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3 December 2015



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

Dear Andrew,

RAIB Report: Fatal accident at Grosmont, North Yorkshire Moors Railway

I write to provide an update¹ on the action taken in respect of recommendation 1 addressed to ORR in the above report, published on 18 October 2012.

The Annex to this letter provides details of the action taken. The status of this recommendation is '**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 becomes inaccurate, in which case I will write to you again.

We will publish this response on the ORR website on 11 December 2015.

Yours sincerely,

Andrew Eyles

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

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.

ORR Decision

1. ORR is content that this recommendation is implemented as the North Yorkshire Moors Railway (NYMR) has:

- updated Section J of its Rule Book, supplemented by briefing notes covering the Rule Book and General Appendix;
- introduced a Professional Shunting Course (in power point) with an associated shunter training day;
- introduced guard and shunter question papers as part of its staff assessment activity, along with practical observation of the task, classroom and practical assessments of competence with reassessment undertaken every two year with practical shunting course; and
- formalised Safety Activity Monitoring.

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

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

Status: Implemented.

Brief summary of progress reported to RAIB

3. On 9 April 2013 ORR reported to RAIB that:

- NYMR had identified changes required to its rule book regarding shunting activities and had also committed to progressively review and update the current NYMR Rule Book;
- all trainee guards had been issued with a log book to monitor shunting training progress, and attendance on a one day shunting course, including both the rules for shunting, and their practical application, had been implemented as a mandatory element for all trainees;
- NYMR had committed in its Safety Management System (SMS) to carry out a practical assessment on all staff who undertake shunting every two years; and
- whilst NTMR does not believe any fundamental change is needed to the process of operational management checks, it had 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, and was introducing a modified form to emphasise the need to record the specific event being monitored, the result observed, and action taken in the event of any discrepancy being noted.

Update

4. ORR has continued to monitor NYMR's implementation of this recommendation through its ongoing inspection activities and liaison meetings with the operator.

5. On 19 October 2015 NYMR provided documentation in support of its implementation of each specific element of the recommendation as follows:

The rules covering shunting

- Revised NYMR Rule Book Section J (Shunting – February 2013), including briefing notes covering the NYMR rule book and general appendix



Section J ST.doc.docx



130322 Briefing Note
Section J.doc



130412 Briefing Note
Gen App.doc

The method of training staff to undertake shunting duties

- Professional Shunting Course along with Shunter training day:



121114 Professional
shunting.pptx



130306
PROFESSIONAL SHUN



Annex E1 (Shunter
Training Day - prograr

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

- Driver, guard and shunter question papers, along with practical observation of task. Re-assessment undertaken every two years with practical shunting course:



Copy of Drivers Rules
Feb 2015.doc



Guards Bi Annual
rules test paper NH 2.



Shunter Question
Paper candidate.docx

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

- Examples of key safety activity monitoring forms:



150526 Key Safety
Activity SR-KD-MD.doc



150225 Key Safety

Activity KJ - MDa.docx



150603 Key Safety

Activity M Jones C Tod



140911 Key Safety

Activity M BellIPearson