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9 April 2013

Ms Carolyn Griffiths Chief Inspector of accidents RAIB Cullen House Berkshire Copse Road Aldershot Hampshire GU11 2HP

Dear Carolyn

#### RAIB report: Fatal accident at Grosmont, North Yorkshire Moors Railway

I write to report on the consideration given and action taken in respect of the recommendation addressed to ORR in the above report published on 18 October 2012.

The annex to this letter provides details of the consideration given/action taken where the recommendation is reported as having been implemented.

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

We expect to publish this response on the ORR website on 23 April 2013.

Yours Sincerely

Chris O'Doherty



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# **Proposed Response to RAIB**

# Initial Consideration by ORR

The recommendations contained in the report were addressed to ORR when RAIB published its report on 18 October 2012.

After considering the report / recommendation, on 12 November 2012, ORR passed the recommendation to North Yorkshire Moors Railway Enterprises Plc asking it to consider and where appropriate act upon it.

Details of consideration given and any action taken, in respect of this recommendation is provided below.

ORR also brought the report to the attention of the Heritage Rail association, as ORR concluded that there were equally important lessons for other heritage railways.

#### **Recommendation 1**

The intention of the recommendation is that the North Yorkshire Moors Railway should review and improve its safety management arrangements relating to shunting.

In particular, it is important that the rules covering shunting represent best practice and that training ensures, and assessment tests, a correct understanding of the dangers inherent in shunting and the control measures in place to allow shunting to be carried out safely.

As a minimum, it is intended that the review includes consideration of:

- updating the North Yorkshire Moors Railway's rule book to include relevant rules covering shunting contained in the national network rulebook that may reflect learning from accidents that have occurred;
- improving the method of training so that it is more formalised and reflects a specific syllabus appropriate to the necessary competence to be achieved;
- how assessment and re-assessment should cover all the necessary areas of competence relating to shunting and how the outcomes of assessments should be documented; and
- the system of management checks and how they should be documented.

The North Yorkshire Moors Railway should review its safety management arrangements with regard to shunting.

The review should particularly take into account the adequacy of, and best practice in, the following:

- the rules covering shunting;
- the method of training staff to undertake shunting duties;
- the method of assessment of staff, which should include elements of both practical and written assessment, being passed out for shunting duties for the first time and on subsequent occasions; and

• the system of management checks confirming that safe methods are being applied.

The North Yorkshire Moors Railway should implement any necessary changes and should document the revised safety management arrangements.

# Details of steps taken or being taken to implement the recommendation

North Yorkshire Moors Railway in its response on 31 January 2013 advised that:

# 1. Rules covering shunting

As the RAIB report notes, the NYMR Rule Book and related instructions are based on those applying on British Rail. The rules relating to shunting are set out in Section J, and for the coupling and uncoupling of Buck-eye vehicles in the General Appendix (Part II Instructions for the operation of Buck-eye automatic couplers and Pullman gangways). Reference also needs to be made to Rule Book Section D in relation to hand-signals.

NYMR agree and accept the recommendation that the rules applicable to shunting should be as up to date as possible to reflect best practice and lessons learnt. It is important, however, that they are appropriate for NYMR's operational circumstances based on the use of heritage rolling stock. While, therefore, we accept the Railway Group Standard Rule Book (GE/RT8000) as a guide, there are certain provisions within our existing rules that we wish to retain (including, for example, the requirement for a 50' separation in some circumstances – a requirement not included in module SS2 'Shunting of GE/RT8000). To maintain consistency with our Rule Book as a whole, we also plan to maintain the existing format for setting out rules on shunting.

In reviewing the need for changes to the rules themselves, we have also considered the guidance note issued by the Heritage Railway Association (HGR-P0014: Shunting; including Coupling and Uncoupling). As a result the following changes have been implemented:

*i.* General Appendix Part II Instructions for the operation of Buck-eye automatic couplers and Pullman gangways: Interim supplementary instructions were issued on the 2<sup>nd</sup> and 12<sup>th</sup> June, to reinforce the key safety procedures that must applied before staff go "in between" two vehicles. Following experience with these, and with the benefit of discussion with an independent expert, a permanent instruction was issued in the September 2012 Monthly Operating Notice (MON).

*ii.* Rulebook Section J: The requirement for a driver to stop if sight of the shunter or the shunter's hand signals is lost (with equivalent provision for loss of transmission where a radio is in use), has been long standing good practice on NYMR, reflected in staff training. An amendment to incorporate the provision within the Rule Book (Section J Clause 3.1) was published in the October 2012 MON. The implementation date allowing for issue, distribution and staff briefing is 1 May 2013. It is of note that accounts of footplate staff actions at the time of the accident shows evidence of this being practice being applied. The RAIB report refers to the fireman no longer being able to see the guard, while the NYMR Internal Investigation was also records the fireman relaying this information to the driver.)

*iii.* Communications: Both GE/RT8000 and the HRA guidance note place emphasis on the need for a proper understanding to be reached prior to shunting operations commencing. A general instruction in relation to the importance of communications was issued through the April 2012 MON, and it is our view that this together with the existing Rule Book instructions covers this requirement adequately. While it may be argued that the wording in module SS2 should be included, our concern is that this would duplicate, and in some circumstances undermine, the communications principles as they apply to all operational procedures.

A decision has also been taken to progressively review and update the current NYMR Rule Book, including converting into electronic format to facilitate amendment. A start is being made with Section J, with a revised draft currently under review. We plan to implement the new Section J from 01 April 2013.

#### 2 The method of training staff to undertake shunting duties

Historically training has been undertaken by allocating a trainee to work with one or more senior guards, supplemented with specific training courses, including shunting, albeit on a voluntary basis. This followed the general principal of "mutual improvement classes" which have a long established and well-tried history throughout the railway industry based on encouraging personal development on a voluntary and self-help basis. In practice the majority of trainees, and some trained guards, took advantage of these training courses, without which their ability to demonstrate competence at the time of final assessment would be that much harder.

NYMR agree with the recommendation that the training programme for shunting staff should include a formal element and commenced development of this approach early in 2012. Thus from January 2012 all trainee guards have been issued with a log book to monitor training progress. This becomes a vital element as they move towards final assessment and examination to demonstrate both specific competencies and experience.

In addition, attendance on the one day shunting course, including both the rules for shunting, and their practical application, has been implemented as a mandatory element for all trainees with the first such course (for Permanent Way staff) held on 04 December 2012. Further courses are being held during February and March 2013 (with opportunity being taken to include refresher training for all existing guards).

The need to gain practical experience also remains a vital element of course, and we believe is still best achieved through working with senior competent member of staffs.

#### 3 The method of assessment of staff which should include elements of both practical and written assessment, being passed out for shunting duties for the first time and on subsequent occasions.

Historically staff have been assessed on the basis of a practical assessment and verbal rules examination prior to initial passing out. Subsequently assessments have been based on biennial oral rules examinations, supplemented by practical ride out assessments at a lesser frequency. Guards intended to work over Network Rail between Grosmont and Whitby/Battersby have been subject to an additional oral examination to establish competence in the relevant Railway Group Standard rules and specific geographical requirements associated with such operations.

The concern expressed by RAIB appears to relate to the lack of recorded details of specific knowledge and competency areas covered during oral examinations, or of the candidates performance. It is of note that the procedure followed by NYMR

closely mirrored that applied throughout the railway industry until relatively recently. Reliance is placed on the competence of the assessor, and by not have a closely defined 'script' to work from, he is encouraged to probe a candidate selectively based on the depth of knowledge displayed.

In parallel with the developments in training, and as noted by RAIB, the assessment process was already under review in early 2012, with an examination record form drafted in April 2012 and about to be trialled. This procedure was fully implemented from 01 July 2012 for guard's periodic re- assessments.

At the same time a detailed examination paper (including required answers) has been developed to cover the initial theory examinations for guards, and for other staff engaged in shunting operations.

NYMR have now committed in our SMS to carry out a practical assessment on all staff who undertake shunting every two years (SMS-8M-S-401 Operations Checks).

# 4 The system of management checks confirming that safe methods are being applied

NYMR's system of spot check observations on various safety critical tasks was introduced several years ago. It is based on the following principles:

*i.* Only senior and competent management and supervisory staff conversant with the procedures undertake these checks.

*ii.* Use of a free form recording process aimed at practical in depth observation rather than a 'tick sheet approach' that could be superficial.

An SMS procedure now defines the frequency for specific checks to be carried out, the aim being that they should inherently be random in order to monitor the correct application of safety procedures as part of the daily routine. It is our belief that, this procedure is appropriate given the nature of our operations and reflects a best practice example for heritage railways.

While, therefore, we do not believe any fundamental change is needed to the process of operational management checks, we have considered RAIB's suggestion for a clearer specification to be given of the scope of each check in terms of the elements of each activity being observed and the specific outcomes. From the start of 2013 operations (16 February 2013) NYMR is introducing a modified form which emphasises the need to record the specific event being monitored, the result observed, and action taken in the event of any discrepancy being noted. This we believe should adequately address the RAIB concern.

In summary, NYMR are committed to learning and applying all appropriate lessons from the RAIB report, with the aim of continuous improvement so far as our safety procedures are concerned.

# **ORR Decision**

ORR is satisfied that North Yorkshire Moors Railway is taking appropriate action to address the recommendation and will continue to engage with NYMR to assure that the recommendation is implemented, as part of ORR's 2013-14 inspection programme .

ORR will write to RAIB if it becomes aware that the information provided in this paper becomes inaccurate.

After reviewing information received from North Yorkshire Moors Railway, ORR has concluded that, in accordance with the Railways (Accident Investigation and Reporting) Regulations 2005, North Yorkshire Moors Railway has:

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

# Status: North Yorkshire Moors Railway is taking action to address the recommendation