

TOC sector reports and responses

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40566 Set EC64 allowed back into service with defective bell or buzzer communication

A reporter has expressed concern that set EC64 was allowed to leave Craigentenny depot and enter back into service with a defective bell or buzzer communication. Working a train with defective bell or buzzer communication means that there is no communication on board the train between the driver and guard. In the event of an emergency or if a passenger was taken ill on the train, this would result in a serious delay in getting assistance.

The reporter believes that the rules state that a train should not return to service from a depot with defective bell or buzzer communication. Is the reporter correct in their assumption?

According to the reporter, National Express East Coast (NEXC) has a contingency plan which allows for a train to stay in service if the bell/buzzer communication fails whilst it is in service, as the train can be worked by flags and whistles until it reaches the most convenient point to take it out of service and take it to a depot. The reporter views this as perfectly adequate. However, the reporter believes that set EC64 was purposely kept from going into the depot and when it eventually did go into the depot, it came back into service and the bell/buzzer communication defect had still not been rectified.

The reporter is under the impression that NEXC are aware of the defect and would like the bell/buzzer to be fixed as a matter of urgency.

Response from National Express East Coast (now East Coast)

EC64 since its temporary lease into the NEXC HST fleet has proved to be troublesome with regards the driver and guard communication system. Numerous efforts to identify and rectify system failings have been made, however at the time of response the set has been fully withdrawn from NEXC fleet and service and will be returned to Porterbrook Leasing company.

The problems experienced on this set associated with inter vehicle connections being life expired were recognised by NEXC and accordingly a significant investment in a full renewals programme of the inter vehicle connection arrangements has been ongoing as part of NEXC's HST refurbishment programme. The kit now installed supersedes the original, which has been in use with no major renewals for in excess of +30 years and is of a much more reliable and technically enhanced system which should provide significantly improved performance and reliability.

In regards to EC64's particular operational difficulties, where reported with defect, there has been remedial attention given to support rectification, although as previously indicated this has not always been successful. Following each event, operational management of the trains continued operation is agreed through NEXC Control based on *Rule Book*, NEXC051 and other associated operating parameters. This ensures the continued safe operation and management of said train.

40809 Incorrect HST safety information

A reporter points out that information on HST safety cards and posters is incorrect. Since May, HST coaches C and E have been swapped around due to changes in operational procedure but the safety information supplied onboard has not been amended. Information about locations of emergency equipment is vital in emergency situations – the current cards and posters would be unhelpful and could cause confusion, according to the reporter.

Could FGW correct the information on the cards and posters to reflect this recent change?

Response from First Great Western

FGW would like to thank the reporter for highlighting this issue. The mistake had already been identified and the cards were in the process of being amended and redistributed.

The new HST safety cards have now been produced and issued on the HST fleet reflecting the swapping of coaches C and E in the formation. This opportunity also took into account to incorporate the new standard class buffet vehicle, being introduced on some HST formations, replacing the conventional buffet vehicle. All HST sets now carry these cards.

40810 Incorrect OHL safety information

Information about overhead lines on safety cards and notices is incorrect, according to one reporter.

The picture below is on safety information cards onboard HSTs:



Areas marked in red show the parts of overhead power supplies that are unsafe due to electrical danger. According to the reporter, this is misleading – the information implies that the 25 kV OHL (overhead line) cantilever insulators and supports (highlighted in orange by the reporter) are electrically safe. The RSSB confirms that the cantilever insulators and the component connected between them and the areas highlighted in orange – the cantilever insulators, frame tubes and registration arms – are to be regarded as live. These safety cards could mislead people into thinking they are safe to touch in emergency situations.

Could First Great Western amend the diagrams and update all safety information to reflect the electrical danger present in the cantilever insulators and connected components?

Response from First Great Western

FGW would like to thank the reporter for highlighting this issue. The mistake had already been identified and was in the process of being rectified.

New HST safety cards and posters incorporating the correct diagram have now been produced and placed on all HST sets.

40748 Bicycles storage and capacity limits on trains

Bicycle storage space and capacity on-board South West Trains are concerns for a reporter. Desiro trains have cycle racks that allow for up to three bikes to be stored per vestibule. However, this limit is regularly exceeded, sometimes with more than ten bikes per train. The problem is particularly apparent during peak hours.

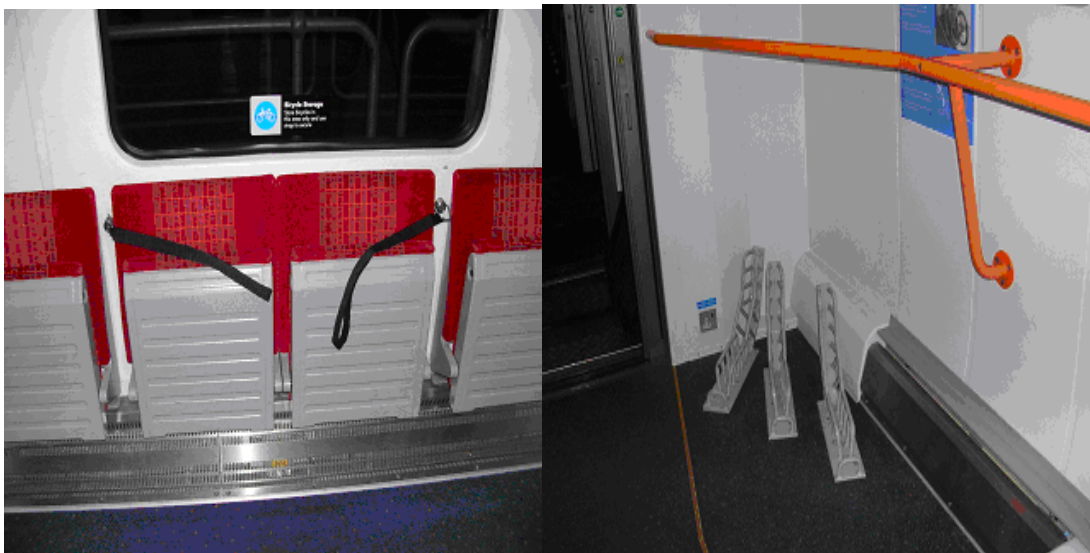
Bikes with very thick tyres do not fit into the racks and other bikes often roll out of them – the reporter is aware of members of staff being injured as a result of tripping over fallen bicycles or dismounted bicycles rolling into them.

The problem appears to stem from guards being told to be more lenient to passengers with bicycles, whereas revenue staff are trying to comply with the safety rules by refusing bicycles on board when there is not enough space to store them safely. If the intention is to allow more bicycles onto trains, the design and layout of the trains needs looking at to ensure safe transportation of bicycles.

- Could SWT consider providing straps for bikes to be held in place so they do not roll out?
- Can the apparent discrepancy in the enforcement of safety rules between the guards and revenue inspectors be resolved?

Response from South West Trains

South West Trains has provided a number of facilities for storing cycles on Desiro Units, these vary depending upon the class of unit. Cycle storage space on Desiro trains contain the following securing methods,



Class 450 straps

Class 444 track for front wheel of bike.

Photos attached for information.

Whilst we try to limit bikes and on some routes have a bike ban during peak hours it is not practical to completely control the loading of bikes, particularly as many stations are not staffed. Even where staff are provided it can be difficult to control cycle access given numbers travelling and multiple platforms and services complicate this. South West Trains consider that the current arrangements do not import a significant safety risk.

Since 2004 we have only recorded 6 minor accidents as a result of bikes being insecure on board our trains, none of these caused serious injury. In addition to the equipment provided on our trains, we have trained guards to patrol trains regularly and take action where bikes are found to be causing a safety hazard. We also ask guards to report services with any problems with bikes and then seek to review arrangements and have also used our rail community officers to support guards with on train patrols.

South West Trains policies for the conveyance of bicycles by train do not vary and should be consistently applied by all staff. If you are in doubt as the correct action to take with regard to conveying bicycles, please ask your manager for guidance.

Reporter feedback

CIRAS received some additional feedback from the reporter following the response, as they do not feel as though the issue has been resolved and they write:

“The response completely ignores the fact that there are regularly too many bicycles boarded. The tactic of quoting numbers of ‘reporter accidents’ is common. This also ignores the point that the majority of accidents go unreported due to the way the company records the details and often blames the victim. If the policies are being ‘consistently enforced’ why are so many guards reporting that they are being told to be more lenient?”

Please comment.

Response from South West Trains

The conveyance of bicycles is difficult to police. Particularly as guards are remitted to constantly patrol their train, when they arrive at a station, they are often operating the doors at a guards operating panel that is away from the bike storage area. Therefore when they see someone loading a bike onto their train they may be unaware of any storage problems in the area the bike is being loaded. They may only find this problem out as they move through the train. They are often then placed in a difficult position, as to move the bikes at the next station stop would cause a delay, and to ask someone to leave the train would often be not appropriate and put the guard into unnecessary conflict with the owner of the bike(s) concerned.

To instruct our guards to always approach someone loading a bike at a station, would result in delays to our services at it would cause overtime at stations and is therefore not practical. This would also cause delays and inconvenience our other customers travelling on the train.

On services where bikes are not permitted, our guards do try to prevent persons with bikes joining these services where possible. This again is difficult to police as they may be loaded out of sight on busy platforms, and away from where the guards are operating the doors from. If the guard is able to see someone loading a bike away from where they are operating the doors, then any attempt to challenge will again result in a delay which would be unacceptable. The guard will again often challenge the bike owner as they go through the train, but the guard will probably face the same difficulties explained above.

If a guard is able to stop someone getting on a train with a bike when it is not appropriate then of course they would make every sensible effort to prevent the bike being loaded.

A high majority of our guards would assess the situation if the bike storage area becomes overcrowded and deal with it appropriately within the constraints I have highlighted above. They will always try to make the area as safe as possible in these circumstances.

This process is constantly monitored through staff assessments and the reporting of any incidents that may occur, it is only through the reporting of any problems encountered by staff that management are made aware of any issues that arise. South West Trains would strongly request all staff to report any accidents and incidents that occur so that the significance of any issues can be taken into account when developing any processes and standards to manage any particular situation.

40786 Contracting staff with no PTS

A reporter is concerned that some contracting staff who require PTS cards at Aylesbury maintenance depot don't carry valid ones. Some staff have lapsed PTS cards, whilst others are believed to have never held them. It is believed Chiltern are genuinely unaware that some of their subcontractors are not ensuring all their staff have PTS cards.

Some contracting staff evidently feel uncomfortable in this situation, knowing that they are crossing open lines to access trains without the required training. The reporter suggests that Chiltern reaffirm to their subcontractors that staff have PTS cards where it is a requirement.

- Could Chiltern conduct an audit of contracting staff at Aylesbury to determine the scale of the problem?

Response from Chiltern Railways

There is no requirement under local procedure for contracting staff working at Aylesbury maintenance depot to hold PTS competence. However, to ensure a comprehensive response to the concern, an audit, details of which are available on request, was conducted to determine the validity of PTS competence of all staff and contractors working at Aylesbury depot and Aylesbury South sidings.

Having reviewed the audit results, we can confirm that all staff including relevant contractors and sub contractors currently working at the above locations hold valid PTS competence as required.

40824 Train movement continues despite isolation of on board safety systems

One reporter has been made aware that after emergency safety systems onboard CrossCountry trains are disabled, trains are still running with passengers onboard. Even though the emergency bypass switch (EBS) and traction interlock switch (TIS) safety systems that control the trains braking and doors were isolated, relevant safety checks were not carried out according to the reporter.

In accordance with the *Rule Book* (Module TW5), a driver must report to the signaller defective or isolated equipment that will affect the movement of a train. For EBS isolations, the driver should examine the defective equipment. All passengers should be disembarked at the next manned station and the train should then continue as empty rolling stock to a suitable location for maintenance attention. In the case of a TIS isolation, train guards should physically check train doors are securely closed.

The reporter is aware of situations occurring when these safety protocols haven't been followed and trains have run with passengers still onboard even though the powered isolation switch isn't functioning – this means that passenger communications cannot be used for the rest of the journey. The reporter's main concerns are that if relevant safety protocol is not adhered to,

doors could be left open and someone could fall onto tracks and passengers would be unable to bring emergency issues to the attention of train crew.

The reporter would like to know why trains are allowed to continue their journeys with passengers on board when the *Rule Book* states otherwise.

Also, could CrossCountry ensure all train crew are briefed about the different safety procedures that must be followed when equipment isolations occur?

Response from CrossCountry

When safety related equipment becomes defective CrossCountry apply the safest method of working at the appropriate time in accordance with both the *Rule Book* requirements and the company specific policy for dealing with defective on train equipment.

The *Rule Book* module TW5 covers both situations mentioned by the reporter and part A 2.10 refers the reader to company defective on train equipment contingency plans. The company contingency plan is a plan agreed with the infrastructure manager, Network Rail. When safety related equipment becomes defective on a train in service both CrossCountry and Network Rail make reference to this document and jointly agree the safest course of action to either repair, turn, top or terminate the train as necessary.

In the specific circumstances mentioned by the reporter CrossCountry and Network Rail control would refer to the contingency plan and agree the most suitable course of action. This would include where the train could be taken out of service without exposing customers to other and potentially greater risks such as adverse weather, inadequate shelter or lighting and unstaffed stations with no support for persons with disabilities or special needs.

The CrossCountry defective on train equipment contingency policy is quite detailed and is aimed for use by control staff. However, guidance is provided to drivers, train managers and senior conductors in the CrossCountry working instructions, general section, which details places where trains may be turned or terminated for operational reasons or following safety related defective on train equipment.

40709 Lone dispatch of slam door HSTs at Luton Parkway

Dispatch of the slam door high speed trains (HSTs) at Luton Parkway is a concern for one reporter.

On platforms three and four, just one dispatcher is now responsible for dispatching the East Midland HST slam door trains. While a risk assessment has deemed this suitable, since the dispatcher is stationed at the north end of the platform, they will not be able to see passengers alighting or boarding the train at the last minute from the south end of the platform.

This is of particular concern because the stairs to enter and exit the platform are at the south end of the platform, resulting passengers rushing to board the train at the last minute. As the doors are not power operated the reporter is concerned that passengers will be able to open the doors or leave them on the latch just before the train is due to depart. The reporter is aware of an incident where a train nearly left the station with one of its doors on the latch.

The reporter feels that there should be two staff on the platform dispatching trains, so while one is dispatching, the other is able to look out for any passengers boarding or alighting at the last

minute or leaving the slam doors open. Alternatively, the dispatcher should be re-positioned on the platform to allow them to ensure a safe dispatch.

Could First Capital Connect look into the possibility of implementing these suggestions?

Response from First Capital Connect

Prior to the introduction of East Midlands Trains (EMT) new timetable on December 14 2008, First Capital Connect (FCC) carried out a series of joint risk assessments at Luton Airport Parkway station involving EMT and the FCC Safety Assurance team. This resulted in a full review of all platforms and an assessment of the type of traction or rolling stock that would be calling there when the new timetable was brought in. EMT planned to use HST sets in a 2+8 formation and Meridian sets.

Train dispatch risk assessments were agreed between all of the train operators involved. This was supported by an internal FCC safety validation. The safety validation was accredited to enable train dispatch duties to be performed from the new timetables' introduction.

Risk assessments were reviewed for each platform and included the method of operation expected when dispatching HST 2+8 sets. The risk assessment indicates that the FCC train dispatcher is positioned at the south end of the platform upon arrival of the set and works toward the middle of the train closing doors where he/she can perform train dispatch duties.

While this activity is taking place the EMT Train Manager takes responsibility for closing all of the doors in the front four coaches. In preparedness he or she will position themselves in the middle of the train where their train dispatch duties can be completed.

All train dispatch risk assessments adopt the 'ALARP' principles. There is no viable reason why this process should involve two members of staff to dispatch a HST 2+8 set when the risk assessment is applied correctly. With rigorous staff training there is no tangible reason to suppose that train dispatch at this location will be any less effective than at any other station.

Therefore, as the concept of this type of train dispatch was relatively new at Luton Airport Parkway, FCC made sure each member of train dispatch staff received a full training brief based on the risk assessment and the processes involved. To support staff with their new duties staffing levels were strengthened in the first few weeks to fully embed the process.

FCC are dedicated to safety and promoting safe working. To that end there are clear instructions available to all staff to report any departure from our robust practices. Any reports received will be investigated and taken forward as necessary with the individual involved.

40719 Single manning of automated ticket barriers in Great Northern north area

Single manning of automated ticket barriers at stations in the Great Northern north area is a concern for one reporter. During off-peak periods, the platforms are manned by only one member of staff which the reporter believes to be unsatisfactory.

The reporter is concerned that staff will be unable to deal with several issues at the same time, such as issuing penalty tickets and opening the barriers if passengers have problems entering and

exiting the platform, which could result in the passengers becoming irate. Staff could potentially suffer verbal abuse and assault from these passengers.

The 2006 version of the gate line operating manual apparently states that the gate line should be double manned at all times.

- Could First Capital Connect provide clarification on whether automated ticket barriers should be single or double manned on each platform in the Great Northern north area during off-peak hours.
- To decrease the risk of abuse, the reporter feels that the barriers should be double manned during peak as well as off-peak periods.

Response from First Capital Connect

The ATGs are currently double manned during the peaks and most locations are single manned as the reporter states outside of the peaks. The local management teams are asked to make a decision on the staffing levels required at each location based on numbers using the ATGs and through use of risk assessments have determined that a number are to maintain double manning throughout the operation of the ATGs, but it is not a requirement for all ATGs.

We are pleased to report that the level of assault continue to decrease, but we are not complacent in our approach to staff welfare and would ask that the reporter discuss the particular station and their concerns with their line manager.

We always maintain that staff can only deal with one issue at a time and the staff are empowered to make decisions regarding the issuing of penalty fares and the opening of ticket gates, we have a robust process for dealing with overcrowding at stations regardless of the number of staff available. At FCC we expect our staff to be able to work in a safe environment that enables them to do the role that they are trained to carry out and deliver the customer service levels expected by passengers.

40849 Clarification on staff no longer requiring PTS training

A reporter would like clarification over whether a change in procedure made by South West Trains is correct. Staff at Gillingham, Honiton and Yeovil Junction stations have been told that they no longer need to be PTS trained in order to use the barrow crossings. The crossings are mainly used for disabled access to other platforms at the station and so staff are helping passengers across the track. The reporter comments that staff always obtain permission from the signaller before using the crossing but that some of the crossings are not visible from the signal box.

- The reporter would like to know if South West Trains are correct in telling their staff that they no longer need PTS to use the barrow crossings in such a way?
- The reporter would also like to know if, with permission from the signaller, staff are allowed to remove items from the track even though they have no PTS training?

Response from RSSB

Rule Book modules G1, section 3.2 and G2, section 1.2 make it quite clear that if you are crossing the line at a level crossing you are not regarded as being on or near the line.

Consequently there is no requirement to have PTS competency to use a station barrow crossing. *Rule Book* module SS1, section 3.1 deals with platform staff retrieve articles from the

platform line. The staff concerned must be trained for that location and local instructions must have been issued. The signaller will provide protection for the platform staff as shown in module TS1 section 13.3 This section starts by telling the signaller that a person without a Personal Track Safety certificate is authorised to go on the track to retrieve articles at station platforms.

40840 Face-to-face safety briefs 'downgraded'

A driver is concerned that face-to-face safety briefs are being conducted far less frequently than they once were at London Midland, both at Worcester and Birmingham New Street.

Face-to-face briefs invite active participation from drivers who can discuss any resignalling arrangements, changes to rules and procedures, and any recent SPADS or incidents that have occurred. They encourage participants to learn the lessons from past mistakes, as well as informing them of changes they need to know about.

But the preference now is to use a monthly booklet to brief out this information, a practice the reporter views as far less effective because it relies more on passively 'soaking up' information.

According to the reporter, some drivers have received no face-to-face briefs in the last six months. Though it is still possible to arrange these, it would normally have to be outside regular working hours. He would like to see less of a reliance on the booklet for briefing out important safety critical information, and a greater emphasis on face-to-face briefs. In his opinion, learning would be enhanced considerably if face-to-face briefs took place on a fixed cycle, say every three months. Please comment.

Response from London Midland

The drivers monthly briefing booklet, *Safety up Front* is issued on a monthly basis and the driver managers will be discussing the contents of these booklets with all drivers each month via a short feedback session. This will take place on a 1-2-1 basis, and will allow the drivers to raise any concerns they may have and allow them to check their understanding of the contents.

The monthly briefing booklets ensure that drivers receive timely updates on safety of the line incidents, best practice in operations, seasonal briefs and lessons learnt. Any driver stating they are unsure or confused with any item within the brief will be given adequate time to understand the issues and will be re-briefed if necessary.

The reporter is correct in stating that the face to face encounters can, and do take place outside of their regular working hours as the drivers have received an enhanced payment for this; however this is not compulsory and as the reporter states it is possible to arrange these inside their working day.

With regard to the group safety briefs, these will be taking place every six months to supplement the *Safety up Front* booklet and to allow the group interaction to take place.

40800 Scaffolding towers

A reporter is querying the assembly of scaffolding towers, which are currently being used for work on Southeastern stations. The reporter is aware of work occurring where scaffolds are unsteady and have been constructed with some parts missing – for example, outriggers and hand rails were not fitted. If the scaffolding towers are not set up correctly, there is a risk that someone could fall from the tower and sustain a serious injury.

Could the company clarify the type of scaffolding towers that are being used on Southeastern station jobs and ensure that they are being used correctly?

Response

In accordance with Southeastern (and Network Rail) rules mobile tower scaffolding used is of fibreglass construction. These towers are supplied by approved plant hire companies. The number and type of scaffolding required is specified, to the hire company along with time date required and the site location.

Staff are only permitted to erect, alter and take down any mobile scaffolding tower if trained, competent and certificated (to PASMA or equivalent) to do so. All mobile tower inspections, after all erection, alteration or movement are recorded in the site diary daily log book. Any mobile towers that are left erected overnight are inspected before first use the next day or before the next occasion of use.

Where any shortages of supplied scaffolding parts are identified, by the competent person, the hire company is notified and the required scaffolding shortfall is requested for immediate delivery (at the latest the following day). The competent person is instructed not to allow the mobile tower to be erected until the required parts are supplied.

Mobile tower scaffolding is erected, on exterior sites, at a ratio of 3:1 (where 1 is the base "footprint" and 3 is the height). Outriggers are not always required as the use of these is dependent on the base size of the mobile tower and the location where it is intended to be used. The use of outriggers will extend the base "footprint" and therefore will proportionally increase the available height.

Regular site audits are carried out each month by all managers and supervisors who are engaged on this contract. In addition the company has a three man safety team that carry out regular site audits with one member of the team (safety advisor) in the field on a daily basis completing site audits and inspections. On a typical day he will visit between four and six sites. As part of this additional resource, and to further improve all site safety issues and concerns, the field safety advisor can be contacted at any time for all site safety concerns and issues and can respond to any request to attend site within one to two hours (dependent on location and travel distance). The safety advisor attends at the start of site work and communicates the site safety requirements, specific to the site, to the COSS.

Information communicated at the site start up include the method statement, site rules, site inductions for all site staff, hazards specific to the site (and controls necessary to mitigate these hazards) and any plant requirements (including mobile tower scaffolding).

As part of the site audits tool box talks are carried out and one such talk covers "working at height" and "mobile tower scaffolding". Part of this tool box talk states "**do not use the tower if any parts are missing-report it to your manager/supervisor**". All staff that are present when the tool box talk is given sign and date the tool box talk "receipt" to confirm that they have been briefed the tool box talk.

The company has a "refusal to work" procedure that is intended for use on this sort of situation which has not been invoked to date for ANY mobile tower scaffolding issues or concerns.

As part of the company "SQE Communication" procedure safety items are briefed to all staff each month. A "mobile tower scaffolding" brief was in the latest team brief, number 008 August

2009 and previously in brief number 004 April 2009. All briefing notes are signed for by all members of staff to confirm that the brief has been received, read and understood.

The company is accredited, by the BSi, to BS EN ISO 9001:2008-Quality Management system. Within this management system is the procedure “Non-conformance reporting and corrective action” (PR/QP/0852) where issues of this nature can be reported and either a “corrective action” or “preventive action” is raised (this CIRAS report has been raised through this procedure and CAR0269 raised) and investigated. All such reports are discussed at the monthly SQE meeting, chaired by the SQE Manager. They are also accredited to OHSAS 18001:1999-Occupational Health and Safety Management system.

In summary the company cannot understand why this issue has been raised through “CIRAS” and not through normal internal reporting channels. All safety issues are taken very seriously and all incidents are thoroughly investigated.

As part of our continual commitment to safety the company will brief out to all staff, to re-affirm, in the September briefing:

- The refusal to work procedure and how/when to use
- The Non-conformance reporting and corrective action (CAR/PAR) procedure
- Mobile tower scaffolding
- How to raise safety concerns.

The “field” safety advisor will ensure that additional focus is given to these areas when he is conducting site audits and inspections. He will also reinforce the safety message on all sites and confirm with site staff the action that can be taken for all safety concerns and issues and that safety issues should be raised on site immediately with the site COSS and with the company.

Long Standing Issues

21792 Poor communication during dispatch at Edinburgh station

A report has been received by CIRAS expressing concern about poor communication between management and staff during the dispatch process of, in particular, slam door stock at Edinburgh station. The reporter and his or her colleagues have been made aware that that this is a reoccurring problem on all platforms, especially platforms that are on a sharp curve.

According to the reporter, dispatching slam door stock from these platforms requires at least two dispatchers, who will have reached a clear understanding beforehand about the division of duties. The concern being expressed by staff is that management are getting involved during the dispatch process, often overriding the way of working agreed between staff before starting the process, without communicating to those involved. It is felt by the reporter and his or her colleagues, that this could potentially cause danger to passengers, those boarding the train and those standing or walking on the platform, if the process is disrupted by the intervention of management.

The reporter and his/her colleagues feel that the current procedure should be revised and that all staff including managers should be called together at the beginning of the shift, to communicate the clear division of duties and the principles of safety. Should there need to be a

sudden change of action by management due to an emergency, this should be communicated clearly to the staff involved. The reporter feels that safety during the dispatch process should not be overridden because of a possible increase in dwell time at the station.

Response from GNER (now East Coast)

GNER would like to thank the reporter for raising the issue. We have recently reviewed the train despatch method statements at Edinburgh which were undertaken jointly by one of our safety assessor managers and a health and safety representative.

The only issue raised was in respect of despatching empty coaching stock trains and this was a route wide issue, and has been resolved via the introduction of an additional training element, which is in the process of being briefed to all respective station teams.

In the longer term comprehensive despatch processes for each station will be produced and maintained as part of the company documented procedures for each type of rolling stock and each platform, which will identify roles and responsibilities for those allocated to take the lead and others who form a dedicated despatch team.

21976 Footpath at Peterborough station

A report has been made to CIRAS about the footpath at Peterborough station. The reporter comments that as the result of a 'drop kerb' being implemented on the footpath, motorbikes and bicycles are now using the path as a route to access the car park. The reporter has witnessed and experienced first hand nearly being run down by cyclists using the footpath in this manner.

The reporter suggests that GNER put in a separate access to the motorbike and bicycle parking area and totally segregate the footpath before someone is injured.

Response from GNER (now East Coast)

GNER would like to thank the reporter for making the report. We would like to highlight that the dropped kerb and tactile at the station front have been in place for several years and were implemented as part of a scope of works to meet the Disability Discrimination Act. We have had no reported near misses or actual accidents occurring, but we will continue to monitor and take into consideration the comments made as part of proposed station redevelopment work.