lower than this threshold, dependent upon their significance.

For issues which may be safety related that are identified within these SPIR reviews there is a tracking system in place for their allocation and completion. We are reviewing our systems to ensure there is clear link with the safety investigation.

For a significant safety related issue we either undertake a joint investigation with Network Rail or an internal investigation. These incidents investigations begin with a 72 hour review process.

All recommendations are tracked through to conclusion using our internal tracking system. Within First Group we have mechanisms for sharing good practice and safety lessons. We also use the SMIS system to record our actions and Rail Notices website for sending and receiving of urgent operating advice. On a wider basis we are members of several ATOC forum including Operations Council and Safety Forum where sharing lessons learnt are a core part of the Agenda.

I understand that Network Rail have recently agreed a national position on these recommendations which we will be working with our Lead Route Safety Improvement to implement.

First ScotRail

My Head of Service Delivery represents the Company in Joint Significant Performance Reviews (SPIR) which are led by Network Rail.

The outcomes of any SPIR will be tracked through to completion by my Head of Service Delivery.

It is our intention that any SPIR outputs which may include transferrable lessons will be advised to our Emergency Planning Manager who will include advising other train operators at the ATOC Operational Resilience forum which he attends.

Grand Central

Grand Central regularly attends OPSRAM meetings chaired by Network Rail. Significant safety incidents and the lessons learned from the investigations of them are discussed between Network Rail and other train operating companies who attend. Outstanding investigations are tracked at OPSRAM meetings. Grand Central

also attends REEPAC meetings, led by Network Rail, at which safety lessons are also discussed.

Heathrow Express

Heathrow Express would have no issues with sharing any relevant SPIR's with both Network Rail and / or any other TOC's operating on the route (Essentially First Group, as our operation is relatively small and we share the route with only one principal operator).

Currently we operate our Heathrow Connect service in partnership with First Great Western so all significant operational events are shared with First Group safety section at Swindon.

Heathrow Express also attends the 8 weekly OPSRAM meetings during which we supply a copy of our safety related / operational incidents for the previous period for discussion, any significant event (Such as a detrainment) would be highlighted to the group and we would detail the event and any lessons we had learned.

However I would stress that we would need a set of defined criteria identifying which SPIR's are to be discussed outside the business and how the data should be provided / collated

First Hull Trains

Safety related lessons are discussed at 2 forums in our Network Rail Zone, at OPSRAM, for the operational side and the Network Rail led REEPAC for the response side. Additionally, we receive copies of documentation from ATOC Emergency Planning Group and First Group internal meetings. First Hull Trains endeavours to attend all of these meetings. RAIB reports published each period are also reviewed at Board Meetings if actions are required for TOCs or could be applied by First Hull Trains.

First Hull Trains provided the additional information below on 12 November 2013.

In addition to safety lessons from SPIR, which are focused on one event, the other meetings we attend also provide useful lessons from events which we are not involved in. These are used to review our processes and share our experiences with interfacing companies. We also hold internal structured debriefing sessions following significant events and review our processes against all information sources which may cause us to review our emergency arrangements. In the specific case of Dock Junction, we believe that our arrangements would have been robust and no changes were required to our plans.

London Midland

London Midland agree with this recommendation and will adopt our internal processes to share any lessons that may be relevant to other railway operators.

The additional information below was provided on 16 November 2012.

In addition to the joint TOC/Network Rail SPIR process London Midland carry out an internal CIPI (Customer Impact Performance Investigations) (Appendix N of our

performance Management Process) whereby we review any incident that results in significant delay (500 minutes or more).

The CIPI Panel involves all parties (Train crew, Control, Fleet etc.). The result of any CIPI must be signed off at Director Level and lessons learned shared at our Internal Performance Exec (IPEX). All functions are represented at IPEX and any best practice, or necessary review of our standards and processes, is identified and the best placed function will then complete any resultant actions.

Any actions are then shared with our Recommendations Review Group who review lessons learned from investigations into accidents and incidents, audit findings and other sources. These may come from London Midland, other Railway Group members, ORR, RAIB and other industry bodies. Actions are agreed and tracked to conclusion. Covered by Standard LM-OCC-104.

London Overground Rail Operations Ltd

LOROL has a robust process in place for undertaking Significant Performance INCIDENT Reviews (SPIRs) with Network Rail and any other affected parties. Any lessons learned and actions required are monitored through a network Rail action tracker to which LOROL has full access. If a particular SPIR identifies an issue that needs to be shared with other railway operators then an action would be generated on the tracker and would be monitored accordingly.

Merseyrail

Merseyrail's current investigation process for significant incident reviews is as follows.

Where there has been more than 30 Public Performance Measure (PPM) failures, Merseyrail undertake a local review of the incident and may well hold a joint review with Network Rail depending on the incident. Merseyrail will now record any safety lessons learnt from significant performance incidents into SMIS.

The additional information below was provided by Merseyrail on 1 November 2012.

In addition to the information provided to you on 19 July 2012, Merseyrail now have additional arrangements in place.

For an incident not involving Network Rail i.e. a failed train, Merseyrail will undertake an internal investigation, part of that investigation will involve an in depth review of our Managing Service Disruption procedure. Any recommendations will be endorsed and tracked through to completion via our Train Service Delivery Working Group which is held every 4 weeks. Merseyrail will record into SMIS any safety lessons that may be relevant to other operators.

Northern Rail

Northern have already agreed internally to include safety related incidents within Significant Performance Incident Reviews (SPIR's). Northern's current SPIR template will be amended and a specific safety related representative will attend any relevant SPIR in future meetings. This process is still to be concluded and will be finalised before the end of September 2012. This process will include liaison and sharing of good practice with other Train Operators and Network Rail.

Northern have contacted Network Rail to recommend including any future works within REPACC meetings and/or ATOC Operations Resilience & Security Forum (EPG).

Southeastern

The Kent Integrated Control Centre issues a daily log which is reviewed for both performance and safety related events. The Safety and Environment team co-ordinate the investigation and reporting to SMIS/ORR/RAIB of all safety related events, with investigations generally conducted by line managers.

Although this has generally operated well on an informal basis in the past, we will now establish formal arrangements whereby any safety lessons and/or recommendations arising from Significant Performance Incident Reviews (SPIR) are passed to the Company Standards and Recommendations Review Group who will formally review and track them to conclusion. These arrangements will be implemented by the end of the year. We routinely share lessons of this nature with colleagues in Govia and other TOCs either through industry meetings or through the Rail Notices System.

Southern

Any safety lessons learned from Significant Performance Incident Reviews are assigned ownership by the chair of the process and managed through to an agreed completion by that process. This is a well-established process that has been consistently conducted with Route and Industry partners.

There is a developing Joint Safety Improvement Plan for the route that is a shared process by all the operators and Network Rail and this informs both the Level 1 and Level 2 meetings that both review safety performance and management of matters arising from incidents and safety related developments.

Significantly we also have the joint Route Control where Network Rail, FCC and Southern are able to coordinate responses and share the learning.

Within our Group structure we operate a Rail Executive Safety Group that meets quarterly to review safety issues and lessons learnt and this is supported by the three Group TOCs meeting every period for a formal 'Better Together' safety meeting headed by 'Heads of'.

From this group we also have attendance by representatives at the ATOC Safety Forum where there is an opportunity to share and discuss lessons learnt from incidents and safety reports.

In our view this shows that the management and review of processes are taken and monitored appropriately and that sharing is established at a number of points in the Route and then wider within the industry.

First Transpennine Express

- *FTPE attend all of the relevant OPSRAM meetings applicable to the routes we operate over.*
- *FTPE attend First Group Operation focus groups.*
- *FTPE attend and on occasion host Level 2 safety meetings with Network Rail.*

- *FTPE have produced in conjunction with Network Rail a Joint Safety Improvement Plan (JSIP) and it is intended to ensure that the recommendations of this report are reviewed as part of that process. The next meeting scheduled for 6 September 2012.*
- *The FTPE control room function is located in Manchester's Square One building and is located only a number of metres from the Network Rail control as such many of the requirements of this report are enabled from this close proximity*.

Virgin Trains

Virgin trains undertake to carry out the following actions to address the content of the recommendation

Tracking Process for Significant Performance Incident Reviews

Virgin Trains will implement a tracking process to record recommendations made at Significant Performance Incident Reviews. The detail of these recommendations and progress on actions associated with them will be reviewed on a monthly basis at Virgin Trains Safety Council to ensure these are concluded appropriately.

Safety Council will be the decision making forum for identifying which safety lessons require to be shared with other operators as applicable, using industry forums such as OPSRAM for sharing the lessons learnt.

Lead Manager: Virgin Trains Senior Performance Manager.

Target for completion: 31 August 2012