



OFFICE OF RAIL REGULATION

Welcome to RIHSAC 92

Dilip Sinha, Secretary, RIHSAC

12 February 2013



OFFICE OF RAIL REGULATION

Fourth Railway Package

Alan Bell

12 February 2013

European Commission proposals for Fourth Railway Package

- ERA 'one stop shop' for EU-wide authorisations and EU-wide safety certificates for operators
- Opening domestic passenger railways to new entrants and services from December 2019
- Ensuring the functions of managing the track and running trains are kept apart
- Protection of staff when public service contracts are transferred

Impact Assessment

- Problem definition:
 - Interoperability and safety rules in member states create access barriers (particularly for freight)
 - Costly and long procedures hinder the EU market and entry of new operators
 - Inefficient functioning of national institutions
- Policy options – ‘shared competence’ between ERA and NSAs chosen: best ratio of costs and benefits

Safety and interoperability proposals

- ERA issues vehicle authorisations and safety certificates (in cooperation with NSAs)
- ERA role enhanced in deployment of ERTMS
- ERA role enlarged in supervision of national rules and monitoring NSAs
- EC aim is 20% reduction in time to market for new RUs and 20% reduction in cost and duration of authorisation of rolling stock

Revision of the Interoperability Directive

How to simplify the authorisation process?

Today:

- first authorisation for placing in service the vehicle in a MS
- + additional vehicle authorisations in other MSs issued by NSAs

Proposed solution:

- one single authorisation to place the vehicle on the market, issued by ERA and valid in all MS
- + RU responsible for checking route-specific compatibility

Revision of the Interoperability Directive

- The single authorisation for placing a vehicle on the market would:
 - *Reflect the compliance with the applicable rules*
 - *State the technical characteristics of the vehicle necessary and sufficient to check its compatibility with the fixed installations*
 - *Be used by the RU in conjunction with the infrastructure register in order to:*
 - *Verify compatibility with the route*
 - *Decide (and take responsibility for) the placing in service of the vehicle*

Revision of the Safety Directive

- ▶ Why do the European Commission want to amend the safety directive?
 - ▶ *Migration towards a single safety certificate*
 - ▶ *Task force on national safety rules*
 - ▶ *Task force on the vehicle authorisation process*
 - ▶ *EC study on responsibilities of all actors in the rail transport chain*

Revision of the Safety Directive

- Towards a single safety certificate:
 - *The principle was already established in the directive in 2004*
 - *ERA issued a recommendation on the migration towards a single certificate and held a workshop with stakeholders on 7 March 2012*
 - *The move to a single safety certificate requires two pre-conditions to be in place:*
 - **ALL actors in the railway sector take their full responsibility under article 4 (3) of EC Directive 2004/49 for managing, controlling and monitoring risks**
 - **There is a harmonised decision making and supervision of the safety of the sector by NSAs**

Summary of modifications

- Article 2 on scope: does not apply to urban/ local transport
- Article 4 on roles and responsibilities
- Article 8 on national rules and removal of annex II
- Article 10 on single safety certificate and removal of annex IV
- Article 16 on NSA tasks
- Article 20 on cooperation on between NIB and judicial authorities
- Consequences of Lisbon Treaty on comitology
- Recast: consideration of previous amendments

National rules

- Merge National Safety Rules (NSRs) and Notified National Technical Rules (NNTRs) into National Rules
- Extension of TSIs should greatly reduce the number of National Rules
- National Rules in very limited circumstances, e.g. to cover open points in TSIs

Conclusion

➤ **Action now:**

- More information and dissemination (ERA)
- More enforcement (EC)
- Strengthened control over the functioning of NSA and Notified Bodies (ERA)
- Reduction of national rules

➤ **Future action:**

- Clarify roles and responsibilities
- Migration towards single certificate for the railway undertaking
- Migration towards a single vehicle authorisation

Stranded trains

John Cartledge

Safety Policy Adviser

Presentation for RIHSAC

12 February 2013

“I’m only here to help”

“My cheque’s in the post”

“This is going to hurt me as much
as it hurts you”

“We’ll be moving again very shortly”

1995	Bourne End	Incursion by farm machinery
1999	Spa Road	Train collision following SPAD
2000	Liverpool St LUL	Circuit breakers tripped by power surge
2001	Waterloo W+C LUL	Compressor failure
2001	Highbury + Islington LUL	Door malfunction owing to malicious act
2003	Stewarts Lane	Detached hose pipe
2003	LUL systemwide	National grid power failure

2004	Bollo Lane	Train gapped on electrically isolated section
2005	Huntingdon	OLE damage
2005	Marble Arch LUL	Damaged points owing to staff error
2007	Plaistow	Plastic sheeting in OLE
2007	Queenstown Road	Distraught MOP on signal gantry
2008	Jubilee line LUL	Power supply failure
2009	Channel Tunnel	Electronics failed owing to low temperatures

2010	Lavington	Collision with fallen tree
2011	Bexleyheath	Relay failed on train
2011	Kentish Town	Vegetation caught in pantograph
2011	Farnborough	Theft of signal cable
2011	South Croydon	Passenger emergency alarm activated
2011	White House Farm	Collision with tractor on UWC
2012	St John's Wood LUL	Inverter module failures

Some common themes

- Front line staff ill-trained to handle situation
- Procedures/instructions/good practice not followed
- No senior managers involved and/or confusion over line of command
- Misdiagnosis of cause of failure
- Preoccupation with moving train not people
- Poor communications with signaller/control
- Attempts to part passengers from their luggage

Some common themes

- Lack of or inconsistent information to passengers on trains and at stations
- Failure of ventilation/toilets/lighting
- Poor handling of displaced passengers downstream
- Alternative solutions not considered (or only at late stage)
- Unhelpful interventions by emergency services
- Uncertainty regarding train locations



SOUTH WEST TRAINS

Independent Review

into the

Serious train service disruption and
significant delays as a result of an
attempted cable theft at Sturt Lane
Substation near Farnborough

Executive Summary

Date:	Thursday 9 th June 2011
Location:	Between London Waterloo and Farnborough



4 The WICC is very heavily focused on train service management with little emphasis on stations or wider customer service requirements. Its role needs to encompass the SSWT vision 'To give our customers the best service they have ever had'.

5 When disruption leads to significant delays or trapped trains the WICC needs to monitor both how long trains have been stationary and where multiple incidents have occurred how long passengers have been delayed since commencing their journey. It needs to use this information in updating the prioritised plan.

ATOC/Network Rail Good Practice Guide
GPG SP01
Issue 2
Date: 14 February 2012

**Good Practice Guide -
Meeting the Needs of
Passengers when Trains
are Stranded**

Authorised by



.....
Gary Cooper
Head of Operations, ATOC

Synopsis

This document provides guidance on the planning for and implementing arrangements to meet the needs of passengers in the event of the train(s) in which they are travelling becoming stranded (for whatever reason), noting that these need to be agreed jointly between Network Rail and Train Operators.



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Paul Sutherland
Ops Principles and Standards Manager,
Network Rail



Contents

Recognising When a Train Has Become Stranded
Determining the Most Appropriate Response
Passenger Needs and Expectations
Command & Control
Key Roles, Responsibilities and Support Needs
Evacuation
DOO
Assistance from External Agencies

Appendices

Possible causes of stranded trains
Dynamic risk assessment – factors to take into account to determine the scale of incident
Suggested timelines from when it is established that a train is stranded



Rail Accident Investigation Branch

Rail Accident Report



**Safety incident between Dock Junction and
Kentish Town
26 May 2011**



Rail Accident Investigation Branch

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 SP01 'Meeting the needs of passengers when trains are stranded'.

The protocols should also consider :

- 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 traincrew of such trains in managing passengers' needs;

Formal Investigation Report

**Investigation: Delayed release of customers from 2 stalled Jubilee line trains
between Baker Street and St John's Wood. 23 May 2012**

LUSEA Ref.: 22006838

Mike Shirbon / Jack Albrow
TfL Health Safety and Environment
Version: FINAL

Date of Issue: 31 August 2012

Recommendation 3

Review the suitability and effectiveness of the methods of rescuing customers from stalled London Underground trains. The review should include:

- The reliability / effectiveness of the methods based on experience,
- How options are risk assessed to inform decision making
- The findings from test scenarios or use in live incidents, with particular regard to stock specific feature or requirements (e.g. isolation of batteries, line contactors, air or electrical systems)
- Compatibility with LU Rule and Procedures (NB: OSN 96),
- The level of training and assessment provided to Operations, Maintenance and Control Teams,
- What information is communicated to customers and how / when this is communicated.

The findings of the review shall be presented in a report containing:

- the decision making criteria to be applied when selecting an appropriate method of rescuing customers from a stalled train,
- Preferred options / approaches to rescuing customers from stalled trains,
- the competence and training needs of maintenance and operational teams (including table tops or exercises)



Rail Accident Report



**Safety incident between Dock Junction and
Kentish Town
26 May 2011**

The protocols should also consider the views of passenger interest groups

Passenger groups' checklist

1. Does the protocol identify a clear line of managerial responsibility, embracing both the TOC and Network Rail, for handling the incident?
2. Does the protocol embody clearly defined rules for determining when a train is deemed to be stranded, the maximum length of time it is permissible to leave passengers on board an immobile train before evacuation begins, and the maximum length of time within which evacuation must be completed?
3. Does the protocol embody clear procedures and lines of responsibility for ensuring that both passengers on the train(s) and enquirers elsewhere are continuously provided with timely, consistent, credible and reliable information – via all relevant media – regarding the cause of the stranding, the action being taken to resolve it, and the timescale within which this will be completed?

Passenger groups' checklist

4. Does the protocol set out (taking due account of the characteristics of each type of rolling stock operated, and the possible causes of stranding) arrangements for ensuring that heat/ventilation, lighting, toilet facilities and at least basic refreshments continue to be (or are made) available on board?
5. Does the protocol address the need to ensure that all relevant staff are fully trained to perform the roles which they may find themselves called upon to perform in a train stranding incident?
6. Does the protocol address the need to ensure that all trains are suitably equipped to enable passengers and their possessions to be evacuated, when necessary, either via the track or by bridging to an adjacent train?

Passenger groups' checklist

7. Does the protocol make explicit mention of any special assistance to be provided to “particularly vulnerable passengers”, as defined in the ATOC/Network Rail Good Practice Guide SP01?
8. Does the protocol identify all of the available points of egress from the railway and the means by which onward travel by road from these would be provided?
9. Does the protocol indicate that suitable arrangements have been put in place to secure the assistance of local authorities, emergency services and voluntary organizations in meeting the needs of passengers on stranded trains, when necessary?
10. Does the protocol take account of the additional challenges likely to be encountered when handling train stranding incidents at night and/or during periods of exceptionally hot or cold weather?

Checklist sent to 23 TOCs on 6.10.12

Reminder sent to 18 TOCs on 10.11.12

As of 3.2.13, 4 TOCs have yet to reply

All replies shared with ORR

(If you have been)

thank you for listening



**BRITISH
TRANSPORT
POLICE**

Managing Fatalities

**Detective Chief Superintendent Miles Flood
Territorial Policing & Crime**

RIAC 12/02/13

History

- Previous SOP very prescriptive
- July 2011 Territorial Policing take responsibility for fatality management
- Review of SOP and Fatality Management
- Strategic priority to minimise disruption
- Increase in unexplained fatalities
- Increasing instances of passengers stranded on trains
- Increase in delay minutes caused by fatalities of 57%

Issues identified

- **No consistent command structure during incidents**
- **Lack of early scene assessments**
- **No searching of the body pre CSE attendance**
- **No consideration of covering the body and partial re opening lines**
- **Minimal rationale for decision making processes and risk management during incidents**
- **Senior Detectives and CSE attending scenes from significant distances**
- **Time taken to move the body post re classification**

Engagement

- **Liaison with Senior Detectives and CSE**
- **Area Focus Groups (PC, Sgt, Inspectors and FCR staff)**
- **Meetings with Area Coroner Officers**
- **Liaison with HM Coroners and Procurator Fiscal**
- **Liaison with a Home Office Pathologist**
- **Regular liaison and presentations to Network Rail**
- **Process Mapping exercise**
- **Teleconferences with Area fatality leads**

Aims of Fatality Guidance

- **Preservation of the life**
- Ensure the **respect and dignity** of the deceased
- Carry out **professional and diligent** investigations
- Maximise the **safety** of the **public** and minimise the risk to **BTP staff**
- Ensure that BTP staff are able to **respond effectively** to all categories of fatal incidents
- **Work with industry partners** to significantly **reduce disruption** on the railway network
- Increase **community and customer confidence** in the BTP
- Provide BTP with an **effective decision making process** to achieve these objectives

New Fatality Guidance

- **National Decision Model (NDM)**
- **Clarity on Roles and Responsibilities**
- **Procedures where the person is still alive**
- **Classifications**
- **Pre classification assessment process (fast time actions)**
- **Post Incident considerations (Next of Kin, HM Coroners and Procurator Fiscal liaison, de brief process and dealing with property)**

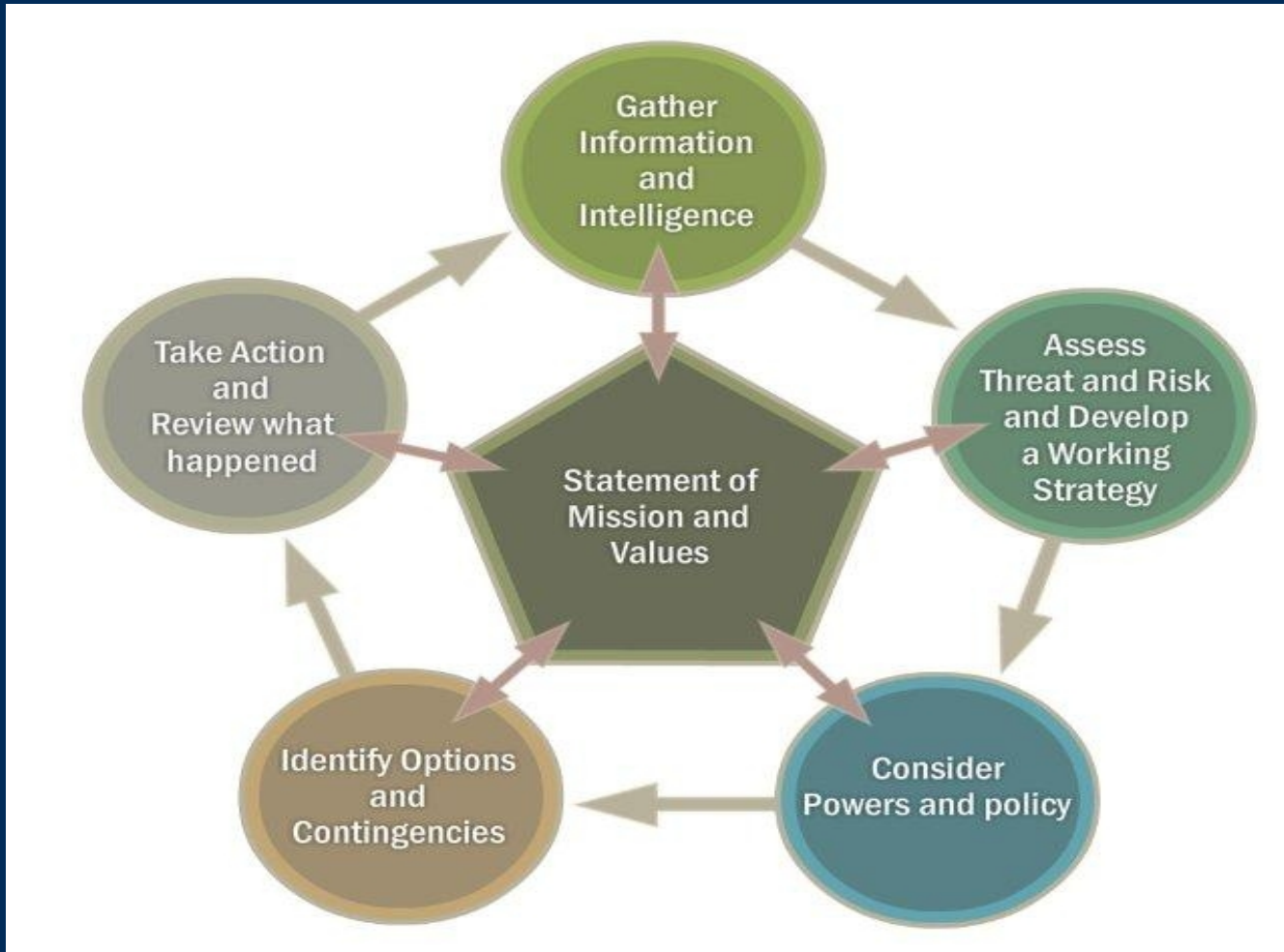
New Guidance cont.

- **Scene Assessments**
- **Searching bodies**
- **Fast time actions**
- **Covering bodies and partial re opening**
- **Multiple fatalities**
- **Witness Accounts (Train Drivers)**
- **Dealing with third party witnesses (possible suspects)**
- **Death following police contact/custody**

National Decision Model

- **Nationally recognised model**
- **Incident Commanders to manage response in a reasonable and proportionate way**
- **Scalable model that can be used before, during and after a fatality incident**
- **Use as a framework to record rationale and command decisions**

National Decision Model



NOT PROTECTIVELY MARKED

Guidance Key Message

All fatalities should be properly managed and investigated by staff at the appropriate level and experience from the moment the call is received until the Inquest into the death is heard with the NDM being used continuously

This will ensure a professional and diligent investigation process during each stage; the initial enquiries, body removal, post area searches, further investigation, liaison with the next of kin, community and coroner liaison and inquest file completion

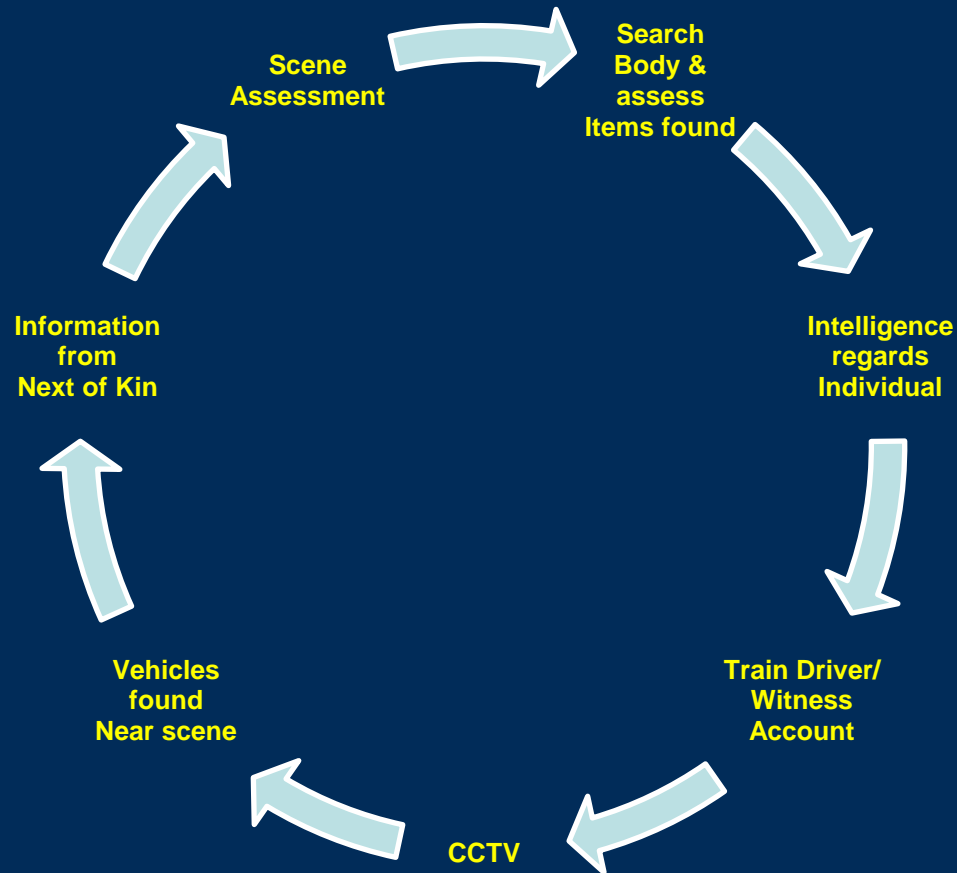
Classifications

- **Suspicious**
- **Non Suspicious**
- **Unexplained**
- **Work Related**
- **Sudden Death**

Unexplained Fatalities

A fatality for which there is no immediate explanation as to the cause of death and there is no available information or intelligence to confirm that the death is either suspicious or non-suspicious

Pre Classification



Research and Analysis

- Fatalities Research and Analysis
- Research on risks and harm
- Qualitative Research (survey of frontline practitioners)
- Review of critical incidents and complaints
- Forensics and body recovery
- Categorisation model
- Homicide Review
- Hypotheses development
- Flanagan

Facts

- No unexplained fatalities have been reclassified as suspicious
- Home Office statistics state that only 4% of Homicides in England and Wales have involved the body being moved from the original scene to a deposition site
- There are no records of the railway environment being used as a deposition site

Fatality Performance

Non suspicious and unexplained incidents (1st April – 6 th Feb)	Number of Incidents	Average time to deal
2011/12	253	116
2012/13	257	84

Unexplained fatality classifications are down **65%** in 2012/13 with **29** compared with **84** in 2011/12

Network Rail Disruption Minutes (April –Jan)	2011/12	2012/13
Fatalities and incidents involving persons who are injured after being struck by trains	422,067	333,920

Chippenham – 7 March 12

New Fatality Guidance

- **20:08 hours** A driver of a train at 110MPH reported seeing a body in the 4 foot
- **20:11 hours** Both lines at a stop and no reports of any train striking person
- **20:35 hours** MOM on scene
- **20:33 hours** BTP on scene and CSE aware
- **21:25 hours** Body searched by BTP. No identification but vehicle keys found. Vehicle was quickly located. Bag inside vehicle gave identification of the individual. The deceased was missing from a psychiatric unit
- **21:38 hours** Declared non suspicious and body recovery commenced
- Once deemed non suspicious, lines were handed back within 13 minutes at 21:51
- **21:57 hours** No trains trapped and earlier effected trains diverted

Old Standard Operating Procedure

- **20:08 hours** A driver of a train at 110MPH reported seeing a body in the 4 foot.
- **Immediately would have been declared unexplained based on the account and Cordon across the railway**
- **20:11 hours** Efforts to trace and stop previous trains through the Area
- **20:33 hours** CSE would be deployed (eta 60 to 120 minutes) and advise attending officers not touch or move anything and coordinate a scene. A Detective officer would also be deployed (eta 60 to 120minutes)
- **20:44 hours** Request to move trains would be refused and passengers potentially stuck on trains in the vicinity
- **22:30 hours** CSE arrive and search the body. Vehicle keys found and take scene photographs.
- **23:00 hours** Forensic recovery commences and vehicle found containing details
- **23:10 hours** CSE and attending Detective state nothing suspicious at the scene and trains in the immediate area moved
- **23:30 hours** Vehicle found and items inside examined and declared non suspicious . **Lines handed back**

Disruption Strategy

- Suicide Prevention
- Cable Theft
- Trespass and other railway offences
- Disorder on trains
- Graffiti
- Level Crossings
- Searches on railway
- Crime Scenes
- Unattended Packages

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OFFICE OF RAIL REGULATION

Red Tape Challenge and health and safety reform

Dawn Russell

Red Tape Challenge and Health and Safety Reform

- Red Tape Challenge launched April 2011 – businesses and public asked to identify unnecessary legislation
- All (secondary) rail health and safety legislation reviewed last year
- Main outcome for ORR (safety) - project to review 3 sets of out-dated regulations:
 - Railway Safety Regulations 1999 covering train protection and Mark 1 rolling stock;
 - Railway Safety Miscellaneous Amendments Regulations;
 - Miscellaneous Provisions Regulations 1999



Red Tape Challenge and Health and Safety Reform ORR's Review of Railway Safety Regulations:

- Policy aims of the regulations considered and reviewed internally and discussed with external focus groups
- ORR public consultation due end March 2013
- One new set of consolidated regulations April 2014

Red Tape Challenge and Health and Safety Reform

Other related government workstreams:

- ***Review of the balance of competences*** – an audit of what the EU does and how it affects the UK. Foreign and Commonwealth Office web-site for details.
- ***Focus on enforcement*** - supports Red Tape Challenge by looking at enforcement of regulations. Series of reviews complete/underway and more to come. Department for Business Innovation and Skills for details.
- Red Tape Challenge : Phase 2

Red Tape Challenge and Health and Safety Reform

Health and Safety Executive workstreams implementing Lofstedt Review :

- ▶ major review of RIDDOR
- ▶ proposals to revise, consolidate or remove a number of Approved Codes of Practice including withdrawal of Management of H&S at work ACOP
- ▶ proposals to exempt the self employed from HSWA
- ▶ proposals to consolidate legislation e.g. on biocidal products

Red Tape Challenge and Health and Safety Reform

- ▶ Coming soon
 - ▶ major review of CDM Regs and ACOP – HSE consultation expected Spring 2013
- ▶ ORR's approach
 - ▶ work with HSE as co-regulator as proposals develop
 - ▶ ensure rail sector needs are properly considered and reflected; encouraging full participation of rail stakeholders in HSE processes
 - ▶ respond formally to HSE as appropriate – responses on ORR web-site under consultations

