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17 October 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,

Derailment in Summit tunnel, near Todmorden, 28 December 2010

I write to provide an update[1] on the consideration given and action taken in respect of recommendation 5 addressed to ORR in the above report, published on 29 September 2011.

The annex to this letter provides details of the consideration given/action taken in respect of recommendation 5 which has been implemented.

We do not propose to take any further action in respect of these recommendations unless we become aware that any of the information provided becomes inaccurate, in which case I will write to you again[2].

We expect to publish this response on the ORR website on 31 October 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)(c)

Recommendation 5

The intent of this recommendation is for safety actions and safety related information originating from Network Rail's buildings and civils – asset management function to be managed to an appropriate conclusion when it is passed to other parts of Network Rail's organisation.

Network Rail should put in place processes for the management and distribution of safety actions and safety related information originating from Network Rail's buildings and civils – asset management function.

This should include a process for systematically reviewing the resolution of necessary safety actions and a process for passing safety related information to other parts of Network Rail's organisation, including confirmation that it has been received, understood and acted upon.

Brief Summary on what was previously reported to RAIB on 17 August 2012

1. Network Rail was still in the process of devolution. A full review of the dissemination of safety related information was planned to occur in the summer of 2012. In the interim Network Rail was enhancing the Infrastructure Group Safety Bulletins.

Update

2. Network Rail provided further information on 6 September 2012 advising that:

The current process for the distribution of Infrastructure Group Safety Bulletins (IGSB) is as follows:

Infrastructure Group Safety Bulletins (IGSB) are distributed internally within Network Rail and externally to others such as Network Rail contractors.

IGSB are authorised by a relevant Functional Professional Head within Network Rail. They are distributed electronically by the National Operations Centre (NOC) to a set distribution list held by the NOC.

They are usually issued in response to an event such as a major accident, incident, near miss, an identified product defect or urgent safety instruction etc.

The bulletins may detail what action is required and may also indicate to whom it is targeted. There is however, not a feedback loop associated with the process as it is operated as an urgent notification process only.

The actions to close out this recommendation centre on a proposal for Buildings and Civils related safety information to be cascaded through the business using a modified version of the current safety bulletin process noted above.

The alert would be produced by either the Head of Asset Management (Network Rail HQ) or the relevant route specific RAM (Route Asset Manager) to emphasis necessary safety actions or lessons learnt from any structures related incident and then distributed in accordance with the normal IGSB distribution procedure, albeit with a distribution list specifically produced by the Head of Asset Management to target all interested third parties beyond the current set distribution who would benefit from receipt of the safety alert based upon the nature of the incident.

Such bulletins will incorporate the required actions arising from the safety alert and will include a requirement for the recipient to acknowledge receipt and provide a status report/close out form to indicate the alert has been understood and acted

upon. The status report/close out form is to be returned to the Structures Asset Management Team at the Centre.

The proposal will require ownership of the revised process by all Route Asset Managers and as such, their consultation is currently being sought so that a workable safety bulletin procedure can be established.

The consultation exercise including the proposed method for obtaining auditable records of receipt and close out of actions is targeted for completion by 28th September 2012. The results of this consultation will be made available to interested parties as required.

Following completion of the consultation exercise, if necessary a revised bulletin template will be produced and briefed to the National Operations Centre.

It is anticipated that this recommendation will be able to be closed out in line with its target completion date of 31st October 2012.

3. ORR in reviewing this response wrote to Network Rail on 9 October 2012 asking it to explain how the revised arrangement captures more ***routine*** types of safety information rather than just those following a significant incident, since this is clearly the intent of the recommendation.

4. Network Rail provided a further response on 25 February 2013. However, ORR concluded that the response did not adequately show that Network Rail had put in place processes for the management and distribution of safety actions and safety related information originating from Network Rail's buildings and civils – asset management function.

5. ORR consequently met with Network Rail, on 28 June 2013, to discuss its response to the recommendation and on 31 July 2013 Network Rail provided ORR with a copy of its 'Closure Statement' advising that:

Closure Statement (extract)

Network Rail Asset Management has reviewed all of its management functions to identify processes which result in safety actions or safety related information to be passed to other parts of the organisation for action.

The review has noted that there are only a limited number of processes where such an interface occurs (i.e. responses to weather events, bridge strikes, minor works, incident capture etc.). For these, specific robust processes and standards adequately control the dissemination of safety related information and the reporting of progress/conclusion of the resulting actions, except the response to wind and heat weather alerts.

The processes around the control of risks associated with extreme weather due to wind or heat have been identified as requiring revision to ensure the Extreme Weather Action Team (EWAT) meetings held in response to such an event consider structures related actions. To achieve this, it is proposed to modify the meeting agendas for wind and heat events, similar to the improvements already made to Network Rail's existing weather management procedures relating to ice management as detailed in our responses to Summit Tunnel RAIB Recommendations 2 and 3.

The Summit Tunnel incident occurred before Network Rail devolved into a route based organisation. The resulting organisational change has led to significant improvement in the management of cross discipline activities.

Following devolution, all aspects of route asset management are delivered under the control of the Director of Route Asset Management (DRAM). The DRAM is singularly accountable for all aspects of Asset Management, Maintenance and Operations.

The RAIB report notes that a presentation was prepared by Buildings and Civils Asset Management which recommended that the Extreme Weather Plan and a list of 'At-Risk' Structures be briefed to track section managers and staff undertaking basic visual inspections. The production of the briefing was outside the normal procedures for management of extreme weather, it was delivered as a local initiative to familiarise maintenance and operations with the requirements of the extreme weather plan. However the briefing was not specific in its requirements for dissemination and there was no record of its contents being briefed to track section managers and inspection staff. The improved cross discipline consultation which has resulted from the newly devolved structure and singular accountability of the DRAM together with the enhanced weather management processes undertaken in response to Summit Tunnel recommendations 2 & 3 will prevent similar miscommunication in the future.

Under the devolved structure, maintenance and operations can undertake works instigated by asset management directly using minor works orders which include, works required, necessary timescales for completion and reporting functions to manage progress.

ORR Decision

6. Recommendation 5 deals with the distribution of safety related information and the systems in place to ensure that it is acted upon, but further context can be found in the responses to recommendations 2 & 3.

7. Network Rail had originally misunderstood the intent of this recommendation, assuming it related to the distribution of information ***following an incident***. However the derailment arose partly as a consequence of Network Rail failing to adequately consider the effect of weather related risks on their structures, such as the thawing of ice. Where the risks ***had*** been considered by the Buildings and Civil Assets function, there was a subsequent failure to distribute appropriate information elsewhere within the organisation, through formal channels, and to ensure that it was acted upon.

8. The RAIB report refers to a presentation given to the Preston IME and the Blackburn TME, amongst others, by someone from within Network Rail's Buildings and Civil Assets function. This presentation referred to an "Extreme Weather Plan" and a list of "At Risk Structures" but it's status was not made clear, and it was not briefed to the Blackburn section manager or to staff carrying out basic visual inspections. The ORR believes that RAIB recommendation 5 derives from the failure of the Preston DU to act on this information. Network Rail's Buildings and Civil Assets function have advised ORR that the briefing of this presentation was "outside normal procedures", albeit delivered by a well-intentioned member of staff. There was therefore no formal record of who had been briefed nor was it clear what if any actions were required subsequent to the briefing. Network Rail have also made it clear in discussions with the ORR that no such presentations will be given in future as there is no interface with the routes or other parts of the organisation which would require this (see below re interfaces). Both the "Extreme Weather Plan" and the list of "At Risk Structures" have since been formally distributed via alternative means (ref recs 2 & 3).

9. In addition to the above, following the derailment, Network Rail have amended their processes to ensure that the risks associated with ice management are addressed through a modification to the agenda of their Emergency Weather Action Team (EWAT) meetings, which are convened in the event of extreme weather being forecast.

10. Following a further review, to identify processes resulting in safety actions or safety related information being passed to other parts of the organisation for action, they have made an additional amendment to the EWAT agenda to include wind and heat. Their review concluded that these were the only amendments required to ensure that the interface between their Building and Civil Assets function and other parts of the organisation is properly managed. All actions arising from EWAT meetings are tracked to their conclusion.

11. Other interfaces between Buildings and Civil Assets and other parts of the organisation, such as the completion of minor works, are tracked through a different process

12 After reviewing all the information received from Network Rail ORR concluded that, in accordance with the Railways (Accident Investigation and Reporting) Regulations 2005, Network Rail has:

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

ORR will write to RAIB again if it becomes aware that the information above is inaccurate.

Status: Implemented