

LUL and sub-LUL sector reports and responses

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40711 Welders asked to weld and carry out fire watchman duties

Concern has been expressed regarding welders at Vital being asked to carry out fire watchman roles whilst carrying out welding duties. The reporter feels that this is a dangerous practice since a fire watchman's job is safety critical and involves full concentration. Fire watchmen are responsible for overseeing welding work and looking out for any hazards which can not be guaranteed whilst carrying out welding duties as well.

The reporter feels that this is a real safety concern as a welder's concentration is likely to be affected from having to carry out two jobs simultaneously. The reporter has been made aware that during fire watchman training, staff are told that the person responsible for carrying out the fire watchman role on site should not participate in any other work.

Can LUL confirm that this practice is prohibited and relay this message on to all staff at Vital?

Response from Tube Lines

The Tube Lines and LU policy on this has always been clear. The fire watchman is appointed to ensure that hot works is carried out in accordance with mandatory safety requirements and controlled. The fire watchman must not undertake any other responsibilities during the hot works. At the end of hot working; the fire watchman shall inform the hand-back (T002) that the works associated with the hot works permit is complete and that areas worked are damped down sufficiently to prevent a track fire. The fire watchman responsible for the hot works shall remain at the work location (platform if tube working) for a period of one hour to guide emergency services to the location of the works in the unlikely event of smouldering or smoke detection.

40567 Drug taking at Lanes for Drains

A reporter is extremely concerned that around half the staff (approximately 20) working for Lanes for Drains are taking drugs. Staff are based at Rainham, Essex, but the problem affects other sites on London Underground where they are sent.

They apparently take cannabis in the mornings on the way to work. This clearly affects their ability to do their jobs safely and competently, though management seem to be turning a blind eye. This has been going on for some time and the reporter says this must be stopped. It is alleged that:

- drugs tests take place, but they are never random;
- staff are normally 'tipped off' in advance and avoid the tests; and
- managers and supervisors are handpicking 'clean' staff to be tested.

The reporter believes only unannounced tests will catch people out. The builders are said to be the worst offenders. Several incidents with the potential to seriously injure someone have gone unreported, or have been 'hushed up'.

The reporter also highlights the widespread of double-shifting and associated problems of fatigue. A check of company wage slips would reveal the extent of this problem.

The reporter would like to see staff properly tested for drugs at Lanes for Drains, and the other issues of non-reporting and double-shifting effectively addressed - this has gone on for too long.

Response from Lanes Group PLC

Thank you for bring this report to our attention, as unfortunate as these instances are, we are always pleased to be given the chance to reply to any allegation, however unfounded they prove to be.

This is not the first time that this report has been brought to our attention as earlier this year we were informed by Tube Lines Ltd. During these uncertain times like all businesses, Lanes Group have taken a close look at the way we operate and in an effort to maximise efficiencies have had to make changes in processes and procedures, some of which have not been welcomed warmly by certain members of our staff and this in turn has lead to what we have proved to be unfounded allegations being made against the company.

We at Lanes have over the last eight months embarked on a comprehensive, totally random D&A testing regime with a company called Medscreen Ltd.

Medscreen has been supplied with the details of all Lanes employees, including the management team and they visit our premises at any time, day or night taking samples at random from our workforce. I have also instructed Medscreen to supply any information on our testing regime to LUL if it is requested.

We at Lanes are committed to a zero tolerance drug and alcohol policy and are ready to be put to the test at any time to verify that fact.

At no time are any members of Lanes staff requested to work double shifts, although in busy periods a selection of our operatives can and do volunteer for overtime.

40645 Staff not adhering to procedure during signal failure

A reporter has expressed concern that staff do not appear to be adhering to the correct procedures when signal failures occur across the network.

The reporter is aware of several incidents over the last few months where staff have not secured the points following signal failures on the Northern line. This is said to be a breach of procedure that could endanger passenger safety.

In the event of a signal failure, the reporter states that there are two ways of securing the points. The first option is to remotely secure the points or alternatively to manually secure the points.

The reporter believes that in situations where the procedures are not being followed, this is resulting in unsafe acts occurring, such as transversing a passenger train over shunt signals. This apparently contravenes *LUL Rule Book 5*, Section 10 which states that 'points must be secured to prevent them moving when a passenger train is to make a move over points under the control of a shunt signal'. Not securing the points in situations such as these may increase the risk of a derailment.

Would LUL please reiterate to all staff, especially staff on the Northern line, that in the event of a signal failure the affected points should be either remotely secured or manually secured?

Response from LUL

Firstly I would like to say that the safety of our staff and customers is paramount and any decision reached is after careful consideration.

The incident to which the report refers involved a cable fault, which resulted in two trains being stalled in section. Normally our first course of action is to secure points and work affected trains through the area, but on this occasion that was not possible as the points ahead were lying against the train.

Initial reports indicated that this failure would take some considerable time to fix, so the senior operational manager on shift together with colleagues on the ground needed to consider how best to ensure we safely moved our customers (to minimise the delay to them) from the incident area to where they might continue their journey. Included in their consideration was the time of day, the distance staff would have been required to walk to reach the location, the detraining of customers and how long it would take, the resources needed to walk customers to the closest station and how long customers would have been on the stalled trains before they could continue their journeys.

The crossover to the rear of the second train stalled presented itself as a method by which we could achieve this, but as the reporter indicated this is a non passenger move signalled via a shunt signal. Before any decision was made to use this route, the senior operational manager consulted with both the line incident manager and rostered duty officer, to confirm the use of this method of moving a stalled train. This consultation is in line with the recognized escalation procedure when dealing with incidents.

This decision was taken given that when the shunt signal is cleared, it is known that the points are indicated correctly and the section ahead to the next colour light signal is clear, it is also the case that the signal and point levers are locked until the train using the route is clear. Also with a train using this signalled route any other points cannot be moved and other signals leading to the same section cannot be cleared, it must also be remembered that these moves are undertaken at low speed.

Line incident managers and rostered duty officers ensure the safe and effective resolution to incidents on behalf of London Underground and that those closest to an incident are supported and given the time to consider all the available options. They give the staff close to the ground a chance to discuss proposed actions and ensure due consideration is given to all the options before proposing a course of action or confirming one already proposed. This is true on all London Underground lines and at all times.

40679 Inadequate rest and double-shifting at West Ealing yard

A reporter is concerned about Clancy Docwra staff based at West Ealing yard taking inadequate rest and double-shifting.

According to the reporter, LUL policy states that a trainee is required to take rest before and after attending a training course, regardless of its duration or length. However, staff are unable to abide by these rules because they fear losing their jobs.

This fear factor is also inhibiting workers to raise their concerns about working shifts back-to-back. The reporter states that management openly encourage double-shift working and that staff feel intimidated to speak up about this.

Because workers are not able to take the required rest between shifts, workers run the risk of experiencing higher levels of fatigue and lower levels of concentration which potentially could lead to someone getting seriously injured.

The reporter believes that the current financial climate is intensifying the situation as it is used as a reason for sustaining unsafe work practices. Consequently, workers are unable to raise legitimate safety concerns internally and are terrified to say anything even if what is occurring is wrong.

Implementing 'Passport to Safety' cards is a solution suggested by the reporter. All existing cards held by a worker, for example personal track safety, entry permits and plasma tickets are combined on this all-in-one card which has the capability of showing when the card holder last worked. This allows the supervisor in charge to permit or restrict entrance onto a site of work. The reporter believes this card could help eliminate double-shifting.

Response from LUL

Clancy Docwra Limited have taken the concerns raised by the reporter very seriously and confirm that the practice of double-shifting is not encouraged, condoned or as the reporter suggests, enforced on employees within an atmosphere of fear prompted by job insecurity or otherwise.

Shift patterns in the preceding month to the report being filed were reviewed and there is no evidence to suggest that double shift working had taken place. What was highlighted was that some entry permit renewals had taken place in the 24 hours preceding a worked shift. Further investigation revealed that it was normal practice to send employees for entry permit renewals (approximately one-two hour duration) at 08:30 on a Monday morning; this was outside shift working patterns as the first and next shift of the week was in engineering hours on Monday night. It was further found that in three instances these permit renewals had taken place at 12:30, which would contravene the 11 hour watershed. The training co-ordinator confirmed that these appointments were taken in preference by candidates to the earlier ones because of the location. To clarify, the 08:30 ones take place in west and north London and the 12:30 ones take place in West Horndon, Essex. It is accepted that this move to accommodate employees compromised the guidelines. Clancy Docwra Limited confirms that all managers and training personnel have subsequently been briefed and training bookings amended accordingly.

Regarding the 'Passport to Safety' (now re-named LUCA [London Underground Construction Access]) cards, the reporter is quite correct in identifying this aspect of its use. Whilst we do not use the system for time keeping, we have already set the card readers to give a warning if someone is exceeding the working time directive. However, this cannot be offered as an immediate solution. Roll out of LUCA commenced at the beginning of this month and it will take at least another year to get all the paper entry permits replaced. We only have a few LUCA sites set up at the moment and it will take another two to three years before all our sites have card readers.

40691 Headlights on '92 Central line stock

Ineffective headlights on the '92 Central line stock are the subject of concern for one reporter. Due to poor filters, the dim lights on these trains only allow drivers to see up to six feet ahead of them in the tunnels.

At full line speed, this gives drivers little time to react and apply the emergency brakes if there happens to be an obstruction on the line.

Incidents of this nature are rare, but have happened in the past – for example, one such incident happened at Mile End a few years ago when a roll of tarpaulin was blown onto the line and led to a derailment.

The reporter is concerned that whilst 20 per cent of the '92 stock light up the tunnels perfectly well, the remaining 80 per cent create tunnel visibility problems for drivers. He questions why the lights on these trains cannot be replaced, or at least modified to allow drivers to see far enough ahead to prevent potential collisions with objects on the line.

Please comment.

Response from LUL

Many thanks for bringing this report to our attention. The Central line fleet management has carried out a thorough investigation and inspection of the condition of the headlights on the Central line 1992 tube stock fleet and have found that nearly half of the headlights had developed minor internal defects which caused slight movement of the reflector resulting in these headlights appearing dimmer than the rest of the fleet. However none were found to be anywhere near as severe as alleged.

As a result of this an order for the necessary replacement components has been placed to enable all headlight housings across the fleet to be replaced in order to correct this deficiency. The expected delivery date for these parts is the end of July 2009 and the Central line fleet maintainers are committing to replace all these components over an eight week period thereafter. They are also reviewing their maintenance quality plans for headlights to improve their processes.

It should be noted that on a high density, short station interval, metro system such as the London Underground the primary function of the on train headlights is not to enable forward vision, instead it is to enable staff working trackside to see the approach of a train from a sufficient sighting distance to allow them to move to a place of safety. This is a point that is made absolutely clear during driver and track safety training courses.

The headlights on underground trains are designed to shine a flat beam of light aimed downwards at the track to a point approximately 30 – 40 metres in front of the train to give sufficient illumination of the area immediately ahead of the train without dazzling passengers on platforms and drivers of oncoming trains. The normal operating speeds and adhesion levels associated with railways that use steel wheels on steel rails mean that the stopping distances are substantial so that even if a more powerful headlight was practicable the driver would still be unlikely to be able to stop the train in time if there were an obstruction on the track.

In addition London Underground operates a 'line clear' access system that severely restricts the work that may be carried out trackside in traffic hours. In tunnel sections and areas where there is restricted access to a place of safety no work is normally allowed during traffic hours at all. In other areas work is allowed subject to the normal track protection arrangements but is restricted depending on the number of trains passing per hour – the greater the number of trains per hour the greater the restriction.

40733 Unsafe practices occurring on Hydrex worksites

Concern has been expressed by a reporter about some unsafe work practices that have been witnessed on Hydrex worksites. These include double and treble shifting by Hydrex staff, staff receiving inadequate rest breaks between shifts, and the loading, unloading and delivering of road rail vehicles (RRVs) by Vaughan Plant Hire staff to Hydrex worksites.

The reporter is aware that Vaughan Plant Hire staff contracted by Hydrex to transport the various RRVs from the plant yard at West Drayton to various worksites are doing so unsafely. The reporter believes that:

- Vaughan Plant Hire staff are not trained on how to move the RRVs, which they need to do when loading and unloading them from the lorries;
- the RRVs are not being strapped down safely when transported to and from worksites. They are only being strapped using two chains - they should be chained at each corner;
- staff are not using banksman slings when they should;
- when delivering the RRVs trackside, the staff do not have the necessary certification to be trackside on their own, nor do they appear to have entry permits where required to be on London Underground infrastructure;
- no risk assessments are carried out on loading/unloading and transporting RRVs to Hydrex worksites; and
- an incident took place where a machine was swung over a live track whilst trains were running during the unloading process.

The reporter has also witnessed unsafe working practices being carried out by Hydrex staff. These include:

- Hydrex staff working double and, on occasion, treble shifts at the weekends. This is occurring because of a shortage of staff who are willing to work these shifts, resulting in staff that are willing to work several shifts in the same weekend;
- staff working several shifts at weekends sleeping in the vans between the shifts as opposed to going home to get adequate rest; and
- staff being onsite for up to 18 hours in one shift, resulting in them receiving inadequate rest breaks between shifts.

For Hydrex:

- The reporter would like to know if Hydrex audit Vaughan Plant Hire on staff training and certification; if not the reporter feels that this should take place as a matter of urgency.
- Are risk assessments carried out on the loading/unloading process at Hydrex worksites?
- Can Hydrex review the shift patterns of their own staff to prevent the double and treble shifting occurring at weekends? (This has been the subject of several previous CIRAS reports).
- The reporter would like Hydrex to ensure that staff receive adequate rest between shifts.

Response from Hydrex

Firstly, we would like to point out that Hydrex is a rental company supplying a wide range of plant (operated and non-operated) to companies in the rail sector. We supply equipment directly to Network Rail for maintenance work, all the “renewals” companies, and the majority of the “enhancement” companies. We are not a principle contractor and as such do not have “Hydrex worksites” as referred to in the CIRAS report.

Secondly we would confirm that, despite the general downturn in activity levels since the beginning of 2009 (which has unfortunately necessitated certain redundancies and a reduction in the supplier base) we have not reduced the size of our Compliance Department which oversees and monitors all aspects of health and safety, competence assessments, and quality systems. The culture at Hydrex is very “open”. We have worked very hard to be inclusive of all staff in safety matters and we are not aware of any of the points raised in the CIRAS report having been raised with our divisional managers, regional managers, or any of our directors.

Nevertheless, we have investigated in detail each of the allegations. Our responses are as follows:-

Vaughan Plant Hire staff (a transport company used by Hydrex) are not trained on how to move RRV's which they need to do when loading and unloading them from lorries.

Vaughan Plant Hire is a company which, as its name suggest, is regularly involved in moving a variety of plant types on low loaders. Hydrex (we think uniquely) offers free training including PTS courses to its transport suppliers, and regularly audits its transport suppliers against a stringent protocol. Any companies not meeting our requirements are removed from our supplier base. We have trained a number of Vaughan Plant Hire's personnel (loading/unloading and PTS). We have also undertaken an audit of Vaughan Plant Hire, the outcome of which is that we have determined to keep using them.

The RRV's (being moved by Vaughan Plant Hire) are not being strapped down safely when transported to and from worksites.

Vaughan Plant Hire, as far as we can see, are working within the CPCS guidelines for "loading and securing of transported items".

Vaughan Plant Hire staff are not using banksman slings when they should.

We are not familiar with the terminology "banksman slings" and cannot understand the exact nature of the issue being raised here. Further clarification would be helpful.

When delivering RRVs trackside, Vaughan Plant Hire staff do not have the necessary certification to be trackside on their own.

Vaughan Plant Hire delivers machines to specific locations for Hydrex. Machines are NEVER delivered to within three metres of any track, staff are not therefore considered to be trackside, accordingly no certification is required.

No risk assessments are carried out on loading/unloading and transporting RRV's to Hydrex worksites.

Risk assessments on loading/unloading and transporting RRV's most certainly have been carried out by Hydrex and have been in place and available to view at every Hydrex depot (for many, many years).

The Reporter has been made aware of an incident where a machine was swung over a live track (by Vaughan Plant Hire) whilst trains were running during the unloading process.

We are aware that a report along the lines described above was submitted to Network Rail recently. The report was investigated by both Network Rail and ourselves in detail. Both Network Rail and ourselves concluded that the report was totally unfounded.

Hydrex staff work double, and on occasions, treble shifts at the weekends. This is occurring because of a shortage of staff who are willing to work these shifts, resulting in staff that are willing to work second shifts over the same weekend.

Hydrex have a robust system of rostering staff. Hydrex depots schedule staff each week and these weekly schedules are submitted to a central control point for review to ensure no working time breaches. After each week's activities have taken place the actual hours worked are compared to the plan. Any exceedance identified are investigated to ensure that appropriate risk assessments were recorded on a timely basis. We are regularly audited in this respect by Network Rail and all the major rail contractors.

Our monitoring systems have not identified instances of double or treble shifting as alleged. Furthermore, our activity levels are approximately 30 per cent down on a year ago.

There is absolutely no shortage of staff available to work weekend shifts. In fact, quite the reverse. We have available to us competent, qualified machine operators who are very willing to work at weekends and for whom we unfortunately have no work.

Staff working shifts at weekends sleep in their vans between shifts as opposed to going home to get adequate rest.

We are not aware of such practices taking place. Hydrex either pays transport costs for machine operators to drive home between shifts or pays a lodge allowance if a drive home is impractical. If it were ever reported to us that a particular individual was sleeping in his van (it never has been) then we would speak to him to establish why, and to quiz him whether he thought he was getting better rest than he would do at home. We would also raise a question if he was charging transport/lodge to Hydrex which in practice was not being incurred.

Staff are onsite for up to 18 hours in one shift resulting in them receiving inadequate rest breaks between shifts.

The Hydrex system of scheduling staff, checking the scheduling and then reviewing actual hours against planned hours means that we are aware of any exceedance that take place. All Hydrex Rail managers are aware that any exceedance need to be risked assessed on a timely basis and this is what is happening. Without further specific information from CIRAS it is difficult for us to investigate this allegation further. However, it should be understood that there are most certainly occasions when overruns do occur on site for a whole variety of reasons and operators are requested by our customers to work longer than 12 hours. That is why we (and our customers) have systems in place to handle such situations.

Observation

We have addressed above the points raised in the CIRAS report. We would, however, like to take this opportunity to make an observation that we have made previously regarding working hours.

It clearly is possible for every machine operator's Sentinel card to carry a recognisable "chip" which, combined with a "swipe card" system, could verify on a real-time basis whether or not an individual has worked in the last 12 hours (when he signs on to a job) and whether he has worked for more than 12 hours (when he signs off). Such a system was previously rejected on the grounds of cost. However, technology has moved on and when most restaurants, cafes, and even some London taxis can accept a swipe card payment is it not time that such a system be introduced which would comprehensively address all working hour issues?

40665 Sharp screws protrude from tin plate hoardings

Self tapping screws which protrude by half an inch behind tin plate escalator hoardings pose a serious risk to those working on escalators, according to a reporter. These screws are extremely sharp and could easily cause a nasty injury. The reporter suggests that if they were on the public facing side of the hoardings something would have been done immediately to protect the public. Why is the safety of workers considered any less important, he/she asks?

The reporter believes these screws are used as a cost-cutting measure, and the standard safe way of doing this would be to use nuts and bolts. This is more time-consuming, however, because it may require the assistance of a second man. The problem tends to arise when new escalators are being fitted.

The reporter is not sure who actually fits these screws in this manner, but suggests an effort be made to find out and re-brief those concerned for any future escalator work. Those responsible for this practice may include the escalator firms, such as KONE and OTIS, and others parties involved, such as Metronet, and any on-site contractors.

Could this information please be briefed out to those who should know?

Response from Tube Lines

A Tube Lines inspector visited Bank Station where Tube Lines are currently replacing escalator No 5. The escalator has a full height full length hoarding which is typical of any of our L&E refurbishment/ replacement sites. The hoarding is made up of a Dexion frame and sheet steel panels secured together by nuts and bolts. The frame is secured to the floor and walls by screws and rawl plugs.

40643 Several health and safety problems reported at Morden depot

A reporter has raised several serious health and safety concerns regarding working conditions and practices at Morden maintenance depot. These relate to heating, washing and toilet facilities, pit cleaning and OHL (overhead lighting).

Depot heating

One of the major concerns is that the depot heating does not function as it is supposed to because one of the two overhead heaters is dysfunctional. Part of the problem appears to be due to the age of the electrical system – the power required to generate heat around the depot cannot be sustained by the old system, and there are electrical circuit issues as well.

Washing and toilet facilities

The washing and toilet facilities are not at an acceptable level of use and the reporter states that a complete refurbishment is required for these facilities to be fit for purpose. There appears to be intermittent issues with the hot water storage tank, one example of this was when staff did not have any hot water to wash themselves for a few days. Additionally, cleaners have resorted to boiling kettles to get hot water to clean trains because the taps do not provide warm water for their use.

Pit cleaning

The reporter states that pits are not cleaned as regularly as they should be. Additionally, he believes that the very unpleasant smells and murky colour of waterlogged areas are an indication of contaminated water in the working area. This is particularly the case with road 18.

OHL

Furthermore, the reporter states that an inadequate amount of light is provided at the entrance to wash roads. Much of the OHL at the depot is in poor condition through a lack of maintenance with light bulbs and tubes coming out of its holders. A temporary solution was implemented but is now inadequate and a longer-term solution is requested.

Despite several accidents and incidents occurring at the depot the reporter is concerned that more people could get injured as a result of these longstanding issues. Concerns have been raised with the management team on numerous occasions but they have yet to be addressed.

The reporter would like health and safety officials to undertake an unannounced audit or inspection of the depot. Is this possible? Also, could LUL outline the measures that will be taken to address the problems outlined in the report?

Response from Tube Lines

Tube Lines have no direct labour staff at Morden Depot, however this will change with TBTC later in the year with a handful of people planned to be there.

The CIRAS comments raised have a response from the Alstom Depot Manager below.

Some part of the complaint could have come from TL sub contractor ISS, the train and depot cleaning contractor. Heating and hot water has cropped up in the past and has been dealt by temporary facilities, as you can see permanent solutions are planned with overhead lighting started.

The depot and its HSQE facilities for the sub contract staff were subject to an ISS audit in January and Morden achieved "blue flag" status the only London Transport site to do so.

40689 Live track during possession

A report has been made following an incident where workers from Enterprise were unknowingly working on a live track and at clear risk of electrocution.

During a weekend possession from on 7-8 March at Pinner station, workers were instructed to take down protective fencing and start working on a live track. Due to a critical omission in their briefing, they were unaware a late engineering train would be approaching their work site only a couple of hours into their shift.

There are several main concerns about this incident:

- workers were under the impression they were all protected;
- they were stepping over the live rail without knowing the potentially fatal risk;
- no Protection Masters were present; and
- ballast bags had been loaded up only six inches from the running rail, causing the train to come to an emergency stop.

It is sheer good fortune that no-one was hurt. The reporter is of the opinion that the protective fencing should never have been taken down, and that workers should not have had free access to the line. Worryingly, lessons that could have been learned have not been briefed out. An opportunity to reduce the risk of this happening in the future has apparently been lost.

What steps will be taken to ensure the risk of this happening again is mitigated?

Response from Enterprise

The incident at Pinner station was reported to LU in accordance with LU procedure and within the required timescale. An immediate investigation into the near hit at Pinner was conducted by LU.

None of the witness statements from project managers, assistant project managers, site inspectors, possession planner, senior SPC and works engineering manager mentioned that operatives were stepping on live rails.

The investigation demonstrated that there was a miscommunication between Enterprise Senior SPC and Enterprise worksite engineering manager.

Indeed, the senior SPC instructed for the bags to be placed at least two metres away from the track but a further instruction by the WEM overruled the first instruction.

Following the recommendations from the investigation, Enterprise method statements now include a section specific to pre-possession works. Enterprise organised seminars in order to communicate the findings and recommendations of this near hit. This was led by Enterprise contracts manager. All management personnel and workforce involved were invited. The seminar encouraged attendees to challenge decisions on site that they might think are unsafe.

The investigation carried out by LU was submitted to Enterprise for review and further consultation between LU and Enterprise took place. This is why an official briefing about the near hit was not held earlier. However, updates were given to the workforce during their monthly behavioural safety meetings.

40022 Lack of PTS training on District line work

A reporter has expressed concerns about Vital Rail and basic safety procedures not being followed during maintenance and renewal work at the eastern end of the District line (Bromley to Upminster). On this section of the line, London Underground and Network Rail track runs in parallel. The reporter says these are red zone working conditions with trains passing very close by on Network Rail infrastructure whilst staff are working.

The situation has deteriorated over the last few months, though the reporter says that for a short period the rules were being followed and RIMINI procedures were adhered to. Staff with the appropriate PTS certification, as well as COSS and lookout staff were assigned to jobs as appropriate.

The nature of the work has not changed, so why are these shortcuts being taken?

A COSS would previously see that all the RIMINI paperwork was signed. This simply doesn't happen anymore - the work is completed without a COSS, lookout or accompanying RIMINI paperwork. Staff have been told that COSSes are too expensive. No safety briefings are given despite the fact there are trains passing through at 70 mph. In short, the reporter says no protection is available to staff in these conditions.

Furthermore, a "don't care" attitude exists at a supervisory level, according to the reporter. The reporter requests a thorough investigation of these issues take place.

Could Metronet comment on who is responsible for setting up the safe system of work in these circumstances?

Response from LUL

Vital Rail had worked in this area, during the time that the report was sent to us, carrying out prevention of buckling and the reporter might have been referring to these works. We use Vital Rail in this area because they have the ability to produce RIMINI plans and afford Network Rail protection to their staff, as they have proved to do so when required. They also have many of their staff trained to Network Rail PTS standard; this means they understand Network rail protection requirements, and if on the night they feel something is not safe they can curtail works on the grounds of health and safety.

However prior to commencing any works we always also consider whether protection from Network Rail is required. The assessment criteria involves the 10ft distance between the two assets, whether a physical barrier is present, and the type of work being undertaken.

40797 Clarification sought on MRL cover

Clarification is sought on guidelines for machine room-less lift (MRL) cover. These lifts - which generally travel from the ticket hall to the platform - are primarily used by mobility impaired customers, but can also be used by other members of the public. They are set to be installed all over the Underground network.

The reporter is concerned that without clear guidelines for cover there is a risk that someone could become trapped in a lift for longer than necessary before help arrives. The guidance issued so far appears to have generated some confusion, and the reporter suggests the issue needs resolving at a more senior level.

Only station supervisors are trained on the use of these lifts. The advice issued previously was that supervisors who left the station, say for a meal break, would have to take the lifts out of service. Managers have now instructed supervisors to ensure the lifts are in operation when they leave the station. However, this situation will often leave no-one who is trained on MRL operation able to respond if there are any difficulties.

Customer service advisors are able to talk to anyone stuck in the lift, but have not been trained to open the doors manually in an emergency or how to change the source of power. If a station supervisor had to come from an adjacent station help might be delayed by an additional 15 to 20 minutes.

Could LUL please comment on who is able to cover the MRIs and what training is required?

Response from LUL

Many thanks for sending in this report.

Lifts have been recently introduced at a number of stations as part of LU's strategy to provide 'access for all' on the network. These lifts are typically 16 person lifts and are machine room-less lifts (MRL), a recently developed lift technology, as opposed to the traditional LU larger lift with a machine room above the shaft.

Should a passenger sound the lift car alarm (e.g. they are trapped in the lift) a bell rings at the lift landing and the phone rings at the supervisors office, the supervisor will respond and deal with the alarm accordingly.

If the supervisor cannot respond to the alarm (i.e. dealing with another incident on the station) the emergency alarm call diverts to either the British Transport Police (BTP) control room or the LU Network Operations Centre (NOC). The operators at these locations will pass the call onto the service manager, who in turn, will call up the supervisor to deal with the alarm and/or summon assistance from local management or stations either side to respond to the alarm.

If the supervisor leaves the station for any reason (including the 30 minute meal relief) they must inform the service manager and the duty station manager. The customer service assistant on duty has been briefed to respond to the lift emergency alarm by using the lift intercom system to contact the customer in the lift assuring them that assistance will be provided shortly. The duty station manager or qualified supervisor from another station will be summoned to deal with the lift emergency alarm.

The lift industry standard response to customer 'trapped in lift' in public buildings, blocks of flats etc. is 60 minutes. The procedure described above will ensure any trapped passengers will be released within this time.

Guidance notes were distributed to the group station managers' (GSMs) of the sites where the new machine room-less lifts have been installed. This included the briefing note to be delivered by NVQ qualified duty station managers' (DSMs) to the customer station assistants' (CSAs) and the risk assessment conducted by SQE.

We have also checked the failure and delay register at all sites to check if we had had any lift entrapments with the MRL's since entering service. There have been none.

The briefing to the CSA's covers how to respond to the lift emergency alarm. The CSA's are asked to talk to the customers and reassure then contact the DSM via Connect radio, auto phone, etc.

The lift emergency alarm will default and be answered by NOC/BTP and their standing instructions for all lift emergency alarms is again, talk and reassure customers then pass on the details to the service controller, they in turn will no doubt ring/radio the station. Once established that the DSM is in control, they will stand down and let the local management deal with it. If they can't raise the DSM, the service manager will contact the station supervisor on stations either side to go and assist. CSA's are not trained to release trapped customers, only supervisors or DSM's can perform this task.

40735 Pigeon infestation at Wembley Central and South Kenton

A reporter is concerned about the increasing pigeon problem, mainly at Wembley Central station but also at South Kenton station.

Pigeons have been a problem for several years at these stations, but it seems to just get worse and worse according to the reporter. At Wembley Central there is a footbridge which is only open to the public on days with major events, but staff have to patrol this area on a daily basis as it is also an emergency exit. The reporter states that this bridge is covered in pigeon faeces, creating a slip hazard and, more seriously, a health risk. Breathing in dried pigeon faeces puts a person at risk of a multitude of illnesses, such as E. coli. At South Kenton station, the island platform has similar problems.

The reporter would like to see drastic action taken to combat the pigeon problem and suggests that a specialist contractor needs to be brought in to get the situation under control. The main obstacle to action being taken seems to be uncertainty of who is responsible for it. Both buildings are owned by Network Rail, but LUL is the tenant.

Could LUL and Network Rail confirm who is responsible for dealing with the pigeon infestation at these stations?

Will the responsible party take decisive steps to eradicate this health risk?

Response from LUL

Thank you for your report regarding pigeon infestation at Wembley Central and South Kenton stations.

In response to items raised within this report I would like to clarify these stations are now managed by London Underground as the station facilities operator while Network Rail

remain the landlord. The footbridge at Wembley Central remains a Network Rail asset however and is therefore not within the London Underground lease at present.

South Kenton – From 04/05/09 – 10/05/09 the following action has been taken to address pigeon issues at this location. The scope of works involved the controlled shooting / cull of feral pigeon vermin roosting within the damaged anti-pigeon canopy netting system at South Kenton station by Rentokil pest control, the removal of approximately half of the damaged netting structure, and the subsequent clean and removal of bird fouling and nesting material. There are currently refurbishment works being conducted at this location and when completed towards the end of 2009 new netting will be put in place.

Wembley Central footbridge: A deep clean was conducted on Friday 22 May 2009. Regular meetings with Network Rail are in place to agree further works for implementation of pigeon proofing and ensure the bridge is regularly cleaned until this mitigation is in place.

Response from Network Rail

Wembley Central station

The cleaning of Wembley Central events bridge was discussed by Network Rail and London Underground Limited (LUL) and it was agreed that a thorough deep clean of the bridge would be carried out on 22nd May 2009.

Furthermore, Network Rail and LUL are in ongoing discussions on the measures that are required in order to provide anti-roost protection on the Wembley Central station events bridge. This requires a separate contract as the work needs to be planned, assessed and delivered by Network Rail in line with the possession and isolation programme. The building engineer, in the week commencing 1st June 2009 obtained estimates of cost to progress anti-roost proposals. Network Rail fully understands that the pigeon droppings will continue to cause difficulties until the anti-roost protection work has been completed. However, the type of the permanent infrastructure work which is needed on the bridge must be properly managed.

South Kenton station

The responsibility of cleaning pigeon droppings from the platform falls within the terms and conditions of the station facility owner being London Underground Limited. The response that LUL gave on receiving this complaint is that anti-roost protection had to be removed to facilitate the refurbishment programme of works that is being undertaken to South Kenton station. In the week commencing the 4th May 2009 an attempt to manage the pigeon infestation was performed. On completion of the refurbishment programme the anti-roost protection will be reinstated.

40749 Crowd control at Kings Cross

A reporter has expressed concerns over the crowd control arrangements at Kings Cross station, following a recent security alarm. The concern relates to crowd control both inside and outside the station. The main concern raised is that there are no procedures in place to disperse members of the public once they have exited Kings Cross station. It is currently the only exit out of the station due to the ongoing building work inside the station.

The reporter states that Kings Cross station was particularly crowded on the morning of 18 May. That morning the station was evacuated due to a security alarm.

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The area at the top of the escalators got very congested, but in particular the area just outside the exit got crowded. There were no personnel outside the station to ask people to move on or turn away people trying to enter, and as the crowd built up, it got harder for people still inside the station to exit. People who smoke tend to stop right outside the exit and light their cigarettes, adding to the funnel effect.

According to the reporter, the consequences of not being able to evacuate the station in a speedy and organised manner in a serious emergency could be fatal.

The reporter is unsure exactly who is responsible for the area outside Kings Cross, but believes it might be Network Rail. The reporter would like to see a system in place whereby staff from Network Rail, or whoever else is responsible for the area, assist LUL staff in an emergency by dispersing passengers once they have exited the station. In general, the reporter feels there should be more efficient crowd control measures in place within Kings Cross station as well as outside. Moving the smoking area further away may help alleviate the crowding issue.

For LUL and Network Rail:

- Who is responsible for managing the area outside the Kings Cross exit?
- Can steps be taken to disperse the crowd outside the station during an emergency?

For LUL:

- Is there any way to improve crowd control measures in the underground area of Kings Cross station?

Response from LUL

On the morning of the 18th there were two incidents that happened which caused the station to be congested and to close; the first was a defective train on the Victoria line (which took 25 minutes to reach Kings Cross from Highbury & Islington on the southbound). Please note station control was already in place for the morning peak. During this period staff filtered customers into the station from the main entrance/exit; this does cause a build up of customers trying to get into the station, however, they are kept moving. Inside the station staff were diverting Victoria line customers onto the other lines. At the same time the Victoria was suspended the Piccadilly southbound service was also suspended; this was as a result of a customer going into labour at Russell Square.

The Piccadilly line incident along with the Victoria line suspension caused the station to quickly become overcrowded. The station Congestion Control Emergency Plan (CCEP) provides detailed guidance to staff on what actions to take in the event of congestion. Based on the CCEP and the station supervisor own competence a decision was taken evacuate the station and close.

There were approximately 4,000 customers evacuated from the station that morning using all five exits that were available. The evacuation did cause some crowding issues outside the main entrance/exit. However, some customers boarded buses, walk to other stations in the area, and the area around the main entrance/exit does clear in a short time.

On occasions, as is the case during this incident, some customers will not move away and decide to wait to see when the station will reopen. When this happens assistance is sought from the British Transport Police, which was the case on that morning where the British Transport Police did assist in moving the customers away from the entrance/exit

The group station manager is always looking for new ways to improve crowd control issues at Kings Cross. This is discussed at team meetings, and health and safety meetings. This matter

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is focused on at our regular safety committee meetings, by reviewing incidents/customer flows at peak traffic hours and also events.

Station management will continue to work with other stakeholders (NR and TOCs) to ensure the continued safe operation at Kings Cross.

Please note the opening of the new Northern Ticket Hall in December this will alleviate many of the congestion problems in the main entrance/exit area.

Response from Network Rail

Network Rail would like to thank the reporter for bringing these issues to the attention of CIRAS.

Although the exit next to the LUL entrance is one of the major entrances to King's Cross railway station, it is not the only one. We also have exits out to the taxi rank, out by the suburban shed and a main entrance/exit onto York Way. On the morning of the 18th May, King's Cross overground station was not evacuated, although the underground may well have been closed for a short time due to over-crowding. This is something which happens relatively frequently and something we at the station are becoming increasingly used to dealing with.

When the area outside the station becomes crowded, LUL personnel are on hand to direct passengers to alternative tube entrances at St Pancras International and also along the road to Euston station. Passengers are directed to the alternative locations via pedestrian foot-crossings. In instances such as these where large crowds gather, Network Rail staff from the concourse come outside to assist LUL staff where possible in dispersing the crowds safely. If the station control is informed by LUL control that the underground station is closing due to overcrowding, PA announcements in the station are made to reflect this and make passengers aware in advance. It is unclear from the report whether the reporter was using the railway station or tube, but we can confirm that the gates up from LUL are always manned by LUL staff, particularly in times of crowds when there is usually a minimum of four LUL staff on hand to help direct crowds.

The line distinguishing Network Rail's boundary lies under the canopy outside the station, but we aim to work together with LUL to jointly clear the area when any passenger build up results from tube closure or congestion.

If the reporter is not a regular user of King's Cross, then it could be that he/she found it unusual to see such a large number of people in a small space. Due to the space constraints we have at King's Cross this is something both LUL and station staff are now used to and they work quickly to disperse passengers safely. Under the emergency procedures for the station, should the occasion arise whereby we are unable to effectively disperse crowds, the Metropolitan Police are called and they can close the road and open the road gates to allow passengers safe access to the road and direct them towards Argyll Square – this is the process we would follow in an emergency situation.

It is hoped the above satisfies the reporter's concerns.

40690 Irregular and inadequate PNBs causing fatigue

The timing and length of personal need breaks (PNBs) are the subject of concern for a reporter. The reporter says that workers are not receiving adequate breaks at appropriate times into their shifts. On occasion, workers are instructed to take a 30 minute break just two to three hours

into their 12 hour shift, and then must do without a break for the remainder. This is said to cause high levels of fatigue, which affects concentration on safety critical tasks. Staff have been disciplined when, craving for food eight hours later, they attempt to eat a sandwich. They need food to concentrate.

The *Working Time Directive 2003* states that workers are entitled to a 20 minute break after every six hours of work to allow a sufficient amount of rest.

Can Enterprise:

- control the fatigue risk;
- review the diagrams to allow the timings of the PNBs to be situated at a reasonable time into the shifts; and
- provide reassurance that they will adhere to the Working Time Directive and ensure that all workers receive adequate rest periods?

Response from Enterprise

All Enterprise possessions are planned on 12 hour shifts with one 40 minutes break generally planned after five and a half hour to six hours.

Enterprise personnel were issued with an extract of the *Working Time Directive*.

Additionally, following CIRAS report, for each possession, the Enterprise project manager produced a break rota in accordance with the directive. This rota is briefed to all personnel prior to the possession and is displayed at the signing in point for reference for both the workforce and management.

Enterprise has in place a database whereby it is possible to identify personnel working excessive hours. Reports generated from the database are then forwarded to the relevant Line Manager for remedial actions.