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OFFICE OF RAIL AND ROAD

31 March 2022

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

Dear Andrew,

RAIB Report: Trailer runaway near Hope, Derbyshire on 28 May 2017

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 19 February 2018.

The annex to this letter provides details of actions taken in response to the recommendation and the status decided by ORR. 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 5 April 2022.

Yours sincerely,

Oliver Stewart

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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 confirm that the competence management of staff with safety critical roles is being effectively implemented.

Network Rail should investigate the arrangements for the management of safety critical competencies at its Manchester Delivery Unit to understand the circumstances that led to the mismatch between the competence records of individuals, the assessments they had undertaken and their actual experience. Network Rail should consider whether these circumstances could exist elsewhere and take appropriate actions against a time-bound plan

ORR decision

1. Immediately following the incident the competencies of all Chinley depot staff were reviewed. The falsifying of records by one of the supervisors at Chinely depot was found to have been an isolated incident. That member of staff was subject to disciplinary proceedings and removed from his post. All discrepancies were subsequently remedied and similar checks undertaken, by senior management, across the whole of the Manchester DU. Nothing else was found amiss, leading to the conclusion that the issue was confined to the actions of one individual.

2. Over the following years Chinley depot was specifically selected for a number of internal audits to provide assurance that issues identified during the RAIB and Network Rail investigations had been properly addressed and new processes fully embedded. These included a Skills Assessment Scheme (SAS) audit in 2019, a technical audit and a management systems audit. No “non-compliances” were found and action plans have been developed and implemented where necessary, to address minor issues arising.

3. Annual Capability Conversations (ACCs) and associated SAS processes, which were in their infancy at the time of the incident, have since been embedded and improved upon. The Sentinel App has matured, swiping is more embedded and downloads showing information on the number of times an individual has used a particular competence are now readily available and checked at every ACC.

4. Although Sentinel downloads may have been technically possible in 2017 the depot did not have wi-fi and signal reception was poor, which has been addressed by the provision of a new depot, with wi-fi.

5. Current practices around overdue and expired competencies are more stringent, with the latter being automatically wiped from Sentinel. This has resulted in a more proactive approach to competency management to avoid the inadvertent loss of competencies, including greater oversight by senior DU managers.

6. The “Management Self Assurance (MSA)” regime has also evolved and every manager (including the IDM) is now required to scrutinise the life cycle of one job/SWP each month. Additional MSA questions, covering SAS processes and competence, were devised by Manchester DU management in response to the incident and have since been added to the national question set. The role of the

Manchester DU OTP specialist has also been enhanced, providing additional assurance around OTP specific competency management.

7. In summary, since the incident occurred in 2017 there are now significantly more "checks and balances" in place for ensuring the effective management and oversight of safety critical competencies. The majority of these arrangements have now been introduced across the whole of Network Rail making it far more difficult for the falsification (or any other "mismatch) of competency records to go unnoticed.

8. A number of local initiatives addressing wider cultural issues have also been introduced since the incident. These included workshops with Chinley depot staff, wider roadshows, staff questionnaires (with actions arising tracked to completion) and monthly meetings between the Manchester IDM and DU Section Managers, where safety is discussed. A senior RMT rep described some of the changes arising from these activities as a "benchmark" for "all depots".

9. Finally, Chinley depot is under new management and a new depot building has been provided. The building in use at the time of the incident was in a very poor state and thought to have contributed to cultural issues, including a perception that Network Rail didn't care about Chinley or its' staff.

10. Although Network Rail has provided written submissions in relation to this recommendation, most of the information and discussion of key points has come from regular meetings with staff at the Manchester DU.

11. 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 implement it

Status: Implemented.

Previously reported to RAIB

12. On 8 February 2019 ORR reported the following:

We have asked Network Rail to provide more detail about the outputs from their review to aid our understanding of how they concluded that the mismatch between the competence records of individuals, the assessments they had undertaken, and their actual experience was attributable to the actions of a single individual.

Update

13. On Thursday 10 September 2020 Network Rail provided the following closure statement:

[N178-04] Hope Rec 2 and 3 Closure Stat

14. Network Rail state the following:

A level 2 safety investigation and disciplinary investigation both took place post the event.

Following the incident the route completed a full review of Chinley Depot's management of competences.

This highlighted the irregularities raised in relation to competency management at Chinley Depot. This initiated an investigation into the behaviours of a section supervisor based at Chinley. Following the investigation, disciplinary proceedings were initiated and these resulted in the supervisor being charged with gross misconduct for the falsification of paperwork. Spot checks were completed at other sections by the management team and no other instances of substandard management were found. It was apparent that the issues were specific to the behaviours of an individual and not systemic.

Since the incident the Self Assurance Question set was also amended to include key questions to review the management of competencies and this is reviewed on a periodic basis from the IMDM through to the Section Manager. Additionally, the DU has set up a competency headline board and register to allow clear visibility for each line manager, of all competencies and their status to support the management and review of the process. Attached is Chinley's by way of example. This has all supported the position that the competency management on the DU is adequate.

From reviewing the details above there is was no evidence to believe this was a systemic issue.

Separate to the review the Head of Engineering Capability and Group HR produced a Competence Enterprise Risk Record which has led to several company wider initiatives to improve the governance of competence.

The Technical Authority is funding the Role Based Capability Programme (£11m) and the competence elements of the Blueprint for Engineering Excellent (£7.5m), the other work is in the early stages of development.

This work although not directly linked to the incident at Hope but should provide the ORR with reassurance that NR takes the management of all competences very seriously and will continue to improve the process nationally.

15. On 31 December 2020 Network Rail provided the following update:

Attached is the local review that was completed, this was shared across the business. No national review was completed as the original review did not find any systemic issues. Learning was shared for each area to act appropriately.

Annex A

OFFICIAL SENSITIVE
PERSONAL Hope Clc

Previously reported to RAIB

Recommendation 2

The intent of this recommendation is to confirm that the competence management of staff with safety critical roles is being effectively implemented.

Network Rail should investigate the arrangements for the management of safety critical competencies at its Manchester Delivery Unit to understand the circumstances that led to the mismatch between the competence records of individuals, the assessments they had undertaken and their actual experience. Network Rail should consider whether these circumstances could exist elsewhere and take appropriate actions against a time-bound plan

ORR decision

1. We have asked Network Rail to provide more detail about the outputs from their review to aid our understanding of how they concluded that the mismatch between the competence records of individuals, the assessments they had undertaken, and their actual experience was attributable to the actions of a single individual.

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, but ORR has yet to be provided with the conclusions of their review and a time-bound plan for any remedial actions.

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 6 November 2018 Network Rail provided the following initial response:

> *Network Rail undertook a review of the arrangements for the management of safety critical competencies at the Manchester Delivery Unit prior to publication of RAIB report. This review was conducted by the local team and identified that the mismatch between the competence records of individuals, the assessments they had undertaken, and their actual experience was an issue confined to the actions of a single individual.*
>
> *This review will be independently assessed by the Corporate Investigation & Assurance team to validate its completeness in identifying and understand the circumstances and causes of these competence management issues and the effectiveness of the actions taken in preventing the likelihood of recurrence.*

The review will also consider the current assurance arrangements for these activities, the effectiveness of these assurance arrangements and assess the likelihood that the competence management issues exist elsewhere.

Any actions resulting from the review will be managed in a time-bound plan. Timescale: 14 April 2019