Oliver Stewart
Senior Executive, RAIB Relationship and Recommendation Handling

8 February 2019

OFFICE OF RAIL AND ROAD

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

Dear Andrew,

Trailer runaway near Hope, Derbyshire, 28 May 2017

I write to report[1] on the consideration given and action taken in respect of the recommendations addressed to ORR in the above report, published on 19 February 2018.

The annex to this letter provides details in respect of each recommendation. The status of recommendations 1, 2 and 3 is **'progressing'**.

We will publish this response on the ORR website on 11 February 2019.

Yours sincerely,

Oliver Stewart

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

Initial consideration by ORR

1. All 3 recommendations were addressed to ORR when the report was published on 19 February 2018.

2. After considering the recommendations ORR passed all 3 recommendations to Network Rail asking them to consider and where appropriate act upon them and advise ORR of its conclusions. The consideration given to each recommendation is included below.

3. This annex identifies the correspondence with end implementers on which ORR's decision has been based.

Recommendation 1

The intent of this recommendation is to prevent ad hoc measures being taken when it is necessary to recover rail mounted trolleys and trailers.

Network Rail should provide clear instructions and training to users of rail mounted trolleys and trailers on its infrastructure, on the procedures to be followed in the event of failures, such as of braking systems, that require them to be recovered

ORR decision

4. Network Rail have reviewed their existing training material, together with the material provided by the equipment manufacturer and are developing a revised document. We have asked Network Rail to provide us with a copy of the revised training material to ascertain if it meets the requirements of the recommendation. We also want to see evidence that they have taken learning point 2 into consideration. Timescales for the completion of the training material and briefing to staff are still to be confirmed.

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, but ORR has yet to be provided with a timebound plan.

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 6 November 2018 Network Rail provided the following initial response:

1/ Review training material for rail mounted trolleys and trailers on the procedures to be followed in the event of a failure.

A review has been conducted and the Original Equipment Manual (OEM) contains instructions for removing the trailers. The content of the training

material has been reviewed and information has been requested from NR Training,

Completed 1/10/18

2/ NR training to update documentation to reference the OEM Manual for rail mounted trolleys and trailers training documentation attachment 27 Trailer.

The OEM manual will include clarification that there is a correct and an incorrect way of securing the linch pin, showing photographs of both conditions. The maintenance regime should also be amended to include an inspection of the linch pin condition.

NRT to cover brake system operation. To ensure the brake system is not mechanically disconnected.

3/ Network Rail training will provide details of how many employees currently hold the relevant competency and how NR will ensure compliance with the new standard.

Timescales

In discussion with NRT. A draft document will be produced by 31/10/18. The intent of the document will be reviewed early November 2018. Timescales for completion to be confirmed.

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

7. 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.

8. 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

9. 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

Recommendation 3

The intent of this recommendation is for Network Rail to improve levels of compliance with standards and codes of practice.

Network Rail should take steps to understand the factors at its Manchester Delivery Unit that led to the non-compliances identified in this report, and implement the measures required to improve compliance with the relevant standards and codes of practice. Network Rail should also consider whether the lessons learnt are relevant with respect to other activities at its Manchester Delivery Unit and elsewhere

ORR decision

10. We have asked Network Rail to provide more detail about the review they are undertaking to understand what led to the non-compliances with procedures related to the use of the gator and trailer.

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
- 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

12. On 6 November 2018 Network Rail provided the following initial response:

Network Rail undertook a review led by the local team prior to publication of the RAIB report to understand the causes of the non-compliances with procedures related to the use of the gator and trailer.

This review will be independently assessed by the Corporate Investigation & Assurance and Professional Head of Plant teams to validate its completeness in identifying and understand the circumstances and causes of these non-compliances and the effectiveness of the actions taken in preventing the likelihood of recurrence.

The review will also consider whether the lessons learnt from the review are relevant with respect to other activities at the Manchester Delivery Unit and elsewhere.

Any actions resulting from the review will be managed in a time-bound plan.

Timescale: 14 April 2019