Oliver Stewart
RAIB Recommendation Handling Manager

1 August 2024

Mr Andy Lewis
Deputy Chief Inspector of Rail Accidents

Dear Andy,

RAIB Report: Near miss with a member of staff at Rowlands Castle station, Hampshire on 19 December 2020

I write to provide an update[1] on the action taken in respect of recommendations 1, 3 & 4 addressed to ORR in the above report, published on 29 September 2021.

The annex to this letter provides details of actions taken in response to the recommendations 1, 3 & 4 and the status decided by ORR. The status of recommendations 1, 3 & 4 is **'Closed'.**

We do not propose to take any further action in respect of the recommendations, 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.

Yours sincerely,

Oliver Stewart

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

Recommendation 1

The intent of this recommendation is to ensure that new and existing MOMs are suitably recruited, trained and managed such that they have the technical and non-technical skills to manage their own and others' safety when on or near railway lines.

Network Rail should build on its work so far in reviewing the role and competency framework of MOMs and other operational response staff, to develop and implement bespoke programmes for selection, recruitment, training, assessment and monitoring at both local and national levels, commensurate with the particular nature of such work.

ORR decision

1. Network Rail has revised the process for selection, training and competence management for Mobile Operations Managers (MOMs).

2. Revision of the MOM selection process has resulted in shorter narrative application screening questions, risk and safety psychometric assessment and a revised interview template, including scenario questions. The closure statement includes a summary of the actions taken by Network Rail routes to implement the changes made in response to the recommendation.

3. Network Rail has introduced new incident management training as part of the MOM initial training programme for responding to operational incidents. The training covers Safe Interactions (conflict management), fatality management, preliminary investigations and the animal care and safety programme. An additional module on track safety for MOMs has been developed and is being piloted.

4. Network Rail has developed and published a new standard (NR/L3/OPS/045/2.24) outlining MOM competence arrangements.

5. 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
- has taken action to close it

Status: Closed.

Previously reported to RAIB

6. On 28 September 2022 ORR reported the following:

We have reviewed the Network Rail action plan and consider it to be appropriate to address the recommendation. We have asked Network Rail for an update as a number of the milestones have passed since the plan was submitted in January 2022. Network Rail have been advised that in order to consider the recommendation

to have been implemented we will need evidence of the outputs from the review and how that has informed actions taken as a result.

Update

7. On 23 January 2024 Network Rail provided the following closure statement:

[N222-13] Rowlands Castle Rec 1 Closure S

Recommendation 3

The intent of this recommendation is to reduce the probability of further impacts on operational safety caused by shortfalls in safety-related management resources in Network Rail's Wessex route.

Network Rail's Wessex route should review its operations management function against the company's Health and Safety Management System to ensure that key safety posts are suitably covered to be more resilient to any prolonged staff unavailability, and take steps to implement any improvements identified.

ORR decision

8. Although the recommendation was made to Wessex route, Network Rail have provided a response that is applicable nationally.

9. Network Rail maintains a register of key safety posts, which includes post holders and their nominated deputies. Network Rail conducted an audit of three regional and three functional posts to assess the provision of suitable cover and compliance with HSMS. The audit identified good awareness and compliance with the HSMS requirements, although five areas for improvement to current processes were found.

10. 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
- has taken action to close it

Status: Closed.

Previously reported to RAIB

11. On 28 September 2022 ORR reported the following:

Having reviewed the initial response from Network Rail, we concluded it did not clearly identify what was being done differently as a result of the Rowlands Castle

incident and the RAIB recommendation. We have arranged to meet the Network Rail lead for the recommendation to clarify this point and will provide RAIB with a more detailed update following that meeting.

Update

12. On 23 February 2023 Network Rail provided the following closure statement and supporting document:

[N210-05] Rowlands Castle Rec 3.doc

Level 2 Functional Audit Report - TA Spe

Recommendation 4

The intent of this recommendation is to reduce the risk posed to passengers at stations from non-stopping trains by ensuring that warnings of their approach are made in a timely manner.

South Western Railway should take action to ensure the adequacy of safety-related passenger announcements and passenger information display messages at all of its stations. In particular, warnings of approaching non-stopping trains should be reviewed and, if necessary, adjusted to ensure that they are made neither too early nor too late to be useful. The continued adequacy of such warnings should then be confirmed as part of routine platform risk assessment processes.

ORR decision

13. Following on from the information provided in our initial response regarding the review by South Western Railway (SWR) of the adequacy of safety-related passenger announcements, we requested a summary of the findings of the audit to assess embedment of change. SWR have provided a summary of the findings of the audit and how they have been incorporated into the PTI risk assessment.

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

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

Status: Closed.

Previously reported to RAIB

15. On 28 September 2022 ORR reported the following:

The response from South Western Railway (SWR) satisfactorily takes the recommendation into account. We have asked SWR what assurance arrangements are in place for the audio and visual announcement audit, PTI risk assessment and safety inspections to ensure consistency.

Update

16. On 28 May 2024 South Western Railway provided the following update:

I undertook the audit following recommendations on announcements pass through at speed that are not stopping at stations. This audit was conducted to cover the recommendations given in 2021.

Findings:
We identified that around 15 platforms were not announcing fast trains passing through. These faults have where rectified sometime ago, and this check was incorporated into our platform train interface risk assessment (PTI RA) at that time of the recommendation.

Warning message:

"Attention: The next train will not stop at this station. For your safety, please stand back from the platform edge."

This is displayed on the CIS and announced audibly.

Platform Train Interface Risk Assessment:
Every PTI RA had the following Section 5d: The assessor should determine what effect trains passing through the platform at speed and/or without stopping may have on the PTI and customers. The assessor should confirm that automatic visual (CIS screens) and audible warnings are enabled and provide sufficient warning time to customers that fast trains are approaching the platform and for them to stand clear. Consideration should also be given to how platform staff supplement this requirement through proactive management of the PTI when trains are due to pass through the platform without stopping.

Note: There are no SWR stations where trains pass through the platform line at a speed greater than 100 mph or freight trains at a speed greater than 75 mph. Between Basingstoke and Eastleigh, only those maximum speeds are likely to be attained by both non-SWR passenger/ECS trains and freight trains, to my current understanding.

Current Practice:
We have since transitioned to the RSSB PTI risk assessment tool, which includes this item. Despite this, some planned safety inspections still reveal that announcements are either not playing due to a local fault or are only displayed on the CIS screen, advising passengers to stand away due to a fast train approaching. When this happens, it is faulted straight away. If the fault is local, we can push a recurring announcement as a mitigation if the issue isn't with the speaker system from our control.

There is currently no SLA (under review) to rectify faults, but if it's safety-related, we can ensure it is fixed within 72 hours, depending on the nature of the fault.

Planned Safety Inspections:
We have also added the fault reporting process for automated platform announcements to be picked up as part of Planned Safety Inspections. All other errors or faults are then picked up on an ad hoc basis.

Previously reported to RAIB

Recommendation 1

The intent of this recommendation is to ensure that new and existing MOMs are suitably recruited, trained and managed such that they have the technical and non-technical skills to manage their own and others' safety when on or near railway lines.

Network Rail should build on its work so far in reviewing the role and competency framework of MOMs and other operational response staff, to develop and implement bespoke programmes for selection, recruitment, training, assessment and monitoring at both local and national levels, commensurate with the particular nature of such work.

ORR decision

1. We have reviewed the Network Rail action plan and consider it to be appropriate to address the recommendation. We have asked Network Rail for an update as a number of the milestones have passed since the plan was submitted in January 2022. Network Rail have been advised that in order to consider the recommendation to have been implemented we will need evidence of the outputs from the review and how that has informed actions taken as a result.

2. 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

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

3. On 31 January 2022 Network Rail provided the following action plan:

Action Plan
Please provide milestones with dates
MOM Selection a) Establish MOM role profile – Dec 21 b) Review current selection process and where there are opportunities for improvement, taking account of the COSS pre-requisites – February 22 c) Pilot new MOM selection process – April 22 d) Consult on new approach to MOM selection – April 22

e) Roll out new approach to MOM selection **June 22**

MOM Training
Update MOM initial training

a) Undertake gap analysis and review June 21

b) Agree priorities for development of new and/or updating existing training modules Sept 21

c) Implement new training programmes from March 22 -Dec 22 – see phases detailed below.

Phase 1: integration of new incident management training for **Aug 21** – completed and includes operational incident responder, tactical incident leader and incident management e-learning.

Phase 2: Includes COSS for Ops, Safe Interactions for MOMs and Bridge Strike Nominee **March 22**

Phase 3: Changes to local training process with publication of a new local training workbook and best practice guide on how to train and mentor new MOMs **March 22**

Phase 4: Includes Animal Incursions, Fatality Management and Operational Decision-Making **June 22**

Phase 5: Spaced learning for initial training for MOMs – pilot to commence in **April 22**

Phase 6: Safety critical communications, preliminary investigations, temporary isolations **Sept 22**

Phase 7: MOM refresher training **Dec 22**

MOM Competence
Draft and publish new competence standard and on-board MOMs onto RailSmart EDS. This includes making a business case to transition MOMs to a refresher training model of competence renewal.
Standard publication date **June 22**
Best practice guide on MOM competence assessment **June 22**
Onboarding of MOMs into RailSmart EDS **Sept 22**

Evidence required to support closure of recommendation

MOM Role Profile
MOM selection process
National Operating Procedures covering MOM Competence and Training (NR/L3/OPS/045/2.24)
Best Practice Guides for Initial MOM training and competence assessment
New MOM initial training programme
Refresher training material

Recommendation 3

The intent of this recommendation is to reduce the probability of further impacts on operational safety caused by shortfalls in safety-related management resources in Network Rail's Wessex route.

Network Rail's Wessex route should review its operations management function against the company's Health and Safety Management System to ensure that key safety posts are suitably covered to be more resilient to any prolonged staff unavailability, and take steps to implement any improvements identified.

ORR decision

4. Having reviewed the initial response from Network Rail, we concluded it did not clearly identify what was being done differently as a result of the Rowlands Castle incident and the RAIB recommendation. We have arranged to meet the Network Rail lead for the recommendation to clarify this point and will provide RAIB with a more detailed update following that meeting.

5. 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

***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

6. On 31 January 2022 Network Rail provided the following initial response:

Action Plan
Please provide milestones with dates
Network Rail provided alternative wording to recommendation 3 at draft consultation, these words were amended to the above recommendation. Network Rail propose to meet the intent of this recommendation by alternative means and beyond the scope of Wessex route. This action plan, although addresses the concerns in Wessex, is business wide. Network Rail Technical Authority has reviewed the Health and Safety Management System (HSMS) and the Local Operations Manager (LOM) role is already a Key Safety Post, this requires each role to have a nominated deputy. This is important because of their key role in training and mentoring Mobile Operations Manager's (MOM) which should not be neglected for any significant amount of time as it could lead to skills fade. Following the findings from Rowlands Castle the Technical Authority will brief all Safety Directors and Heads of Operations Delivery (or equivalent) on the requirement and request they confirm their compliance with the HSMS. A level 2 audit will be conducted by the Technical Authority between April – Sep 2023 regarding the understanding and compliance of all Key Safety Posts in the HSMS. --

Wessex Route
Network Rail Wessex Route accepts the recommendation in so far as:

The LOM role is identified as a Key Safety Post in the HSMS, thus the posts need to have identified post holders and identified deputies to have been briefed on the contents of the Job Description and signed a copy of the job description documentation.

The Head of Operations, Operations Managers both Inner and Outer are aware of the need to comply with the requirement of the HSMS as it pertains to Key Safety Posts.

Wessex Operations (Outer):

- Has reached an agreement to recruit into all LOM roles. This necessitated the addition of two LOM post in the organisation chart to cover two LOM roles that were filled by individuals not reporting to work pending conclusion of a long IR investigation, not yet concluded.

- Of the six LOM posts, four posts have permanent postholders, one post holder is a secondment, and one role has an existing LOM assigned as responsible for the accountabilities and responsibilities for role supported by two deputies.

- In particular, a permanent LOM for the Outer Response Team has been recruited into the role in the last three months. A named deputy has been identified and has been briefed on the responsibilities and accountabilities associated with the role.

- All nominated deputies for these roles have been identified and briefed. All deputies will have signed the associated job descriptions by 21st January 2022.

Wessex Operations (Inner)

- Has seven permanent postholders in eight LOM posts. All postholders have signed the associated Job Descriptions. Deputies have been identified, briefed on the accountabilities and responsibilities of the roles, all but two have signed the associated Job descriptions. The two remaining deputies have recently moved geographical areas and will sign the associated job descriptions to reflect this by 21st January 2022.

Resilience additional action: The LOM roles have been identified as suitable for inclusion within the Wessex HR business strategy succession planning workstream. This seeks to identify and encourage talented individuals and prepare them for future key roles.

Recommendation 4

The intent of this recommendation is to reduce the risk posed to passengers at stations from non-stopping trains by ensuring that warnings of their approach are made in a timely manner.

South Western Railway should take action to ensure the adequacy of safety-related passenger announcements and passenger information display messages at all of its

stations. In particular, warnings of approaching non-stopping trains should be reviewed and, if necessary, adjusted to ensure that they are made neither too early nor too late to be useful. The continued adequacy of such warnings should then be confirmed as part of routine platform risk assessment processes.

ORR decision

7. The response from South Western Railway (SWR) satisfactorily takes the recommendation into account. We have asked SWR what assurance arrangements are in place for the audio and visual announcement audit, PTI risk assessment and safety inspections to ensure consistency.

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

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

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

9. On 7 July 2022 South Western Railway provided the following initial response:

Following the receipt of the recommendation from the ORR we put in place the following:

1. *Audio and Visual Announcements Audit*

    - *An audit document that captured several key areas including CIS screens functioning correctly but most importantly the time it took for an automated announcement to be made prior to trains passing through the station and after. This was undertaken between October 2021 and December 2021.*
    - *Our expectation was that an announcement made in good time was no less than 15 seconds but no more than 60 seconds before a fast train arrived.*
    - *If an error was found or no announcement was made at all this was faulted to the station property team to be corrected.*
    - *The vast majority of stations either work correctly or have no such announcement as generally or a fast service does not pass through that location.*

2. *Platform Train Interface Risk Assessment*

    - *Every PTI RA has the following Section 5d*

- *The assessor should determine what affect trains passing through the platform at speed and/or without stopping may have on the PTI and customers. The assessor should confirm that automatic visual (CIS screens) and audible warnings are enabled and provide sufficient warning time to customers that fast trains are approaching the platform and for them to stand clear. Consideration should also be given to how platform staff supplement this requirement through pro-active management of the PTI when trains are due to pass through the platform without stopping. NOTE: There are no SWR stations where trains pass through the platform line at a speed greater than 100mph or freight trains at a speed greater than 75mph. Between Basingstoke and Eastleigh only those maximum speeds are likely to be attained by both non-SWR passenger/ECS trains and freight trains so due consideration should be given to the potential aerodynamic effects at Micheldever, Winchester and Shawford. Further guidance on considering the aerodynamic effects of passing trains is shown in RIS-7016-INS (Interface between Station, Platforms, Track, Trains and Buffer Stops) Section 10.*

3. *Planned Safety Inspections*

- *We have also added the fault reporting process for automated platform announcements to be picked up as part of Planned Safety Inspections, which are completed monthly. All other error or faults are then picked up on an Ad hoc basis.*