

**Oliver Stewart**  
**Senior Executive, RAIB Relationship and**  
**Recommendation Handling**

Telephone 020 7282 3864

E-mail [oliver.stewart@orr.gsi.gov.uk](mailto:oliver.stewart@orr.gsi.gov.uk)

14 July 2017



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

Dear Andrew,

**RAIB Report: Signal passed at danger on approach to Wootton Bassett Junction, Wiltshire, 7 March 2015**

I write to report<sup>1</sup> on the consideration given and action taken in respect of the five recommendations addressed to ORR in the above report, published on 5 May 2016.

The annex to this letter provides details in respect of each recommendation.

The status of recommendations 1 is '**implementation on-going**'; recommendations 2, 3 and 4 are '**implemented**'; and recommendation 5 is 'progressing'.

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 17 July 2017.

Yours sincerely,

Oliver Stewart

---

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

## Initial consideration by ORR

1. All 5 recommendations were addressed to ORR when the report was published on 5 May 2016.
2. After considering the recommendations ORR passed recommendation 1 to RSSB; recommendations 2, 3 and 4 West Coast Railways (WCRC); and recommendation 5 to Network Rail, asking them to consider and where appropriate act upon them and advise ORR of their 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 that the risk of overrun by trains operated by steam traction on Network Rail managed infrastructure is reduced as far as is reasonably practicable.*

RSSB, working in conjunction with operators of steam traction and Network Rail, and in accordance with normal industry processes, should undertake a review of the current standards, policies, procedures and risk assessment tools intended to assess, prevent and mitigate the risk associated with overruns on Network Rail managed infrastructure.

This review should consider if these arrangements adequately control the risk of overrun associated with the movement of trains formed of steam locomotives and/or preserved vehicles. It should specifically consider:

- the extent to which existing railway group standards and associated guidance adequately mitigate the risk of operating such trains;
- if there are features of steam locomotives and preserved vehicles which may potentially increase the likelihood or magnitude of overruns (such as reduced forward visibility or braking systems not designed to meet modern standards of performance) or which may potentially make the consequences of an overrun worse (such as vehicles not being designed to meet modern standards of crashworthiness);
- the compatibility of braking performance of steam-hauled trains and/or preserved vehicles with signal spacing on lines where signals are more closely spaced (eg lines where different maximum permitted speeds apply to passenger and freight trains);
- how the train crew of steam locomotives interact with the controls and visual and audible indications of the Automatic Warning System and the Train Protection and Warning System;
- if the minimum crewing level for steam movements specified within GO/RT 3440 Issue 2 remains appropriate; and
- if steam movements are adequately accounted for within existing tools intended to assess the risk of overruns (such as SORAT).

Companies operating steam locomotives and/or preserved vehicles on Network Rail managed infrastructure and Network Rail should implement any measures identified by this review as being required to adequately control the risk from overrun

### ORR decision

4. RSSB is facilitating industry-wide action to improve understanding of the risks associated with steam trains operating on the main line. This work includes making amendments to relevant standards, GO/RT 3440 (Steam locomotive operation) and GM/RT 2003 (Certification requirements for registration of steam locomotives).

5. 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
- is taking action to implement it by December 2017.

**Status: Implementation ongoing. ORR will advise RAIB when actions to address this recommendation have been completed.**

### Information in support of ORR decision

6. On 18 June 2016, RSSB provided the following initial response:

*First, I am pleased to report that RSSB accepts the recommendation, though we must note – regarding the final bullet point – that the ORR should seek clarification on SORAT from the owners of SORAT (ie Network Rail). This is not a matter for RSSB.*

*RSSB's acceptance is based on a wider industry understanding of the issues surrounding heritage operations on the main line. Indeed, the industry has formed a Charter Train Group, which is chaired by Alan Tordoff, a man highly experienced in this field, but now working for RSSB as part of its Industry Engagement Team. As part of that wider understanding, RSSB was already in the process of facilitating amendments to GO/RT 3440 (Steam locomotive operation) and GM/RT 2003 (Certification requirements for registration of steam locomotives). However, we must note at this point that the review of '3440' is likely to result in a RIS or guidance document rather than an RGS. Provided all train operators adopt and comply with the content we are confident that it will provide safety improvement.*

*That said, the proposed work involves a more holistic approach. Thus the new '3440' will look beyond steam to encompass other charter train operations. The amendments to '2003' will involve a suite of requirements in four parts:*

1. *Design/engineering requirements and guidance to support the build, re-build or when making engineering changes to heritage vehicles such that they are compatible with the GB mainline network.*
2. *The process for assessing technical compatibility with the GB mainline network and the route(s) on which the vehicle is going to operate.*
3. *Guidance and requirements on how to operate a vehicle safely.*
4. *Guidance and requirements on how to maintain a vehicle's capability to operate safely and compatibly with the network and route(s) it operates on.*

*Note that the revised '2003' will encompass all heritage vehicles, including coaching stock and non-steam locomotives (many of which are older than some 'rebuilt' steam locomotives and need to be brought up to minimum standards). Work on GO/RT 3440 and GM/RT 2003 will be supported by the afore-mentioned stakeholder support group to ensure engagement with a cross-section of heritage industry practitioners during the drafting process.*

*Both documents are scheduled to be published in December 2017. We will keep ORR informed of developments.*

7. RSSB pointed out that SORAT is owned by Network Rail. ORR therefore sought clarification from RSSB if they use any other existing tools to assess the risk of train overrunning signals at danger.
8. On 7 September 2016, RSSB provided the following response:

*SORAT is the tool for assessing SPAD risk locally (at a specific signal). We support Network Rail in its development and use (sitting on the SORAT Steering Group) and don't have any equivalent tools in RSSB.*

*The Safety Risk Model (SRM) estimates SPAD risk at the national level. The risk estimates, which are published in the Risk Profile Bulletin, are disaggregated by the cause of the SPAD, the train involved (passenger or non-passenger) and other characteristics, for example SAS SPADs are shown separately, as are plain line and junction SPADs.*

*SORAT is calibrated against the SRM.*

*The SPAD Risk Ranking Tool is used to monitor SPAD risk. Each SPAD is scored (by Network Rail) and an important component of the score depends on how close the train came to reaching the potential conflict point, based on the length of overrun and distance from the signal to the location at which a conflict could have occurred. Furthermore, the SPAD at Wootton Bassett – and the fact it reached the conflict point – will inform the next SRM update.*

## Recommendation 2

*The intent of this recommendation is that an external party reviews the implementation of changes to West Coast Railways' safety management system following this incident in order to ensure that they have been effective. The review should also consider the company's safety culture.*

West Coast Railways should make arrangements for a review of its safety management system and safety culture to be undertaken by an external independent party whose suitability has been agreed with the Office of Rail and Road. The review should consider if the changes made following the SPAD of 7 March 2015 have been implemented and if they have improved the capability of West Coast Railways to control risk and the prevailing safety culture within the company. This review should specifically examine;

- governance, policy and leadership;
- control and communication and how this is organised;
- the co-operation and competence of employees;
- the planning and implementation of risk controls and how this is managed;
- and
- monitoring, review and auditing of compliance to the safety management system and how this is managed.

West Coast Railways should make any changes identified as necessary

## ORR decision

9. West Coast Railways (WCR) appointed an external body (Risktec) to review their safety management system. Risktec produced a report making eleven recommendations on WCR. Our visit to WCR on 12 May 2017 provided assurance that they have taken steps to improve their management of safety in line with those recommendations.

10. ORR has carried out an audit of WCR's safety management system focussed on four key areas: corporate governance, communication, staff competence and safety culture. WCR demonstrated performance in these areas at a level comparable with good performers in the industry.

11. In February WCR completed a review of their key procedure "Capabilities and Responsibilities of WCR Roles". This added some key elements and from our contact and inspection of the company it is clear they much more effectively delivering in practice what is written down on paper.

12. Our findings show that the WCR Health & Safety committee is now meeting regularly, is attended by staff of an appropriate seniority and is tackling the right issues. The WCR non-executive Directors' are well engaged with these meetings and are known to members of staff. Overall, we are confident WCR has significantly improved its independent review of their health and safety performance at board level.

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

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

**Status: *Implemented.***

### **Information in support of ORR decision**

14. On 28 April 2017, West Coast Railways provided the Executive Summary and recommendations from the Risktec report:

*Risktec Solutions Ltd (“Risktec”) has been contracted to undertake a programme of safety management and safety culture activities. West Coast Railway Company (WCRC) identified the need to undertake a Skills Gap Analysis to assess the competencies and capabilities of the Senior Management Team (SMT) and Operations Managers against the roles and responsibilities as required by the WCRC procedures. The output of this exercise is contained in this report.*

*The competencies outlined in the WCRC Work Instruction (WI) 003, Capabilities and Responsibilities of WCR Roles, forms the foundation for this comparative exercise.*

*The Skills Gap Analysis was conducted on site with a series of face to face interviews with the relevant managers appointed to the key roles at Carnforth and Rugby. The interviews considered the roles as outlined and assessed competency to deliver the key areas of responsibility based on training records, relevant experience, professional development and an assessment of the quality of key deliverables, for example accident reports, Health and Safety (H&S) Committee Meeting minutes, briefings to staff on key issues, etc. The capabilities and competencies documented for the team were also benchmarked against the expectations for similar roles in the railway industry where appropriate.*

*The exercise therefore had three levels:*

- *Comparative assessment (evidence based) of the competencies of each key individual against their role and capability requirements as outlined in WI003;*
- *Gaining an understanding of the role requirements in terms of responsibilities and deliverables in relation to the overall management team and need to deliver the WCRC management system and meet key railway and safety legislative requirements. This includes deputisation duties to cover planned or medium to longer term unplanned absences; and*

- *Assessment of whether the roles as outlined on paper are appropriate to the needs of WCRC as a business, i.e. “future proofing” the role profiles in the event of future recruitment for the roles.*

*In order to meet the aim of the brief for the Skills Gap Analysis the interviews were based around a general discussion of the manager’s role, background experience and the inter-relationship between their role and the functioning of the management team as a whole.*

*The overall impression of the staff at WCRC was that of a vastly experienced team of competent and dedicated railway personnel. A set of eleven specific recommendations based on the interviews and document reviews have been identified and these are summarised below.*

**Recommendation 1:** *All members of the Senior Management Team should attend an appropriate H&S course. The IOSH Managing Safely course is a suitable course which would provide a consistent and appropriate level of training to support the H&S aspects of the Senior Managers’ roles.*

**Recommendation 2:** *Revise WI003 in relation to the role of QSM/ Fleet Liaison to ensure that the role description suitably reflects:*

- *the involvement in T&RS incident investigation, either as a sole investigator or as a leader of a team of investigators, depending on the nature of the incident; and*
- *the participation in emergency exercises and the capture of strategic operational experience gained.*

**Recommendation 3:** *Revise WI003 in relation to the role of Head of Operations to ensure that the role description suitably reflects the current responsibilities, assuming that the Head of Safety and Standards has recently taken over the responsibility for functions such as the promotion and facilitation of H&S awareness and education.*

**Recommendation 4:** *WCRC should consider the need to develop a more detailed ‘how to’ procedure for incident investigation and write up including a template report. Further consideration should also be given to the provision of formal incident investigation training for all managers responsible for incident investigation. This will provide assurance of competency and ensure investigations are undertaken in a consistent manner. It will also support investigating managers in identifying all immediate and root (underlying) causes and ensure appropriate remedial actions are recorded and tracked through to closure.*

**Recommendation 5:** *Revise WI003 in relation to the Head of Safety and Standards competencies to ensure the role reflects the need for a manager with not only appropriate H&S competency such as CMIOSH (or equivalent proven practical experience) but also a demonstrable background in:*

- *Liaison with the Regulatory Bodies such as ORR/ RAIB and other third party stakeholders such as Network Rail;*
- *Safety Assurance and Safety Justification (Railway Operator environment);*
- *Application of ALARP to risk management decision making such as cost benefit analysis and consideration of additional risk factors (for example human error);*
- *Role in leading safety strategy and planning at management level; and*
- *Developing and maintaining a SMS.*

**Recommendation 6:** *Regular monthly face to face management meetings should be scheduled where company management issues and priorities can be discussed and resourcing agreed. (Additionally this provides a more robust audit trail of risk management and decision making than reliance on conversations and emails).*

**Recommendation 7:** *Revise WI003 in relation to the Head of Engineering role and competencies to ensure the role reflects the need for a manager with not only appropriate engineering competency but also a demonstrable background in:*

- *Performance monitoring and failure modes for locomotives;*
- *Recovery of incident vehicles;*
- *Auditing (to support the QSM role);*
- *Safety Assurance and Safety Justification (Railway Operator environment); and*
- *Application of ALARP to diesel, electric traction or hauled coaching stock with regards to assurance of vehicle modifications and consideration of additional risk factors.*

**Recommendation 8:** *WCRC should consider risk assessment training where appropriate for managers whose roles require this. It is noted however that a general 'Managing Safely' course would include the information required without going into unnecessary detail.*

**Recommendation 9:** *WCRC should consider how deputisation of key Head of Engineering duties will be covered and also continuity of specialist knowledge. The development of a mentoring or training scheme should be considered to 'pass on' this knowledge and experience.*

**Recommendation 10:** *A management strategy with a set of KPIs should be developed by the SMT.*

**Recommendation 11:** *Participate in a 1 day interactive Leadership Workshop.*



*In addition, five observations were noted which, whilst not necessarily directly within the scope of the Skills Gap Analysis work, it was felt that had a significant or potential impact on the ability of the SMT to deliver their roles. These are outlined in the report.*

*A Skills Gap Analysis has been carried out and the results are outlined in this report. The overall impression of the staff at WCRC was that of a vastly experienced team of competent and dedicated railway personnel.*

*WI003 was thought by the Risktec Auditors to provide a comprehensive and realistic description of the capabilities and responsibilities for the majority of the roles of the Senior Management Team, subject to the eleven recommendations and five observations identified.*

*It is recommended that WI003 (and associated procedures such as CMS600) and the job roles outlined are reviewed to reflect any additional tasks the management team are taking responsibility for outside the scope of their current job role descriptions. It is advised that this is undertaken through coordination with the individual jobholder. The following considerations should also be taken into account:*

- *Prioritisation*
- *Support required*
- *Cover for absence*
- *Resources*

### **Recommendation 3**

*The intent of this recommendation is that West Coast Railways implements arrangements for the acquisition and retention of route knowledge by drivers which are in line with industry best practice. It is also intended to ensure that West Coast Railways observes the requirements of mandatory standards with respect to identifying signals and signs which may be difficult to see from steam locomotives.*

West Coast Railways should review the arrangements by which drivers that it employs acquire and retain route knowledge. This review should take into account whether these arrangements meet with the requirements of RIS 3702 Issue 2 'Route Knowledge for Drivers, Train Managers, Guards and Driver Managers'.

West Coast Railways should also consider how proposed routes for steam operations are assessed in order to identify signals and lineside signs which may be difficult to see from a steam locomotive cab and how drivers of West Coast Railways operated steam trains are to be provided with additional competent assistance in sighting any signals or lineside signs falling within this category. This should be done with regard to the requirements of GO/RT 3440 Issue 2 'Steam Locomotive Operation'.

West Coast Railways should make any changes identified as necessary

## ORR decision

15. WCR has taken action to address the recommendation by reviewing the arrangements for their drivers to acquire and retain route knowledge. This was in line with the requirements of an Improvement Notice issued by ORR 1 April 2016.

16. Following our inspection on 12 May 2017, WCR were able to provide us with examples of Route Knowledge Questionnaires completed by drivers and verification that over 200 assessments have been completed. We were therefore able to write to WCR on 15 May 2017 informing them that they had complied with the notice and our reasons for reaching that conclusion.

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

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

**Status: *Implemented.***

## Information in support of ORR decision

18. On 28 April 2017 West Coast Railways provided the following update:

*In order to provide a fuller explanation we have included a number of examples as appendices;*

*Appendix D WCR/WI/035*

*Appendix E RA008*

*Appendix F examples of completed route risk assessments.*

*The competency requirement for Guards and Firemen are contained within elements of the WCR competence management system CMS 300 and CMS 200 each of which has a series of accompanying documents to validate the competency and route familiarisation for each individual.*

*The Route risk process is in RA/008 the route risk forms in WI/035 are derived from the RRA, the Driver when learning a new route completes form B1 which covers general route information that is required to be known. Form B2 asks about generic risk on the route. Form B3 is a specific route risk assessment which the company completes to ensure that the driver is aware of specific RR that may lead him astray. The B3 form also includes specific risks for a steam locomotive. This would include signals that we term as "Fireman Signals" where the Fireman gets the 1st sighting when running on cautionary signals.*

*Over 230 routes have gone through a B3 Specific RRA. Which includes Steam in the consideration.*

*WCR have all drivers route knowledge logged in the WCR database this is kept electronically and is issued to the driver and is available to WCR Control & Ops Managers. This gives dates of route refresher request and reviews carried out. Also being trialled is another database that gives the date when a driver was last over the route as well as the paper version the Ops managers keep.*

*We could attach a list of B3 Specific risk assessments carried out and a sample of the B3 Form completed.*

#### Recommendation 4

*The intent of this recommendation is that West Coast Railways implements arrangements for the maintenance of On Train Data Recorders which ensure that this equipment can meet the requirements of the relevant mandatory standards.*

West Coast Railways should review the arrangements by which On Train Data Recorders fitted to trains that it operates are maintained. This review should specifically ensure that such recorders are maintained in a way which means that they are capable of supporting the key objectives for data recording as laid down in GM/RT 2472 Issue 2 'Requirements for Data Recorders on Trains'. These include:

- the use of systematic safety monitoring as a means of preventing incidents and accidents;
- the identification of driver, train and infrastructure performance in the period leading up to and (if appropriate) immediately after an incident or accident; and
- the recording of information relating to the performance of both the locomotive / traction unit and the person driving.

West Coast Railways should make any changes identified as necessary

#### ORR decision

19. Following our inspection on 12 May 2017, we were able to verify that the information provided by West Coast Railways in their submission of 28 April 2017 is being used in practice. Nearly all OTDR downloads are now loaded into a database and are reviewed when necessary.

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

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

#### Status: Implemented

21. On 16 August 2016, West Coast Railways provided the following initial response:

*Review maintenance of OTDR with regard to supporting the objectives of GM/RT2472.*

*WCR/WI/060 Issue 2 was produced 29/06/15 to require the routine downloading of OTDRs, and the assessment of the data with regard to equipment functionality (OTDR recording in general and individual channels in particular). This process is now well established within WCR and the action is considered closed.*

22. On 28 April 2017 West Coast Railways provided the following update:

*Once again we would demonstrate how implementation of the procedure has satisfied the requirement by providing examples of completed process.*

*Appendix G WCR/WI/060*

*Appendix H An example of a driver / journey analysis – Steve Beams*

*Appendix I An example of an incident where the data download was key to completing the investigation – SPAD at Craiglockhart.*

*Appendix J an example download following a TPWS activation.*

*We can show that the process of analysis is enabling the identification and ongoing of individual component faults particularly with the extreme conditions on steam locomotives, each fault identified, on its own may not have high significance but under our old regime of annual checks the faults were able to accumulate over time resulting in a very poor record of availability of data when it counted - as a result of investigation.*

*Now we are able to be confident that data is consistently available although to be fair, we do still encounter individual component failure - it's just that it's quickly identified & reported to the maintainers who are able to attend to repairs prior to next operations.*

*From the 09.05.2015 to the end of 2015, 114 individual locomotives were downloaded that was all the locomotives used on WCR services. This equated to 162 individual downloads attributed to 62 drivers*

*In 2016 301 downloads were taken from traction used by WCR. This equated to 412 downloads attributed to 57 drivers. 100% of drivers driving trains for WCR were downloaded.*

*Each OTDR download was interpreted to check for any anomalies or violations. All incidents that had been reported to WCR were followed up with an OTDR download these were logged and tracked in the WCR database. Items such as AWS late Cancellations / Failure of AWS to Cancel/ Failure to TPWS TI when shunting/ Failure to TPWS TSO were all logged & followed up.*

*Failure in OTDR recording has reduced considerably main failure of OTDR was internal batteries going out of date before their time, this did not stop the OTDR from recording but resulted in the OTDR when switched on commencing recording with the default date & time.*

*AWS / TPWS systems are sealed with unique indentifiable security tags checked and recorded at each Fitness to Run exam prior to a locomotive entering service and a database is maintained to record each change.*

*We hope that you find the information satisfies the requirements of the recommendations, post Wootton Bassett we believe that we have emerged with a more robust governance and safety management system that both*

*strives for full compliance and remains workable for our bespoke train services.*

## **Recommendation 5**

*The intent of this recommendation is to ensure that emergency and temporary speed restrictions are designed and implemented in a way which results in clear and correct information being provided to train drivers.*

Network Rail, in association with any contractors who carry out such work, should review how the design and implementation of emergency and temporary speed restrictions is managed by the Swindon Maintenance Delivery Unit and how this resulted in the errors identified in this report. This review should consider:

- the information, instruction and training given to designers of TSRs;
- the procurement process for designs, including the circulation list for information and designs provided to Network Rail;
- the process for conversion of ESRs to TSRs, including the criteria for deciding whether an ESR design is modified, or if a new design must be used; and
- the process for implementing ESRs and TSRs, including the checking of designs and the action to be taken if conditions on the ground do not match the design.

Network Rail should also determine whether any of the issues identified may apply to other maintenance delivery units and take action as necessary to make any changes required

## **ORR decision**

23. Network Rail have a plan in place for addressing the recommendation, although timescales have slipped and the actions were not completed to meet the original deadline they had set. Network Rail have not yet communicated to ORR a revised time-bound plan for addressing the recommendation but are planning to do so by April 2017.

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

- taken the recommendation into consideration; and
- is taking action to implement it, but have not yet provided ORR with an updated time-bound plan.

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

### Information in support of ORR decision

25. On 28 July 2016, Network Rail provided the following initial response:

*Network Rail carried out a review at Swindon Delivery Unit on 20 June 2016 to take evidence on each of the issues identified in the recommendation to determine the status at the time of the incident.*

*The review has identified that there was a significant non-compliance with the company standards in place to govern the management of ESRs and TSRs. They were not incorporated into the contract with the TSR designer and not referenced or used by the track staff involved in imposing and removing ESRs and TSRs.*

*Recent briefing and Level 2 assurance activity has not resulted in any change in practice or move to compliance with the standards and associated forms, other than the examples of the use of form SMF/SG0202 at Didcot SM[T].*

*The following next steps are proposed:*

*A management review meeting to be arranged with the acting RIMD, acting DRAM, IMDMs, RAM[T] and commercial manager for the TSR design contract to consider these findings, the reasons behind the failure to implement actions from previous assurance activities or directly in light of the incident;*

*Following step 1, an action plan should be developed to implement a regime which:*

- complies with the standards;*
- has controlled documentation used by the TSR designer;*
- has controlled arrangements to identify mismatches between the fixed equipment and the TSR equipment as designed insofar as they affect the compliance of the TSR as presented to train drivers;*
- improves the control of the design of ESRs outside the availability of the TSR designer by the track level 2 on call / ICC staff and has them checked;*
- reviews the implementation of requirements arising standards briefing by level 1 assurance activity;*
- reviews the management control and implementation of level 2 assurance actions and how these are shared across management units.*

*Target completion date: 30/09/16*

*This review and the actions in response to it will then be shared nationally for adoption and implementation as applicable across Routes, DUs and TSR designers.*

*Target completion date: 31/01/17*

26. On 23 September 2016, Network Rail provided the following update:

*Further to the initial response given to ORR in July I have carried out a field review of progress against the items agreed to be implemented as part of the action plan and met with Western colleagues accountable for implementation.*

*The required action plan has not been developed to meet the requirements set out in the response and hence there is little confidence in completing the actions required by 30 September 2016. This will undoubtedly impact the timescale for national implementation, which at this stage was only really notional, until the Swindon DU arrangements have been determined and implemented.*

*Martin Jones, on behalf of Western has committed to provide an action plan detailing the actions, resources, timescales and outcomes by 15 September 2016. When we have this we should be able to estimate what national implementation of the same requirements should look like.*

27. On 21 March 2017, Network Rail confirmed that they are developing a revised time-bound plan to address the recommendation which they plan to finalise and share with ORR in April 2017.