Chris O'Doherty
RAIB relationship and recommendation handling manager
Telephone: 020 7282 3752
E-mail: chris.o'doherty@orr.gsi.gov.uk

OFFICE OF RAIL REGULATION

29 January 2014

Ms Carolyn Griffiths
Chief Inspector of Rail Accidents
Rail Accident Investigation Branch
Block A, 2nd Floor
Dukes Court
Dukes Street
Woking GU21 5BH

Dear Carolyn,

RAIB Report: Fatal accident at James St Station Liverpool

I write to update you on the consideration given and action taken in respect of recommendations 1 and 2 which were addressed to ORR in the above report, published on 27 November 2012.

When we previously responded to you on 17 October 2013 we committed to update you on recommendations 1 and 2 by 31 January 2014. The annex to this letter provides further details of the consideration given/action taken in respect of these recommendations where both recommendations have now been implemented.

We expect to publish this response on the ORR website on 12 February 2014.

Yours Sincerely

Chris O'Doherty

Initial consideration by ORR

1. The recommendations contained in the report were addressed to ORR when RAIB published its report on 15 February 2012. After considering the report / recommendation, we passed recommendations 1 and 2 to Merseyrail asking it to consider and where appropriate act upon them. Recommendation 3 was directed to ORR in conjunction with industry parties

2. On 17 October 2013 we reported that all three recommendations were 'in progress' and that we would update RAIB by 31 January 2014. Details of further consideration given and additional action taken, in respect of the recommendations 1 and 2 is provided below.

Recommendation 1

The objective of this recommendation is to reduce train dispatch accident risk by improving the way in which trains are operated.

Merseyrail should evaluate equipment and operational arrangements that allow the person responsible for train dispatch to:

a. observe the platform and train without interruption for as long as possible, ideally until the train has left the platform; and
b. stop the train directly and quickly in an emergency.

Equipment and operational arrangements should be evaluated for existing trains and platforms, and for planned changes and upgrades. The outcome of the evaluation should be a plan to implement appropriate measures to improve safety at the platform/train interface.

Previously reported on 17 October 2013

3. We previously reported that Merseyrail had provided a paper to us, produced by QSS that described the approach Merseyrail would take to implement this recommendation. The paper did not provide sufficient evidence that the recommendation had been or was being addressed. We undertook to meet with Merseyrail and to update RAIB by 31January 2014.

Update

4. ORR met with Merseyrail on 29 October 2013 and raised a number of issues. A further meeting then took place between ORR, Merseyrail and QSS on 14 November 2013 where a number of issues were raised with the QSS report. The final QSS report is attached at Annex B.

5. This report concluded that having completed a full evaluation of the available options identified through the 'Taking Safe Decisions process' that none of the four best options (page 5 of QSS report at Annex B) whether implemented individually or in combination give a return in risk reduction commensurate to their cost. However a number of practicable control measures were proposed that Merseyrail should consider incorporating into dispatch activities which may reduce or mitigate serious dispatch activities, these were as follows:

a) Enhanced briefing of guards to ensure they are aware of and positioned in such a way at the dispatch location to observe as much of the dispatch corridor as possible during dispatch. This capability is helped on 3 car formations as the length of the dispatch corridor is halved;

b) Enhanced briefing to guards to ensure that factors that may increase the potential for a dispatch incident are addressed early in the dispatch process and where possible before the train driver is given the ready to start signal. Such actions may include:

- Delaying dispatch until risk is reduced/removed;
- Challenging of high risk passengers to move clear of the dispatch corridor through verbal warning/use of whistle;
- Liaison with driver to reduce acceleration rate when departing a platform (to give greater potential for injury mitigation should an incident develop as the train departs.

6. A number of control measures have been incorporated/reinforced within Merseyrail's Competence Management System through additional training and briefing, these can be summarised as follows:

- The current Merseyrail Power Operated Door procedure (POD) covers a) and b) above, as the procedure mandates that guards should step off the train onto the platform and observe passengers board and alight the train. In addition the guard should not dispatch the train before they ensure that it is safe to start the train.
- Guards day release courses and safety briefings were delivered in 2012 and 2013 within which the POD procedure and the Passenger Train Interface (PTI) risk were covered in detail, including:

  Issues/hazards that guards would face whilst managing the platform train interface during dispatch (this highlighted the to them the potential for serious injury/death from incidents at the PTI and was to aid them to understand the risks and hazards and manage them effectively;
  Duty of Care – Legal obligations were included, including relating to all people during the train dispatch;
  Types of incidents that could happen and preventative measures (this topic covered at great length the factors that would increase the potential for a dispatch incident and guards were advised to not give the ready to start until they were absolutely sure that all people were clear. This would include advising people to move clear and also reporting high risk passengers)
  Human factors (Situational awareness in relation to the train dispatch process and risks associated with lack of attention/distraction)
  Videos relating to passenger behaviours and being distracted. The passenger behaviour video would lead to discussions about vulnerable passengers and how to manage these.
  Roll back of trains (Passenger Train Interface Risk and how to be managed by drivers/guards
  POD incidents – (highlights risks associated with failure to comply with the mandated POD procedure – lessons learned)
  Use of whistles – where/when/how (implemented at all high risk locations between 15.00 and 17.00)

Merseyrail intend to share the outputs of this report with the relevant trade unionsand engage their support in the continued application of the control measures detailed within

Merseyrail's train dispatch procedures through the on-going training, assessment, monitoring and briefing modules contained within the bespoke Driver/Guards Competence Management Systems.

ORR decision

7. ORR has reviewed the work undertaken by QSS and the four main recommendations it made and concluded that the approach to risk assessing the mitigation controls was suitable and sufficient and the conclusions are reasonable for existing trains and platforms, given the wider activity of Merseyrail. Merseyrail have previously reported that work is on-going to procure new fleet for Merseyrail and consideration is being given to incorporating engineering solutions to both trains and infrastructure within this project to address the risk at the platform train interface. ORR intends to meet with Merseyrail, the PTE and Network Rail to discuss possible future procurement.

8. ORR in reviewing the response and considering the documents provided by Merseyrail has concluded that in accordance with the Railway (Accident Investigation and Reporting) Regulations 2005, it has:

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

Status: Implemented so far as is reasonably practicable.

Recommendation 2

The objective of this recommendation is to reduce the likelihood of falls through the platform edge gap.

Merseyrail, in consultation with Merseytravel, Network Rail and other relevant industry bodies, should evaluate equipment and methods that reduce the likelihood of a person falling through the platform edge gap. Platform edge gap fillers and vehicle body side panels should be included in the evaluation, the outcome of which should be a plan to implement measures when appropriate to do so, for example when trains or the infrastructure are changed, improved or replaced.

Previously reported on 17 October 2013

9. We previously reported that Merseyrail had explained that at the RSSB/ORR workshop, to consider recommendation 3, on 27 March, 2013 it had proposed that RSSB undertake research and produce guidance into platform train interface activity. It confirmed that a number of actions associated with this recommendation would be linked to recommendation 3 and it would use the output of that research when appropriate to do so. In the meantime Merseyrail had been proactive in engaging with Merseytravel, Network Rail and other industry bodies to discuss the potential risk to passengers associated with the interaction between platforms and trains on the Merseyrail network.

10. Merseyrail had explained that the quick win measures identified were in the process of being implemented and that the strategic actions had been input to the industry workshop held on 27 March 2013. We undertook to meet with Merseyrail and to update RAIB by 31 January 2014.

Update

11. As a result of meetings held between ORR and Merseyrail on 29 October 2013 and 14 November 2013 Merseyrail provided an updated list on completed and on-going actions. This list is included at annex C. ORR recognises that further work may be necessary as a result of the outcomes of the RSSB research and guidance in relation to recommendation but Merseyrail in the interim have taken appropriate actions.

ORR decision

12. ORR in reviewing the response and considering the documents provided by Merseyail has concluded that in accordance with the Railway (Accident Investigation and Reporting) Regulations 2005, it has:

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

Status: Implemented