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22 March 2018

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

Dear Andrew,

Near miss between a train and a track worker at Shawford, 24 June 2016

I write to report[1] on the consideration given and action taken in respect of the three recommendations addressed to ORR in the above report, published on 23 March 2017.

The annex to this letter provides details in respect of each recommendation. The status of all three recommendations is **'insufficient response'.**

ORR will advise RAIB when further information is available regarding actions being taken to address these recommendations.

We will publish this response on the ORR website on 22 March 2018.

Yours sincerely,

Oliver Stewart

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

Initial consideration by ORR

1. All 3 recommendations were addressed to ORR when the report was published on 23 March 2017.

2. After considering the recommendations ORR passed all 3 recommendations to Network Rail asking them to consider and where appropriate act upon them and advise ORR of its conclusions. The consideration given to each recommendation is included below.

3. This annex identifies the correspondence with end implementers on which ORR's decision has been based.

Recommendation 1

The intent of this recommendation is to increase awareness that lengthy travelling times before and after a work shift can cause staff to be fatigued, which in turn can reduce alertness and increase the risk of those staff making unsafe decisions while carrying out safety critical work.

As part of its management of fatigue for staff undertaking safety critical work, Network Rail should continue its work to implement a process to require its managers who are directly responsible for staff working on or near the line to consider:

- l the fatigue that regular long journeys, both before and after a shift, can cause, so that staff are not required to commute long distances to their place of work; and
- l the actions that can be taken to reduce the amount of time staff spend travelling, where necessary, such as revised working times or providing lodging near to the work where appropriate

ORR decision

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

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

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

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

Information in support of ORR decision

6. No information provided by end implementer.

Recommendation 2

The intent of this recommendation is to improve the resilience of the rail testing and lubrication section within Eastleigh (now Wessex Outer) delivery unit to loss of resources and sudden increases in workload so that such situations do not compromise safety.

Network Rail should:

a. Carry out a review to identify improvements in how the Eastleigh (now Wessex Outer) rail testing and lubrication section manages rail defects so that it is more tolerant of changes to staff resourcing and peaks in workload. The review should include consideration of:

- the resourcing levels needed within the section to manage and deliver its work bank arising from planned inspections and likely volumes of work arising to support maintenance activities;
- the impact that planned runs by ultrasonic test trains can have on the management and delivery of the section's workload when a large amount of time dependent work to verify suspect defects is generated by multiple runs taking place in short succession; and
- the impact that missed or partially completed runs by ultrasonic test trains can have on the management and delivery of the section's workload.

b. Take steps to implement any improvements from the findings of the review (paragraph 96).

This recommendation may also apply to other rail testing and lubrication sections within Network Rail.

ORR decision

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

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

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

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

Information in support of ORR decision

9. No information provided by end implementer.

Recommendation 3

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

Network Rail should:

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

ORR decision

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

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

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

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

Information in support of ORR decision

12. No information provided by end implementer.