

Network Rail and sub-Network Rail sector reports and responses

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40642 Untrained ISCs taking on IC role

A reporter is concerned that if an incident controller (IC) at York is on leave or off sick, their role is being covered by incident support controllers (ISCs) who are not trained to carry out this role. Subsequently, while ISCs are taken of their jobs to cover the IC's role, their own jobs are left unmanned. This could result in phone calls left unanswered all day, any of which could relate to an emergency.

Moreover, ISCs are not trained to carry out an IC's role and put out NRN calls should they be required to do so in event of an emergency. Can Network Rail ensure that untrained staff are not permitted to cover an IC's role and if in any case they are, then they be fully trained to use the NRN system?

Response from Network Rail

The subject in question relates to an event that occurred as a direct result of a request for annual leave last December. A request was made for annual leave and no staff were available to cover. The request went to the team on shift who agreed to cover with a post down. As this was a team agreement the leave was approved. At no time does York Control manage shifts purposely to leave posts unmanned, or especially with untrained staff.

Further clarification sought from NR. Answers below:

1. Does Network Rail provide assurance that staff covering IC's role have adequate training with which to perform the job safely?

All staff that need to use NRN are trained and any member of staff not trained will not use.

2. CIRAS have also enquired how the report was related to the incident described in the response.

The event in question was as a request for A/L and no cover could be found. The member of staff agreed with the team that they cover to allow A/L to be taken on that night.

The event was highlighted when it was pointed out that with some extra shifts being worked the desks could have been covered. This would have involved Rest Day working not only on the day but the day prior and day after. As such I stated this was not viable and the desk was covered with staff on shift. It was highlighted in this case to CIRAS. In addition with staff trying to take last minute leave before year end other instances occurred which were dealt with by rostered staff covering.

All staff that were covering had been trained in NRN.

40791 CD indicator for platform one at Slough station

A reporter believes that working the Windsor and Eton Central branch would be more comfortable if platform one at Slough station had a close door (CD) indicator. Dispatch procedure at Slough involves drivers leaning out of the cab, looking down the platform and waiting for the platform staff to display a white baton, shortly followed by a green flag and whistle. Sometimes, drivers are looking down the platform for long periods of time, which leaves the reporter with an aching neck. This is particularly the case during cold weather, because

unlike most of the other platforms, platform one is not protected by a canopy. Although it has a right away (RA) indicator, it is also the only platform without a CDRA indicator.

A CD indicator for platform one would eradicate the need to stretch back and look down the platform for the signal and would make working the Windsor and Eton Central branch more comfortable. Could Network Rail consider installing a CD indicator at this location?

Response from Network Rail

Network Rail would like to thank the reporter for raising the above concern. Safety is a highly important issue for Network Rail. Network Rail is aware that the arrangements for the branch service from Slough are as described by the reporter. The branch previously ran with diesel multiple unit (DMU) slam-door stock, and this is part of the reason the current equipment is as described.

We do consider that the current arrangements are safe and, on discussion with colleagues at FGW, recognise that the short turn-around time at Slough for this service will, in most cases, mean the driver is not required to look back along the train for a long time. Colleagues from FGW are more appropriately placed to comment on platform duties, and the requirements on the driver, and I believe will do so.

Network Rail has agreed with FGW that we will carry out a joint risk assessment of the method of working, and ensure that all relevant factors are taken into account, before deciding whether introduction of a CD indicator, or any other changes, are appropriate.

40792 MOMs not given training to cover new area

A reporter is concerned that mobile operations managers (MOMs) at Harlow have not been given training after they were recently asked to cover Cambridge and Tottenham on Sundays.

According to the reporter, MOMs have been told they can use time during their shifts to visit the new areas. The reporter feels that this is insufficient and that Harlow MOMs should be accompanied by an experienced MOM from the new area to fully understand the dangers present. New MOMs are given several weeks to familiarise themselves with the area they have to work in, accompanied by an experienced MOM, and the reporter feels that the Harlow MOMs should have been given the same opportunity when asked to cover these extra areas.

MOMs need to be familiar with crossings, points, the running of trains and many other safety related issues within an area, and the reporter fears that insufficient knowledge will put the MOM's at risk. The reporter would like Network Rail to provide Harlow MOM's with appropriate time and opportunity to familiarise themselves with the Cambridge and Tottenham areas, with the help of local MOM's. Can this be arranged?

Response from Network Rail

Network Rail would like to thank the reporter for sharing their concerns.

The area of cover for each MOM boundary has not changed. Since 2006 MOMs have always had a secondary area of cover which included parts of the neighbouring area in case of such things as sickness and unplanned leave etc. This secondary area has now become part of the basic role for the Harlow MOM on Sundays only. To ensure that MOMs have all the correct knowledge required allowing them to carry out their role safely and with confidence we have arranged for the MOMs to shadow experienced staff. If they felt that additional local knowledge was needed they are to contact the relevant experienced MOM for the area concerned and

shadow them whilst on duty during weekdays and Saturdays. If any MOM feels an additional training plan would be beneficial the Local Operations Manager can provide this locally.

40801 No lighting at Chaddesden Sidings since May 2008

A reporter is concerned about the lack of lighting at Chaddesden Sidings, which is the site of a busy shunting and marshalling yard. The yard is in constant use and is open 24 hours a day, but at night there is no illumination at all, despite the fact lighting infrastructure is in place. The reporter suspects that the lighting problem is down to wiring. Unfortunately, the situation hasn't been resolved since Fastline Freight began using the yard in May 2008. Network Rail are believed to be responsible for the lighting at this location.

In terms of the safety risk posed, the reporter states that if a train was sent down the wrong road by mistake, a low speed collision with wagons could occur if a driver wasn't able to see ahead properly. Also, when uncoupling wagons the risk of injury is much greater when it is not possible to see properly; uncoupling requires the use of both hands and any hand lamp needs to be put down.

The lighting problem is compounded by overgrown vegetation – six foot high in places – and wiring left lying around posing an obvious slip and trip hazard.

Could Network Rail please clarify when the lighting is due to be operational?

Could Fastline Freight clear the yard of slip and trip hazards?

Response from Network Rail

The lighting that is referred to by the reporter is not Network Rail Infrastructure. Commercial property have investigated this and concluded that a previous occupier installed it. There is no agreement for a lighting system to be supplied by Network Rail within this Network siding.

When the sidings were occupied by Midland Mainline in 2007 as part of the Etches Park refurbishment, they supplied their own temporary lighting system which they removed when the project was completed.

Network Rail have already undertaken vegetation works at these sidings and will continue to maintain as required.

40804 Different safety rules for MOMs when breaking ground

It concerns a reporter that operations staff (MOMs) are not required to submit a 'buried services search' when breaking ground, where as other staff are. A buried services search is submitted to a specialist team in York, who will check with utility companies and other sources whether there is anything of consequence buried in the area.

MOMs have been tasked with installing information signs at all access points on the Midland Mainline between London and Derby, which involves digging holes for posts. MOMs have been instructed to carry out a CAT scan of the ground before digging, but they are not required to submit a buried services search, whereas maintenance and P/WAY staff are. The reporter states that CAT scans might not detect everything buried in the ground, putting staff at risk of hitting live wires or cables which could cause electrocution or serious burns. This is possibly a nationwide issue.

The reporter would like to know:

- why MOMs are not required to carry out the same safety checks as other staff, even though they are carrying out the exact same task; and
- if Network Rail considers it safe to only carry out a CAT scan before breaking ground?

Response from Network Rail

Network Rail thanks the reporter for advising CIRAS of their concerns. Following the report all work on installing access point safety signage has been temporarily suspended while a review of the project is undertaken.

Network Rail company procedure *NR/L3/MTC/SE0113 "Surface and Buried services – Avoidance of damage to and danger from"* requires that prior to any work commencing, enquiries shall be made to all potential services owners to obtain available information and/or plans that indicate the positions of buried services.

This places a requirement on the work planner to apply to the Buried Services Investigator for this information but local knowledge to identify any new or previous unrecorded services likely to give rise to risk within the area should also be sourced including documents such as the Hazard Directory.

However, on occasion there may be the necessity to carry out ground disturbance that is not planned. Before work of this nature is started, the team on site shall have knowledge of the procedure (*NR/L3/MTC/SE0113*); possess the competencies in the use of cable avoiding tools (CAT scanner), and risk assessment and method statement preparation. In this case there are additional requirements to complete site surveys which need to be documented on the appropriate forms.

There will also be many cases when the utility companies have not been able to provide full information on their services or the results from the onsite survey are inconclusive. Again in this case the procedure allows for hand dug trenches to be created in addition to CAT survey. The responsible planner for the excavation shall then decide on the extent and need for trail trenches based on depth, method of excavation and likelihood of services in the vicinity.

It should be noted that employees undertaking any roles and responsibilities for activities requiring ground disturbance should be familiar with and work to the requirements of Network Rail company procedure *NR/L3/MTC/SE0113 "Surface and Buried services – Avoidance of damage to and danger from"*.

40805 & 40807 Inadequate training and high workload for customer service assistants

Two reporters have independently come to CIRAS with concerns about inadequate banksman training and high workload for customer service assistants at St Pancras station.

The reporters feel that the hour and a half training they have received does not suffice compared to the five day training course they should be taking. Furthermore, they should be issued with a recognised construction plant competence scheme ticket to allow them to direct and operate machinery – something they have not been given. It is worrying that in the event of an accident, a customer service assistant will hold no official ticket to indicate that they should have been directing any vehicles.

The high workload customer service assistants are facing is a concern for the reporters. It could prove difficult with one person performing both customer service assistant and banksman duties within the Midland delivery yard.

Can Network Rail ensure that customer service assistants are provided with suitable banksman training and are given a recognised ticket?

Response from Network Rail

Background:

During the re-development works at St Pancras station, the Principal Contractor provided Banksmen to control vehicle movements into and out of the Midland Road Delivery Yard area. On completion of the works, the Banksmen were withdrawn and the responsibility for managing the area transferred to Network Rail (CTRL).

A decision was then made by Network Rail (CTRL) that its Customer Service Assistants (CSAs), whose duties involve working in the delivery yard, should receive Banksman training. The rationale being that this would give staff a broader scope of knowledge, which in turn would mitigate against personal injury accidents and damage to the building structure / fabric.

The introduction of these changes were planned to coincide with a wider organisational change and indeed formed part of the formal consultation with staff representatives. However, the implementation was delayed for approximately three-months, whilst training was being arranged. Through this period, contracted Banksmen were provided on a temporary basis.

Training:

Train the Trainer:

The Royal Society for Prevention of Accidents (RoSPA) was engaged to deliver "Train the Trainer" training for a core group of volunteers from the Station Management team. The "Train the Trainer" training is a five-day course and was delivered on site at St Pancras International station.

The trainee Trainers were advised by the RoSPA trainer that there was no specific length of time required for each Banksman training session. However, the training sessions must include both theory and practical. The Trainers were informed that individuals have different ways of learning; therefore some individuals would absorb and retain the knowledge easier / quicker than others.

Further to the above, there was no requirement for any written assessment or for a certificate of attendance to be issued.

Banksman Training:

The current status is that 29 CSAs have received Banksman training. Training sessions average 2.5 hours, with the minimum time being 1.5 hours. At each training session, once the Trainer is satisfied that the trainees are competent, individuals are specifically asked if they have any questions or concerns. These are addressed at the time. The only concern raised with the Trainer thus far is the possibility of delays in getting vehicles into the Delivery Yard and the knock-on effect that this may have on traffic in Midland Road. This issue is addressed by explaining that CSAs responsibilities do not extend beyond the station threshold (Midland Road is a highway and the vehicle driver is responsible for deciding to wait on the road or to drive on).

Workload:

The number of deliveries to the Midland Road Delivery Yard vary throughout each day. However, the peak time is between 08.00 and 09.00, Mondays to Fridays. The maximum number of deliveries logged within a one-hour period, over the past three-week period, was 10.

CSAs have been informed that, for their own safety and that of others, they must work at their own pace and should not be put under any pressure by waiting vehicle drivers.

The process that should be followed by CSAs is as follows:

- Vehicle arrives at entrance to Delivery Yard (entrance and exit controlled by security road blockers, which prevent vehicles from physically accessing the area)
- CSA checks driver's details against the delivery schedule and records details
- Subject to a parking bay / area being available, CSA lowers the security blockers and allows the vehicle into the Yard.
- CSA raises the security blockers, to prevent another vehicle from entering the area.

Average time for this process to be completed is 90 seconds. However, 1:6 vehicles should be security checked prior to being allowed into the Yard. This adds time to the overall process.

The CSA on duty in the Midland Road Delivery Yard is also responsible for undertaking security checks of the area.

An office is located within the Delivery Yard, which is used by the CSA, when not carrying out the above duties.

Hours of Duty:

CSAs work an 8-hour shift in the Midland Road Delivery Yard. During each shift they have two booked breaks; one of 20 minutes and one of 30 minutes.

Considerations:

The safety and health of our staff is treated as the utmost priority and there is a continual programme of formal and informal training, which provides staff with skills that benefit the individual and Network Rail alike.

Whilst no complaints have been made to the Trainers or members of the management team, by people that have been trained in Banksman duties, anyone that does come forward will be offered additional training and re-assessment.

Banksman duties are now listed on the Competence database and as such refresher training and re-assessment will be provided on an annual basis.

Subject to available resources, the General Purpose Relief CSA will be used to assist in the Midland Road Delivery Yard between 05.00 and 09.00 Mondays to Fridays.

40812 Signallers not using the phonetic alphabet

CIRAS has received a report about signallers on the Sheffield - Doncaster route not using the phonetic alphabet when communicating with drivers and/or shunters. Staff use the phonetic alphabet when communicating with signallers to ensure that they are in contact with the correct signal box. However, the reporter comments that recently this has become difficult as some signallers are not using the phonetic alphabet when responding.

As all staff on the railway have to go on a Network Rail communications course, to learn how to use the phonetic alphabet, the reporter feels its use is essential in avoiding an incident on the running line.

Could Network Rail re-brief all signallers in the area on the importance and necessity of using the phonetic alphabet?

Response from Network Rail

Firstly Network Rail would like to thank the reporter for bringing their concerns to our attention.

Secondly, as an experienced and proud Network Rail manager responsible for the overall management of this issue, I would find myself hugely disappointed if the facts reported in this letter are found to be factual and referring to the signalling staff within Doncaster and Sheffield PSB.

The reasoning behind this bold and honest statement is that we, as the operations team at Great Northern, strive daily to raise the bar in every aspect of our respective roles. This includes the standard of safety critical communications.

To this end I have listed below, recent evidence that we treat this issue with the utmost respect and importance I have listed below.

Approximately three months ago the HMRI took random downloads independently. These downloads were taken live. The lowest score received was a C which is a score deemed acceptable by the current operations manual.

In Doncaster PSB for period 4 2009, 30 random downloads were taken: 26 scored C or above and the 4 that scored below the required standard resulted in informal meetings with the staff concerned. Action plans were developed to help the staff elevate their individual communication standard to an acceptable level. These are currently running.

Any individual scoring a C was spoken with on a one to one basis to highlight areas where the communication could be improved.

In period 5 2009, 27 random downloads were taken and all conversations scored C or above. No action plans were developed, although one to one feedback was given as required, in an effort to improve scores where needed.

Through local SWG (station working groups) and the LPG (local performance groups) the team also actively discuss SCC (safety critical communications) with our TOC and FOC customers alike whenever issues are highlighted.

Following receipt of this report we have downloaded 6 voice communications that involve signallers at Doncaster dealing with drivers carrying out shunt moves in and around the station, I can report all were found to be an acceptable standard and in all the cases the phonetic alphabet is used.

As the information provided is a little sparing, it is difficult to identify if this is the example the reporter is referring to.

40790 Long shifts and travel times causing fatigue

Travel times to and from worksites and the potential for an accident on public roads are concerns for one reporter. A combination of travel times of at least an hour each way coupled with a 10 or 12 hour shift are resulting in staff generally only getting 10 hours' rest time between shifts. Working weeks range between 50 and 70 hours, excluding travel time. The reporter comments that work is spread throughout the country and staff are expected to travel to and from the site as well as carrying out their shift with no extra rest time allowed for. In addition staff are not receiving a 20 minute PNB for every 6 hours worked (set out in the *Working Time Directive*) adding to their fatigue.

This has resulted in drivers falling asleep at the wheel and even some having accidents whilst travelling home from a site. The reporter is aware that the company has procedures in place to ensure all staff receive adequate rest periods but comments that this does not work out in practice.

Could the sub contractor please comment on the possibility of including travel times within shifts or supplying drivers to transport staff to and from work sites?

Response

Firstly we would like to thank the reporter for raising his or her concerns over this matter.

Whilst we have noted that it is acknowledged that we have procedures in place to ensure all staff receive adequate rest periods, we are concerned to read that these procedures are apparently not working out in practice and, of equal importance, that the reporter has not felt able to bring his/her concerns to our attention.

With regards to travel times, due to the geographical location of our company, we have a number of control measures in place such as trackers fitted into all vehicles (early 2008) to ensure we can accurately monitor travelling time and safe driving. Since the introduction of trackers the number of road traffic incidents and accidents has reduced, we attribute this also to our safe driving initiatives and safe driver training.

With regards to shifts, a significant amount of our work is throughout the country and where we are not able to accommodate work patterns that fall within the '14 hour door to door' rule, this has led to specific arrangements such as; booking hotel accommodation for our staff to rest in advance of shifts or after shifts, organising dedicated drivers and utilising contracted coach services. Our Roster System also ensures that all working hours are recorded.

All traffic accidents are thoroughly investigated. We are aware of only one accident of alleged driver fatigue. However, on investigation, it was found that the accident followed a shift of 7½ hours with 2 hours travel time. In addition, the driver had had some 14 hours rest prior to commencing this shift. We therefore conclude that neither the working methods used, nor travel time allowed was responsible for this accident.

In conclusion, we do not find that we have or are compromising the health and safety of our employees, by planning to exceed working time directives. We do acknowledge and are aware that situations on site can change at short notice and that this can result in working longer hours. As such we do understand the nature of the concerns raised, that we need to spend time involving our employees at the planning stage so they understand the implications.

For some time we have been looking to see how we encourage our employees to speak out about any issues or working methods that they believe compromise safe working practices. In

August 2009 the sub contractor's CEO and MD launched Plan Safe: Work Safe campaign. Whilst this has been followed up with training sessions and a poster campaign, we have also set up a Plan Safe: Work Safe Council which includes track-worker and plant operator representation. We hope that by demonstrating a hands-on approach, we will be able to proactively prove that issues can be raised openly, will be taken seriously and acted upon.

In conclusion to the final question asked, the answer is that the company already does consider including travel times within shifts and supplying dedicated drivers to transport staff to and from work sites. We now need to involve and communicate this more effectively to our workforce.

40601 Safety of gangs near Exeter

A reporter is concerned about several safety issues when working on the Taunton to Cullompton to Exeter main line (MLN1) and on the Castle Cary to Taunton (CCL) line. In particular, the reporter is concerned about the safety of workers working on this bi-directional line when it is open to traffic, with trains travelling at speeds of up to 100 mph.

The reporter believes that an insufficient number of lookouts have been employed to work with gangs and suggests there should be at least two, if not three, lookouts with the gangs on this stretch of line – one on their side, one in front and one behind. He is concerned that a worker might get seriously hurt if this issue isn't resolved as the insufficiency is compounded by tight line curves at Cullompton. Warning workers to get out of a train's path is very difficult on this stretch of line in particular.

Additionally, the reporter sites several stretches of line where COSS's have difficulty setting up safe sites of work because ballast has been piled high where a cess is required. Furthermore, the reporter feels that managers are unjustly pressurising workers to engage in unsafe practices, telling workers to get on with the work at hand even though they are raising legitimate safety concerns.

The reporter would like more lookouts to be provided and for managers to listen to the workers safety concerns.

Could Network Rail investigate the working methods employed on the Castle Cary to Exeter route and ensure safe methods are introduced?

Response from Network Rail

Network Rail would like to thank the reporter for raising the above concern regarding the safety of gangs near Exeter. Safety is a highly important issue for Network Rail.

The MLN 1 and the CCL are not classified as Bi-Directional, although any line that is open to traffic must be considered at all times as being possible for train movements in either direction until liaison with the controlling signaller has been made to ascertain if single line working is in operation or wrong direction movements are being made. The Cullompton curves that are referred to is a red zone prohibition location, therefore it can only be worked in during a green zone possession- which means lookouts are not required during the possession.

If a COSS believes the safe system of work set up is unsafe, with one lookout, it is the COSS's duty to carry out an additional risk assessment and implement what he/she has assessed as a safe system of work. In addition, any member of staff can raise the Work safe Procedure, where the process is then followed and investigated to ascertain if the system of work being followed is indeed unsafe. Staff are regularly briefed that they can do this and will be supported in doing so.

The issue with the cesses being eroded due to high ballast shoulders and therefore not giving the staff a sufficient position of safety to stand in is already being looked at by Western Route Managers in conjunction with discussions with the High Output Ballast Cleaner (HOBC) project to find a better way to work and re-instate or improve the cesses.

LOWs (Lookout Operated Warning system) is currently being introduced on the Taunton to Exeter MLN1 following a mapping process for the equipment, which should assist in setting up a safe system of work with Lookout protection.

The planned risk assessments of the identified areas in the issue raised will be looked into by the Delivery Unit Safety and Environment Advisor for this location and the Route Safety and Environment Advisor. The results of this will be briefed to the related depot from where this issue is believed to have originated from.

Network Rail will also investigate the suggestions that Local Managers are pressurising the staff to complete tasks without listening to, or considering safety concerns raised by the staff. This is not a practice that is condoned by Network Rail.

40789 Lack of sun visors on rail grinding machines

A reporter has contacted CIRAS over the lack of sun visors in the cab of switch and crossing rail grinding machines, which are owned by Harsco Rail and used nationally by Network Rail. There are five of these machines in total.

The machines function as a train when going to or from a work site, and the lack of sun visor means drivers can get dazzled by the sun, which makes it difficult for them to read signals and look out for people on the tracks. According to the reporter, this issue has been raised repeatedly over about four years, but a resolution is still to be found.

Can a sun visor or blind be installed on these rail grinding machines?

Response from Network Rail

The Network Rail OTM Grinder fleet team are aware of this problem. The Plain line machines have all been fitted with sun visors and the fitment to the S&C machines is subject to an engineering review. This matter was under review and was part of the agenda at the Grinder fleet technical meeting, week commencing 10th August 2009.

The RGH20C Type Railgrinders are owned by Network Rail and operated and maintained on behalf of the National Delivery Service (NDS) by Harsco Rail.

The NDS Fleet Team initiated an operational risk assessment with Harsco Rail driver/operators. In addition, the NDS Fleet Team, NR T&RS Team and Harsco Rail Engineering have worked for some time on identifying two potential designs. These are currently being evaluated to identify the optimum design which will be trial fitted if the risk assessment identifies sun visors as being necessary and if fitment does not affect the driver's line of sight for signals and track workers.

40648 Smoking in vans

A reporter has contacted CIRAS with concerns that some staff in depots on the east Kent coast consistently smoke in the work vans.

The reporter is concerned that non-smoking staff are being exposed to passive smoking, and states that the situation creates an atmosphere of animosity and stress, as some smokers react aggressively when asked not to smoke in the vans.

The reporter would like to see management take a much firmer stance with staff who consistently smoke in the vans. The reporter states that staff have been repeatedly informed by management that smoking is not permitted, but that these instructions are persistently ignored by some smokers and therefore more effective measures are necessary to create a deterrent.

Can Network Rail take steps to ensure that staff do not smoke in vans and ensure that staff are disciplined consistently if they do break this rule?

Response from Network Rail

The Network Rail policy on smoking is that smoking is not permitted in company road vehicles including cars, vans and all leased vehicles when considered in relation to this raised concern. Breaches of the policy by employees will be dealt with under normal disciplinary procedures. In addition, employees, consultants, contractors & visitors may find themselves subject to legal action & fines by enforcing authorities following conviction for breaches of legislation and/or the Railway Byelaws

This policy was briefed to all staff to meet the July 2007 change of law on smoking; but arrangements will be made to re-brief this policy to staff in this area via the usual briefing process. Increased visits by local managers will take place to help eradicate any potential problems.

40734 Ultrasonic testing not detecting serious track defects

The ultrasonic test train used by Network Rail has some quite serious limitations, according to one reporter. The train is routinely used to identify potential defects caused by 'rolling contact fatigue', before ultrasonic testers conduct their own track checks on foot with Sperry sticks. The ultrasonic testers are provided with a GPS coordinate and then test 22 yards (or one chain) either side of it.

The reporter is concerned by many real-life examples where the train has initially failed to detect serious defects at all, or erroneously put them in a lower risk category. The most serious of these – category '1A' defects – refer to cracks of more than 50mm long and 15mm deep, with the potential to derail trains. These defects require immediate attention, which includes clamping and the imposing of a 20 mph speed restriction. An additional concern is that some ultrasonic testers have been told to stop testing by managers where there appears to be a significant chance of finding further defects.

From personal experience, the reporter states the following sequence of events can and does occur:

- the ultrasonic train finds minor defects for which GPS coordinates are provided;
- ultrasonic testers go out to investigate these specific defects;
- they then test further in the general area, finding far more serious '1A' defects. Immediate action is taken in accordance with standard procedure;
- local managers decide to put a stop to any further testing;
- objections are raised by testers who wish to continue testing, but these are ignored;
- these objections prove well founded when, at a later date, testers find their suspicions confirmed – for example, there are indeed more category '1A' defects in the area; and

- in the meantime, trains have been running over these potentially 'high risk' defects.

The assumption is that the risk is 'zero' until proven otherwise - despite suspicions to the contrary. In other words, nobody wants to be in possession of guilty knowledge. But what if those suspicions are routinely found to be correct in areas where there are known problems? The reporter cites one particular example where there were numerous defects on a known gauge corner cracking site, but local managers stopped work with only two and half chains to go. Testers returned to the site a week later to find many '1A' defects. Though it is true to say no-one was in possession of guilty knowledge, the considerable risk was still present for a week. Listening to the concerns of testers at the time would have mitigated the risk.

With a gauge corner cracking site, one can argue there is a high probability of finding serious defects so risk management approaches should allow for prompt, investigative action. The reporter believes there is currently no robust system for logging a suspicion that a section of track is highly likely to contain serious defects.

The test train clearly fails sometimes to detect significant track defects. Could the following be addressed?

- The risks may be well-understood, but can they be reliably detected and pinpointed on a map?
- Are there any statistics on what proportion of defects is missed by the train?
- Given that the train and its onboard equipment are probably here to stay, what measures are in place to mitigate the risk of failing to detect defects?
- Is there any better technology in the pipeline?

At the moment, where ultrasonic testers have well-founded suspicions based on the probability of finding further defects in a given area, the follow-up testing procedure appears to rely on an undocumented, mental note of where defects may be located.

- Could a system be implemented to log these? This may imply guilty knowledge, but in many cases this would surely be preferable to living with a large, potentially catastrophic risk over an unspecified period of time.

Response from Network Rail

The defect types, sizes and probability of detection for the ultrasonic test trains vary slightly from that expected from ultrasonic testing on foot. However, this is taken into account in our testing frequencies, reporting rules and verification timescales. In addition, although ultrasonic test trains are not specifically designed to detect rolling contact fatigue, they are capable of detecting isolated defects that lie within rolling contact fatigue. Testers are required to follow current standards and carry out additional foot inspections for rolling contact fatigue sites to reinforce test integrity. This use of multiple testing techniques provides more complete detection than was previously available using foot inspections alone.

We continue to explore additional ways of checking the integrity of the track and we are currently evaluating the possibility of detecting rolling contact fatigue sites using an eddy current system onboard the ultrasonic test trains. In addition there are weekly calibration checks and the ultrasonic test trains are scheduled to run regularly over test rails with known defects. The results of these activities are monitored to confirm the performance of the trains and their ability to detect the defects in the test rail.

The move to train based testing has allowed us to improve the investigation process, giving better visibility of the number of defects missed. It has also given us the opportunity to test at a higher frequency and the ability to compare current outputs with previous test results. Our procedures are detailed and thorough. They require the ultrasonic tester to test 22 yards (plus handheld GPS inaccuracy) either side of a suspect location. We also have the ability to report any serious defect for ultrasonic testing within a shorter timescale.

The reporter alleges that managers have put a stop to testing when further defects may have been found. However, in order to investigate the allegation further we will need details of locations and times when this is alleged to have happened. The reporter provides a particular example where it is alleged there were numerous defects on a known gauge corner cracking site, but local managers stopped work with only two and a half chains to go. We would encourage the reporter to provide additional information so we can fully investigate this specific allegation.

In a number of instances we have carried out follow-up investigations to examine allegedly missed cracks of more than 50mm long and 15mm deep once these sections had been removed from the track. We would highlight that in these instances the investigations confirmed that the defects did not warrant immediate attention.

For rolling contact fatigue, the standards require the sites to be classified based on the surface length of visible cracks. A statistical relationship has been proven between visible crack length and depth of penetration of the cracks down into the rail (statistically a visible crack length of less than 20mm will have a depth of significantly less than 5mm). Standards are written to reflect this relationship with an increased frequency of inspection required as the length of surface crack increases. Minimum actions for the removal of defects are more onerous where the defect lies within heavy or severe rolling contact fatigue.

The recently developed and implemented Rail Defect Management System database allows the condition and history of all rolling contact fatigue sites to be recorded. The Rail Defect Management System also allows the location and history of all isolated rail defects to be recorded and cross referenced with either current or historic rolling contact fatigue sites. This means that further actions can be implemented in heavy and severe rolling contact fatigue sites and risks reliably detected and pinpointed on a map.

The reporter alleges that where ultrasonic testers have well-founded suspicions of finding further defects in a given area the follow-up testing procedure appears to rely on an undocumented, mental note of where defects may be located. However, this should not be the case, as rolling contact fatigue of any severity should be recorded in the Rail Defect Management System for future monitoring. We have the ability to record small defects including those which lie below the reporting threshold. Our future strategy for reporting defects (sizes, thresholds and minimum action codes) is currently being reviewed.

40529 & 40551 Delay in communicating ESRs to Drivers

Two reporters are concerned about the lack of notice given to drivers about emergency speed restrictions (ESRs). The *Rule Book* requirement has been recently changed, and emergency speed restrictions that are only in place for a short time no longer need to be communicated to drivers. One reporter cites the following information provided in a traction bulletin at work:

“A recent amendment to the *Rule Book module SP* has withdrawn the requirement for Network Rail to issue a special notice advising of emergency speed restrictions that will be in place for a short time. These notices will no longer be published in late notice cases.”

Both reporters feel that this change could have very serious consequences, as vital, safety critical information is not being communicated.

One reporter gives the specific example of Shalford Junction, where an emergency speed restriction of 20mph was put in place. For the previous six weeks the line speed had been 40mph. The only notice that drivers received about the change was a reminder board just outside Guildford, but this didn't state the change in line speed. Unless a driver actually brought a train into Guildford, this would not even be seen. The reporter states that there is a risk of derailment if a driver is not aware of such a change. If the drop in speed is greater, say from 60mph to 20mph, and is not communicated there is an even greater risk.

This exact scenario was experienced by the second reporter who came from Guilford to Aldershot station and continued North. At Aldershot station there was a reminder board at the end of the platform, which did not indicate the speed. The driver had received no information of the speed restriction imposed on that line. The driver later found out that the speed board was placed on the south side of Aldershot and only trains coming from Farnham would see it.

The usual speed restrictions on the piece of track concerned are 50 mph through a tunnel and then 70 mph after the tunnel. After the tunnel there is a bend in the tracks and here the driver was confronted with a 20 mph speed board. The train was going at more than 50 mph and the driver had to brake sharply. Even though the driver was aware that a speed restriction was coming up, he was alarmed to see that it was as severe as 20 mph. The reporter states that it is very difficult to reach the correct speed in time in such circumstances and if the speed restrictions are due to damaged tracks, there is a real potential for derailment.

The first reporter states that anywhere where you can sign on and not know what the speed restriction is further down the line is dangerous. Both reporters would like to see all emergency speed restrictions published in the late notices as they used to be. The second reporter feels that speed boards should be displayed at the end of platforms, so that no drivers risk not seeing a speed board because they come in to a station from a certain direction.

Please could the RSSB specify why there is not longer a requirement to communicate information about emergency speed restrictions on late notice boards? What was the rationale behind the change?

Has Network Rail reviewed the way emergency speed boards are positioned since the *Rule Book* was changed and drivers no longer receive notification of emergency speed restrictions? Will Network Rail consider displaying emergency speed boards at the end of platforms so that drivers are aware of the exact speed restriction?

Response from Network Rail

Network Rail would like to thank the reporter for raising the above concern regarding communication of ESRs. Safety is a highly important issue for Network Rail.

Has Network Rail reviewed the way emergency speed boards are positioned since the Rule Book was changed and drivers no longer receive notification of emergency speed restrictions?

The Rule Book change to the requirement to issue a special notice advising train operators of an Emergency Speed Restriction, (ESR), was withdrawn in June 2008, as the result of a change proposal submitted to the Rail Safety Standards Board (RSSB) by a Train Operator. Emergency Indicators and additional portable AWS magnets are provided on all the

approaches to an ESR. These provide drivers with a visual, and audible, warning when approaching an ESR.

Will Network Rail consider displaying emergency speed boards at the end of platforms so that drivers are aware of the exact speed restriction?

A review of these rules have taken place and amendments to *Rule Book, module SP* will be published in the December AM module (issue 9). We would also like to remind readers that, where drivers may experience confusion with the position of the ESR boards, they should stop their train and communicate with the controlling signaller to make certain of a clear understanding of the speed restriction required.

Response from RSSB

The RSSB proposed changes to lineside signs which were agreed by the relevant Standards Committees. These new lineside repeating warning board (R Board) will show the actual speed a driver must travel at over the restriction. The new lineside signs have been included in Rule Book module SP – they will be published in October in Module AM and will be in force from the first Saturday in December 2009.

40350 Signal EY672 obscured by a mobile phone mast and a building

CIRAS has received a report expressing concern that signal EY672 is no longer visible from the AWS magnet because a mobile phone mast and steel building, housing electronic equipment, have been erected next to the signal. Signal EY672 is located on the Up line between Inverkeithing and North Queen Ferry on the East Coast Mainline.

The reporter states that drivers can no longer see the signal as they pass over the AWS magnet, which they feel contradicts the *Rule Book* which states that “*the AWS does not relieve you of your responsibility for observing signals*”. The reporter does not know how this is possible at signal EY672 as the drivers can not see the signal until they have travelled 70 feet or more past the AWS magnet. The reporter is concerned that this could create a SPAD trap, especially as some trains travel over this section of the line at up to 65mph.

The reporter would like Network Rail to take action to resolve this matter by either putting a banner repeater signal next to the AWS magnet or by moving the building back so the signal is visible from the AWS magnet.

Response from Network Rail

The mobile phone mast and metal building, which is referred to, is a GSM-R tower and associated Radio Electronic Block (REB) housing the telecommunications equipment, which will provide continuous communications between drivers and signallers once commissioned.

Due to the curvature of the line, the rock face and the vegetation, it is somewhat questionable whether the signal could be observed from the AWS magnet. However, when we became aware that there was a possibility that the REB affected the signal sighting, a signal sighting committee was convened and action to remove the REB was undertaken and completed in September 2008.

40671 Unsafe practices at Ebbsfleet International station

A reporter has contacted CIRAS with numerous concerns relating to unsafe practices occurring at Ebbsfleet International station.

The first issue of concern for the reporter is that workers are required to use tools and equipment with insufficient training. Incorrect usage of equipment could potentially be fatal. Additionally, the reporter is concerned about the misuse of tools by some workers. The reporter notes that some equipment has not been used for the correct job.

Instances where tools and machinery are maltreated by some workers are also a point of concern for the reporter. In addition to being abused, the reporter has highlighted that some equipment has been used for the wrong jobs.

Another matter of safety involves not adhering to rules and regulations. For example, when told to load material into bags, or lift bricks, workers are disregarding guidelines and putting their own personal safety at risk.

The reporter is concerned about the lack of safety precaution taken by staff at this station and feels that this stems from a general lack of safety awareness and active implementation of health and safety guidelines. If the appropriate safety practices required on the site are not executed, the reporter feels it could result in serious injuries or fatalities.

- Is Network Rail aware of these unsafe practices occurring at Ebbsfleet?
- Could Network Rail investigate the problem and resolve the issues raised in this report?

Response from Network Rail

Network Rail takes such matters very seriously and we appreciate the reporters concerns. There would appear to be two principle issues, one where the workforce are being asked to use tools when insufficient training has been given by the employer. This is in breach of *Health and Safety at Work etc. Act 1974* which places a clear duty on the employer to provide sufficient training, information and instruction to employees.

The other concern is that individuals are placing themselves and others at risk by not following specific instructions given to them.

The Network Rail Works Package Plan Process (WPP) appears in this case to have been ignored with regard to risk assessments and controls for use of tools and for disregarding the details and instructions contained in the Task Briefing Sheet (TBS). Network Rail continually monitors quality of WPPs and TBSs and challenge as necessary. This specific case has not been previously raised though if more site specific details are provided then we will certainly challenge the company and individuals involved.

September 2009 Update

Proactive inspections have increased since April 09 in this area; to review the methods for both work, and training.

40825 Platform 10 four-foot of Glasgow Central station

A reporter has expressed concern about the detaching of the '5M11' which arrives onto platform 10 at Glasgow Central station. Drivers are expected to detach the locomotive once it has arrived on the platform. To do this they have to stand in the four-foot of the platform where the ground is full of old oil, stagnant water, human waste, and other waste products.

The waste is said to come from passenger toilets – of local passenger services – that are being used while the train is stationary on the platform. The reporter would like the ground to be cleaned regularly to avoid the risk of slipping and the risk of catching any sort of disease from these hazardous substances. Is this possible?

Response from Network Rail

Network Rail would like to thank the reporter for raising the above concern regarding platform 10 of Glasgow Central station. Safety is a highly important issue for Network Rail.

Station inspections have also highlighted the reporters concerns and as a result an action plan has been implemented to address this unpleasant issue. Work will commence at platform 10 on Wednesday 26th August 2009 supported by additional work over a further two weekends taking in platforms 1,2,6,7 which have been identified as the worst contaminated platforms. Periodic work will be then be undertaken to manage the contamination problem at this location. It is anticipated that the situation at Glasgow Central will be vastly improved before this report is published.

40816 COSS/IWA packs not issued for Thursday site visits

A reporter is concerned that staff who carry out site visits on Thursdays, prior to weekend possessions, are not issued COSS/IWA packs. This happens because the work is being classified as 'emergency work', despite the fact that it is planned more than 24 hours in advance.

Instead of the COSS/IWA packs, staff are being asked to fill in a 9937 form themselves, which contain information about directions of traffic, line speed and other safety critical information and is usually part of the complete COSS/IWA. However, staff do not have an up-to-date sectional appendix or the hazard directory so they cannot fill it in correctly.

The reporter would like to see the sub contractor issue a COSS/IWA pack for all track visits, along with a copy of the sectional appendix and the hazard directory for the location. It is suggested that COSS/IWA packs should be issued on Thursdays at the latest. The argument for not doing this is that the blocking points might change for the weekend, in which case a new COSS/IWA pack has to be written up, but the reporter states that this only happens one or two per cent of the time and so the benefits would outweigh the drawbacks.

Could the company;

- consider issuing COSS/IWA packs for Thursday site visits; and
- ensure that workers have access to an up-to-date sectional appendix and hazards directory?

Response

We would like to thank the reporter for bringing this matter to our attention. At the moment Network Rail's staffing requests are received by our company on Monday of each week to cover work on the forthcoming weekend and following week. Once the resource request is received a delivery plan has to be formulated and the work allocated to the staff before the Thursday pre-possession meetings. Staff are normally contacted by our resource team late Wednesday afternoon and given details of the possession they have been allocated to along with their role in relation to the possession.

We have always made it quite clear what is expected from its staff at the pre-possession meetings and these are briefed out at induction, team briefs and face-to-face briefings.

Set out below are the points that we brief out to the staff:

- Where possible staff must attend the pre-possession meeting.
- After the pre-possession meeting, staff are required to find the access points for the possession.
- At the access point the staff must complete a risk assessment form, detailing all the risks at that location.
- At no time are staff instructed to access the infrastructure without the correct documentation.
- Where possible staff must ascertain where the blocking points are, by orientating themselves with the line diagrams provided.
- Where possible staff must try to see the blocking points, from railway access points, platforms and bridges.

At the moment due to time constraints it is not possible to issue any RIMINI packs for site visits. All of our staff are trained to COSS/IWA and therefore competent with the rule book module T7 section 3.1/3.2.

Network Rail has assured us that they will start to request staff six weeks out, this would then make it possible to provide RIMINI packs for all site visits.

In addition to providing all staff with line diagrams for all areas, we will be placing a compendium of all access points with the relevant sections of the hazard directory, sectional appendix, line diagrams and photographs. This is to comply with rule book module T7 3.1/3.2. These will be placed in all of the possession centres so staff can easily access all the information they require should they need to access the infrastructure. Staff can also contact the office at any time and speak to one of four RIMINI planners who have access to the hazard directories and sectional appendices should this be required?

We will be briefing this new system out at the pre-possession meetings in September and in the next Newsletter.

40828 Electrical contractors 'too close' to platform edge

A reporter is querying the practice of electrical contractors working close to the platform edge to install and maintain lighting. Electrical contractors working for Network Rail are usually non-railway staff, the reporter states, and are therefore less aware of the specific risks associated with the railway's operation. The report has been prompted by recent lighting installation work witnessed by the reporter at two large stations carried out close to the platform edge.

Though station staff are responsible for the safety of people working on the platform, they are not normally briefed on the section of the *Rule Book* about using plant or equipment when working on or near the line. Consequently, the risk is greater because they are not always fully aware of the dangers.

In particular, the reporter is concerned that platform lights are frequently being installed on the limit of the safe working distance (four feet) from the platform edge. Because scaffolding and ladders, for example, often need to be three metres tall to reach the lights, they could foul the running line if they fell. Hence, work done in this way could import safety risk unless specific measures are taken to limit it. There is also a risk to passengers who may attempt to walk around scaffolding, bringing them closer to the platform edge. In such cases, a possession

should be taken for any work with scaffolding and ladders close to the platform edge, according to the reporter.

For Network Rail:

The reporter believes Network Rail may benefit from reviewing the practice of having contractors work so close to the platform edge with ladders and scaffolding. Also, why is lighting being installed so close to the edge if it makes future maintenance more difficult? In some cases, such as at Shrewsbury, new lighting appears to have been installed closer to the platform edge than before; this means that all future maintenance work must take place closer to the edge by necessity.

For the RSSB:

The reporter would like to know whether the *Rule Book* confirms that a possession should be used where, for example, scaffolding three metres high is used just a few feet from the platform edge. Does the equipment used affect how far contractors can work from the edge?

Response from RSSB

The reporter is concerned about the installation of lighting, which as such, must be considered as engineering work and thus is being performed 'on or near the line' if carried out within 1.25m of the platform edge where a COSS must be appointed to take charge.

However, if a ladder or scaffolding tower is to be erected then consideration to rules must be given even at a greater distance than 1.25m from the platform edge, since other factors such as OLE or obscuration of signals, fouling of structure gauge and effect on passenger circulation and egress from trains. The method statement given to the contractor of how the work is to take place should take account of these factors.

Just because a ladder is erected within 1.25m of the platform edge does not mean that possessions or blockages to trains must be arranged, as the work itself may be able to be carried out without the safety of passing trains being affected as scaffolding towers on wheels can be secured to prevent movement and ladders can be secured. It will be up to the method statement to describe how this will be done.

To help understand this, it is necessary to read Rule Book module G1 and T6. G1, section 3.2 states that you are 'on or near the line' if you are on a station platform and you are carrying out engineering or technical work within 1.25m of the platform edge. So, although not all of the work may be 'on or near the line' when the work is more than 1.25m from the platform edge, module T6 section 8.1 lists several types of work that must be considered as work that will affect the safety of the line. This list includes work attaching anything to a railway structure or equipment such as a bridge, station roof, signal or electrical equipment. The list also includes work affecting wires, cables or signalling equipment; using ladders, digging holes or stacking materials or equipment close to the line or near the edge of a platform. Module T6 section 8.2 goes on to tell the person in charge of any work that will affect the safety of the line that a COSS must be appointed and the COSS must agree for that work to start.

40826 Site visits and down gradient protection

A reporter is concerned that very few workers in supervisory roles, such as COSS's, machine controllers and supervising engineers, are given white board meetings and site visits prior to a possession. According the reporter, this is a nationwide issue and one which results in workers turning up to a site without sufficient knowledge of the site in general and of any specific hazards present.

The reporter would like to know whether RSSB agree that a white board meeting and a site visit should be given to anyone in a supervisory role and anyone operating machines prior to a possession, particularly when a lift is planned?

The reporter also questions why down gradient protection is no longer used, as a machine could still run away as a result of driver error. The reporter would like to know how one would stop a machine running away on a gradient greater than 1 in 250 without down gradient protection? Please comment.

Response from RSSB

The reporter's concern about the apparent lack of opportunity to gain prior information concerning the detail of planned engineering work is noted. The Rule Book does list in module T3 a number of matters that must normally be agreed at a pre-planning meeting, but the arrangements for organising such a meeting, the scope of its agenda, and the details of required attendees is not covered by any RSSB standard. These are addressed by Network Rail's own internal procedures, and that organisation would be in a position to comment in detail on what actions are required by those processes to make sure that anyone involved in a possession has sufficient understanding of what is to happen.

In answer to the second part of the question, so far as on-track machines are concerned, the rules applicable to drivers and shunters (module SS2) apply equally to those involved with these machines, including those that relate to ensuring that the vehicles are properly secured before being left. Requirements that formerly existed for gradient protection for securing vehicles on gradients were based on the existence of vehicles such as rail-mounted cranes that were completely unbraked, which no longer exist on the network. Current on-track plant must comply with a Rail Industry Standard that requires they are equipped with a fail-safe parking brake able to hold the vehicle on a gradient of 1 in 29. For this reason, the likelihood of a vehicle running away in the manner that the reporter visualises has been greatly reduced by comparison with earlier years.

40817 Blackhorse Road station worksite port-a-cabins

A reporter is concerned about the safety of staff lodging at the Carillion yard, at Blackhorse Road station, following the set up of five port a cabins as accommodation on this worksite.

The port-a-cabins have been placed on the worksite rather than offsite, which the reporter finds unusual. Although rules stipulate that PPE must be worn from the point of entry and at all times whilst on a worksite, the reporter believes this will not happen when staff living in these port a cabins are off-duty – they could be walking around the worksite without PPE. With engineering work occurring at night, this could mean they are not clearly seen by those operating road rail vehicles.

Could Carillion investigate the accommodation arrangements at Blackhorse Road station and check they are suitable for the staff requiring lodging whilst working at this site?

Response from Carillion

Carillion would like to thank the reporter for raising the above concerns. These arrangements have been removed from site and at present there is no intention of providing this type of accommodation again on this project.

Any future consideration of such arrangements will be the subject of a suitable pre-planning assessment that covers all the legal and moral requirements before such arrangements are physically established at the chosen location.

Carillion would request that CIRAS relates that it is still promoting its own internal "Don't Walk By" process and this report would have received the same response if raised internally. The DWB process allows site staff to sometimes gain further information that the confidentiality of CIRAS does not always allow. Whilst not critical in this case other situations may benefit from a direct rather than anonymous approach.

Long Standing Issues

21507 Off indicators at York station

CIRAS has received a report concerned with the poor visibility of the OFF indicators at York station, on platforms five, six, ten and eleven. The reporter believes that visibility of the OFF indicators is affected by their size, their position on the platform (all platforms at York are on a curve) and the fact that they are situated below and in front of the station lights.

The reporter is concerned that poor visibility of the OFF indicators could lead to the indication being misread, with the driver being given the signal to start incorrectly, contributing in a signal passed at danger (SPAD). It is felt that in order to maintain safe working practices Network Rail should remove the current OFF indicators and replace them with fibre optic indicators.

Response from Network Rail

Network Rail would like to thank the reporter for raising the issue of poor visibility of the OFF indicators at York station.

The Off indicators at York station have been reviewed and the work to install new style indicators is currently set for completion mid to late February 2007.

2009 Update

The local infrastructure maintenance delivery manager confirmed that the work was completed and the OFF indicators are now of the LED type.

21531 Access points not having standard locks and keys

Concern has been expressed about access points at the depot in Leicester not having standard locks and keys. The reporter is aware that a certain number of non standard keys are held by staff, but believes that there are times when all the staff holding non standard keys are out of the depot. The reporter is not aware of any keys being kept at the depot in case of an emergency. It is felt that in the event of an accident the use of a non standard lock and key would prevent or at least delay the emergency services and other staff from gaining access to the depot and authorised walking route used to access the track. The reporter feels that this is a serious safety concern and believes that all access points at the Leicester depot should have standard locks and keys.

Additional Information

If it is the case that the emergency services have spare keys or are aware of where to obtain keys in the event of an emergency, the reporter believes that should this information be cascaded to staff it would alleviate any concerns they have.

Response from Network Rail

The Track Maintenance Engineer from Leicester delivery unit confirms that this information was cascaded to all staff at the time of the original report. The gate is owned by DB Schenker (formerly EWS) who fitted a security lock after several instances of trespass onto the sidings which they own when the gate was fitted with a 222 lock. This requires a key for entering on to the live railway infrastructure but not for exiting as there is a handle with a catch.

Keys were distributed to managers at the time. The adjacent signal box which is manned 24 hours a day holds a key for any emergency access for whenever the offices are unmanned.

21757 Non-reporting of near miss

A reporter is concerned that an incident that happened in August 2005 (week 31) may not have been reported to the HMRI, despite the fact it involved a near miss and potential loss of life. This was not followed up, even though at the time it was indicated there might be a formal inquiry and statements were taken. Consequently, the reporter feels important lessons that could have been learned have been lost.

The incident details are as follows:

- Item 177 in the West Midlands between Kings Norton and Bourneville station
- The intention was to take possession of two suburban lines
- The marker boards were put down in the wrong place
- On removing them, the boards were knocked out of someone's hands as a passenger train passed

The reporter believes a major cause of the incident was lack of local area knowledge, with staff called in at short notice. The reporter would like to know why no inquiry ever took place despite initial leanings in that direction.

Additional information

The HMRI have been contacted to check whether or not they knew of this incident.

Network Rail Control Log:

WM/13; Possession Irregularity Item 177 00.20; Saltley PSB advise the Driver of 5R95 (Central) 23.55 Redditch – New St reported hitting a Marker Board on the Up line at Bourneville. Following investigations and consultation with 2nd & 3rd line On Call, various anomalies were found in the Work Pack. Work suspended until a reassessment undertaken. For Cause screening arranged for PICOP and ES. Possession taken at 05.07 with a new PICOP.

Response from Network Rail

This incident was followed up immediately it was reported (copy available if required). The exact details were confirmed through interviews and a number of recommendations made. The investigation and report were carried out by the (then) area delivery planning manager. The PICOP involved was supplied by a third party who assisted with the interview process and shared the findings of the investigation.

There is no doubt that the late notice sickness of the planned PICOP and the consequent late stand in of the replacement meant that a considerable amount of understanding of the possession arrangements, obtained by the original planned SPICOP during pre planning sessions leading up to the possession, was lost.

The report conclusion was as follows:

Following weeks of intensive planning the PICOP, who had been integral to the process, booked sick. This led to another PICOP, being put in the position of managing a high risk, multi train and multi worksite possession, at very short notice. These factors led to the basic cause of the incident which was the miscommunication/misunderstanding between the PICOP and ES as to the location of the worksite being requested.

The PICOP assumed that it was within the section of the possession already granted due to the time of the request, yet it was, in fact, within the portion of the possession that had not yet been taken.

In hindsight, given the nature of this possession and the late notification of the PICOP booking sick, the decision to either cancel the possession altogether, or cancel the first shift, would have been more appropriate. However, in trying to salvage the possession, and given the availability of a substitute SPICOP, it was decided to allow the possession to be taken. It would seem that this person was overwhelmed on the night with phone calls and the pressure of taking a possession he was not fully conversant with. This is a lesson which will be given due consideration in the future if a PICOP books sick at short notice.

Key recommendations were made as follows:

Recommendations to take immediate effect.

Replacement PICOP's

Following advice that, at very short notice a PICOP is not able to take duty for what ever reason, the Possession Delivery Team decides what course of action to take.

This decision must be made upon the following factors:

1. The availability, area knowledge and experience of a replacement PICOP.
2. The content and extent of the possession details.
3. The time factor for rebriefing, not only the replacement PICOP but also the Engineering Supervisor's working within the possession.
4. The amount and complexity of train movements within the possession.
5. The amount of worksites.

Once all the above factors have been considered, the decision must be escalated to the ADPM /IMM before authority for the replacement PICOP to take duty.

Communication

1. Robust communication must be set up and tested prior to the start of any possession. Where possible the PICOP must attend one of the controlling signal boxes to discuss and agree the possession details with the duty signaller.
2. The PICOP ensure safety critical communication is used at all times, including the use of the phonetic alphabet.
3. Use, where possible, voice recorded telephones for all conversations.
4. Make comprehensive notes of all phone calls and messages both made and received.
5. When granting worksites, the PICOP must quote the lines where MB's are to be placed and exact mileage of the MB's on each line. The PICOP must ensure the ES repeats back this direct instruction. Only once the PICOP is satisfied the ES has fully understood the instruction can the PICOP allow the worksite MB's to be placed.

Paperwork

1. All PICOP Possession Packs to be fully reviewed by the Possession Co-ordinator, both before and after the PICOP briefing. Once the PC is satisfied the Pack is completed to the required standard, the PC must sign to confirm.
2. The PICOP must produce a second (back up) Possession Pack for all possessions, which the Possession Co-ordinator's are to retain at the Delivery Unit office.
3. If a replacement PICOP is required to take over a lead shift on a possession, the PICOP must counter sign the Possession Pack to indicate their full understanding of the details contained within it.
4. At the PICOP meeting the PICOP must issue a possession briefing pack to all attendee's complete with a unique reference number. This pack must be produced and the reference number quoted prior to the start of the possession as evidence of the ES on site being full briefed, if the ES was unable to attend the PICOP briefing.

Reference

MB	Marker Board – placed at limits of work site
ES	Engineering Supervisor - Responsible for work site, signs in to possession with
PICOP	Person in Charge of Possession – Takes possession of line from signaller

These recommendations were put into immediate effect in the rea (West Midlands and Chilterns) and the lessons learned/outcomes shared at Route Level and national level via periodic review.

Note also that the controlling box on (Saltley) was subsequently fitted with voice recording on the phone system.

40220 Inadequate radios at Kings Cross

A reporter has contacted CIRAS regarding the poor life of the radio batteries used by GNER staff at Kings Cross.

The reporter states that the older radios die at least once a day, in some instances it has been known for these radios to die up to three or four times a day. The reporter believes the reason for this is because the radios are not discharged each night before they are recharged and therefore the batteries run down much quicker than they should. According to the reporter, staff are unable to discharge the radios because they have not been provided with the correct equipment to do this. The reporter is concerned that with unreliable radios staff do not have a first line of communication in the event of an incident. This breakdown in communication could result in staff not being able to pass on information quick enough or cause a delay in getting help.

The reporter would like Network Rail to put in place a proper radio maintenance regime at Kings Cross, whereby the batteries are checked at set times and replaced when they have reached their shelf life. The reporter would also like Network Rail to provide a discharger, so that staff can discharge the batteries before recharging them again preserving the battery life.

Response from Network Rail

Network Rail would like to thank the reporter for raising their concerns regarding the radios at Kings Cross.

The radios at Kings Cross go through quality checks and we replace the batteries as we do with our own radios. There are not currently any issues with radios or radio batteries that Network

NR and sub-NR sector

Rail or National Express are aware of and we have a regime in place to replace batteries when they require it. We have an external contract which supplies and replaces radios annually.