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

Dear Andrew,

RAIB Report: Passenger trapped and dragged under a train at West Wickham on 10 April 2015

I write to provide an update[1] on the action taken in respect of recommendation 2 addressed to ORR in the above report, published on 29 February 2016.

The annex to this letter provides details of the action taken regarding the recommendation. The status of recommendation 2 is **'implemented'**.

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

We will publish this response on the ORR website on 28 May 2020.

Yours sincerely,

Oliver Stewart

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

Recommendation 2

The intent of this recommendation is to increase the opportunity for seeing incidents and accidents at the platform-train interface during the train dispatch process, therefore reducing the risk that a train departs with a passenger in an unsafe position. Although continuous monitoring of all doors is preferable during this period, the recommendation acknowledges that this is sometimes impracticable (eg if staff cannot see all doors at the same time).

The RSSB, in consultation with the railway industry, should include in suitable guidance that train crew undertaking dispatch duties should, where practicable, monitor train doors during the door closing period. This is additional to the existing railway rule book requirement for a train safety check after doors are fully closed.

ORR decision

1. RSSB has amended industry guidance to state clearly that closing doors should be monitored by staff undertaking dispatch duties on the platform, in addition to those on the train.

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

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

Status: Implemented.

Previously reported to RAIB

3. ORR reported the following on 13 February 2017:

"By reviewing the RIS relevant to train dispatch and monitoring of the PTI, RSSB is taking steps to address the risk of passengers becoming trapped in train doors. RSSB wish to provide train operators with greater clarity on train dispatch procedures and PTI risk, as the current version of the RIS was being misinterpreted by industry as applying only to infrastructure managers. RSSB are planning to publish the revised RIS-3703-TOM in December 2017."

Update

4. RSSB sent the following information by e-mail on 20 October 2017:

"We said we would expand the scope of RIS-3703-TOM (Rail Industry Standard for Passenger Train Dispatch and Platform Safety Measures) explicitly to include platform staff as well as train staff.

This is addressed as detailed below:

3.2 The dispatch corridor

3.2.1 Staff involved in the train dispatch process shall be provided with a view that enables them to observe the train dispatch corridor to:
a) Monitor passenger behaviour on the platform. The types of behaviours that may increase risk during dispatch can be found in *Appendix L Staff Training and Assessment* on page 66.
b) Determine nothing and/or no-one has fallen onto the track or is trapped by the train doors.
c) Where practicable, monitor all train doors during the door closing process.
d) Determine that all doors are securely closed and the train can safely depart from the platform.

G 3.2.5 The ability of all staff involved in the train dispatch process to view all the train doors for which they are responsible for observing during the door closing process, allows staff to identify if anything or anyone has become trapped in the train doors. If anything or anyone does become trapped within the train doors, this view would allow staff involved in train dispatch to stop the train dispatch process and only restart the process when it is safe to do so. This view also enables staff involved in the train dispatch process to ensure that all train doors are closed prior to the train departing the platform.

G 3.2.7 Staff responsible for train dispatch are to be provided with a view of all the train doors for which they are responsible for observing during the door closing process.

G 3.3.7 When deciding on train dispatch modes and associated equipment, the following factors could affect which mode is used:

f) The ability of all staff involved in the train dispatch procedure to observe all train doors during the door
closing process.

G 3.4.5 Specific emphasis within the dispatch plan is to be placed on monitoring during the door close process and during train departure. Such processes are to be designed to mitigate the risk from staff involved in the train dispatch process failing to observe a person falling between the platform and the train, a person trapped in the doors or any other potentially dangerous occurrences taking place.

The amended RIS – issue 3 – was published on 2 September 2017. It may be found here: https://www.rssb.co.uk/rgs/standards/RIS-3703-TOM%20Iss%203.pdf

With this development, we consider the recommendation to be closed.”

Previously reported to RAIB

Recommendation 2

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The RSSB, in consultation with the railway industry, should include in suitable guidance that train crew undertaking dispatch duties should, where practicable, monitor train doors during the door closing period. This is additional to the existing railway rule book requirement for a train safety check after doors are fully closed.

ORR decision

1. By reviewing the RIS relevant to train dispatch and monitoring of the PTI, RSSB is taking steps to address the risk of passengers becoming trapped in train doors. RSSB wish to provide train operators with greater clarity on train dispatch procedures and PTI risk, as the current version of the RIS was being misinterpreted by industry as applying only to infrastructure managers. RSSB are planning to publish the revised RIS-3703-TOM in December 2017.

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

- taken the recommendation into consideration; and
- are taking appropriate action to implement it, but have not yet provided ORR With a time-bound plan.

Status: Progressing

Steps taken or being taken to address the recommendation

3. In its response of 24 November 2016, RSSB provided the following summary of work they have done around the monitoring of train doors during the door closing period:

Period 12 update:

An outline of the incident and Recommendation 2 was presented to TOMSC at its 1 March 2016 meeting. TOMSC requested that a subgroup be established to consider the issue in full. We will report further once this has been done.

Email to ORR, 20 April 2016:

RSSB has discussed the recommendation at TOM SC, which decided to establish a subgroup to consider both it and Platform Train Interface (PTI) issues in the round. The subgroup's first meeting has been set for 10 May 2016. It will work in conjunction with the PTI Strategy Working Group, whose focus themes for 2016/17 include 'trap and drag' and improved competence management.

Period 2 update:

No update has been received from TOMSC as the 10/05/16 meeting was cancelled. However, the PTI Strategy Group noted a number of workstreams at its April meeting, which move towards satisfying the recommendation:

	RECOMMENDATION RESPONSE	LEAD/NOTE
1.	RED 45: reconstruction of trap and drag.	PTISIG/TORG
2.	Right Track: series of related articles that build upon learning points 1-3 that have emerged from the investigation (see Appendix B).	PTISIG/TORG
3.	Platform Safety: The facts and your role: this booklet contains guidance for all dispatch in relation to visual checking and not relying on interlock indicators.	Completed
4.	RSSB Non-Technical Skills training course: inclusion of West Wickham as a case study, along with other relevant PTI incidents relating to NTS.	Underway
5.	Non-Technical Skills Integration Guide: inclusion of West Wickham as a case study when reissued in September 2016. This guide will also include information on how organisations can develop NTS in train driver instructors/managers etc. and how NTS can be maintained for safety critical roles within the workplace.	Completed
6.	T1064 Developing tools to extend non-technical skills to non-driver roles: due to be published in November 2016. This project covers dispatch staff.	PTISIG
7.	RSSB driver training course: inclusion of further case studies within the tailored elements of the course to ensure that sufficient emphasis is placed on the operators risk profile.	
8.	Risk-based training needs analysis (RBTNA) toolkit: encouraging the use of the tool across the industry.	Promotion work amongst PTISIG
9.	Project 15/021: scope of project to be expanded to ensure all of the learning from the West Wickham accident and other similar accidents are incorporated into Rail Industry Standard RIS-	RSSB Rail Ops

Period 5 update:

At the TOMSC's 14 July 2016 meeting, RSSB presented proposals to review RIS-3703-TOM (Passenger train dispatch and platform safety measures) in light of the recommendation. The object of the proposal is to provide greater clarity on train dispatch procedures and impact PTI risk. It has been recognised that the RIS as written was being misinterpreted by industry as applying only to infrastructure managers. TOMSC approved the proposal and the high priority afforded to it.