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24th July 2019

By email to: jasper.beston@dft.gov.uk

Dear Jasper,

RE: CONCERNS OVER TRACKWORKER SAFETY: AN EVIDENCE PAPER

Further to our previous submissions to the Williams Rail Review, I promised to provide an additional evidence paper about safety concerns that we have in relation to staff working on or about the railway. The importance of the material attached to this letter has added poignancy because of the recent deaths (3rd July 2019) of two Network Rail staff at Margam in South Wales and the publication on 11th July 2019 of the Rail Accident Investigation Branch's report into the death of a track worker on 6th November 2018 at Stoats Nest Junction, Purley.

Essentially, our point is that whilst Britain's railways are seen as amongst the safest in the world, that situation is now seriously under threat by a combination of a rise in the number of near misses that are occurring as well as an increase in incidents arising from line blockages. In both of these areas, the safety of track workers is put at risk.

Our concern is that in any change that results from the Williams Review, safety of staff working on the railway must be front and centre and not compromised by any other considerations, like cost cutting or profit.

Attached to the email that sends this letter to you is an explanation of our concerns as well as a spreadsheet that lists incidents that have occurred. We would be happy to meet with Mr Williams to explain this detail further.

Yours sincerely

Rob Jenks
Policy Officer

TSSA SUBMISSION TO WILLIAMS RAIL REVIEW: TRACK WORKER SAFETY

1.Background

On the 6th November 2018 at Stoats Nest Junction, Purley, the first trackworker fatality for almost five years occurred, an horrific reminder of the severest consequences of working on the railway infrastructure. Tragically, this has not been a single incident because on 3rd July 2019, another two track workers were killed, this time whilst working on the permanent way at Margam, South Wales.

In response, Network Rail announced that a Track Safety Alliance Task Force would be set up and a sum of £70m allocated to a series of objectives designed to improve track worker safety. At the same time, the Office of Rail and Road (ORR) also issued Network Rail with two improvement notices intended to get the company to do more to improve track-worker safety.

2.Introduction

There is an accepted theory in health and safety practice of a pyramid or triangle effect of accidents with any one fatality being underpinned by a series of lesser incidents, such as lost time injuries, minor injuries, near misses and unsafe acts. Accurate recording and reporting of these events should lead to suitable potential and common intervention points between each stage of severity.

However, post the previous fatal accident of a trackworker near Newark North Gate station on 22nd January 2014 it can be seen that too many regular occurrences are still happening and that insufficient actions are being taken to implement a reduction in the risk to track workers.

3. TSSA's review

TSSA has carried out a review into the ever-present dangers of the railway environment and especially the serious number of near misses that are a regular occurrence.

The review looked at information sourced from previously published articles and reports from RAIB (Rail Accident Investigation Branch) and the more notable details published in the weekly logs from RSSB (Rail Safety Standards Board) which have revealed a grim picture of the state of working on the railways in 2019.

For instance, RAIB has investigated 38 accidents or incidents (full reports and Bulletins/safety digests) since October 2005. Those investigations can be broken down into:

- 23 where the work was planned on open lines (ie, with trains still running);
- 15 on lines where work was planned on blocked lines (ie, where trains should have stopped operating)

In the last 5 years there has been 11 in each scenario, leading the RAIB Chief Inspector, Simon French, in his review of 2018[i] to say:

> "There have been too many near misses in which workers have had to jump for their lives at the last moment. In the case of the near miss at Egmanton in October 2017 (report 11/2018), a multi-fatality accident was only avoided with two seconds to spare."

The Chief Inspector went onto add:

> "…the number and type of near misses in recent years is deeply disappointing given the efforts made to address track worker safety during that time. Every near miss, however caused, should be viewed as a failure of the system to deliver safety."

The Class investigation[ii] that was undertaken by RAIB and published in April 2017 took data from 70 incidents, including near misses and operational irregularities, which happened in a single year but they are just the tip of the iceberg as many incidents are investigated internally by Network Rail. TSSA research shows that:

- Between the 28th February 2017 and 6th June 2019 there have been 128 reported near misses
- Between the 2nd April 2017 and 11th June 2019 there have been 124 reported line blockage irregularities.

Each of the near misses and line blockage irregularities appear in the attached spreadsheet.

3.1 Open Lines Situations

When carrying out reviews with the daily incident logs, it can be seen that many constant factors arise in relation to open line situations:

- staff being unfamiliar of the location and lines that they are working on;
- local knowledge of planners not now the norm;
- staff not knowing which are the up or the down lines;
- lookouts being in the wrong place;
- insufficient sighting distances;
- communication errors;
- incorrect documentation.

Inconsistent mapping of the track infrastructure is a key concern and until 'one version of the truth' is provided that is used by signallers, planners and track workers these issues will remain constant with potential for serious consequences,

3.2 Blocked Line Situations

In blocked lines situations repeated cases of protection (Possession Limit Boards, Work Site Marker Boards and detonators) being placed on the wrong lines or the wrong locations, all of which do little to enhance Network Rail's (or its contractors') safety reputation, whilst also undermining trust that these activities are being correctly resourced and managed.

Alarmingly reports such as the one that follows seem to be all too common place and as a result seem to have lost the impact that they should! The following is extracted from

Network Rail's "National Safety, Health & Environment Performance (SHEP) Report 2018/19, Period 13":

> 'Staff working within a Route Business LNE Central managed possession reported a near miss with a passenger train on the Up Main line between Sheffield South Jcn and Dore Jcn (line speed 80 mph). The staff had been walking to their worksite after being informed that the line was blocked to traffic when a train approached and the staff observing it and moving clear at the last moment. It was established that the engineering supervisor had handed back the Up Main line without the knowledge of staff.'

This incident occurred on 2nd March 2019 and was classed as a "Staff near miss with train."

There are several cases that have been identified from TSSA research where trains are signalled into areas that have been 'blocked for maintenance work' with staff reporting near misses as a consequence.

4. How do we explain why these issues are occurring?

In TSSA's analysis there are a various reasons why these issues are occurring:

4.1 Planning and Delivery of Safe Work (PDSW).

The roll-out of the Planning and Delivery of Safe Work programme was suspended following serious issues identified as a result of initial implementation in the East Midlands area. Attached is a report prepared by TSSA and passed to Network Rail in 2016 following an extensive investigation based on a series of interviews with affected staff.

Subsequently introduced, the Planning and Delivery of Safe Work (Network Rail Standard NR/L2/OHS/019) was designed to change ways of working and to improve safety for those working on or near the line. It was designed to improve safety by:

- having a 'person in charge' (PIC) of both safety and work, combining previous arrangements that separated these functions;

- involving the PIC with the Works Planner in the planning process to identify which task, site and risk controls should be included in the Safe Work Pack before going to the work site;

- the Responsible Manager is then tasked with approving each Pack in advance of the work being carried out which includes ensuring that the PIC understands what needs to be done, has the correct controls in place as well as the right team and resources;

- use of a new hierarchy of warning and protection methods.

However, as the TSSA PDSW report shows, the Network Rail Executive brought "the system into use prematurely without adequate planning, training, resources or system testing. Network Rail also clearly failed to effectively engage the workforce as a whole,

the project did not gain the confidence of staff in using the supporting systems, and as a result the project is regrettably discredited amongst many staff as a result."

Network Rail's own analysis[iii] in October 2018, a year after implementation, showed a number of issues with the system, including fundamental ones such as staff not always understanding the process, PIC's not always being available to participate in the planning process because of "operational reasons," and Planners capability and capacity.

All of these issues undermine the whole process whose aim is to enhance safety.

TSSA members have also reported issues of insufficient resources and staff to be able to carry out work safely whilst manager members have informed the Union that the Safe Work Packs can be so numerous that it is impossible to adequately check and sign them all off (one manager reported having to sign off between 40 and 50 a day!).

4.2 Risks arising from issues with works planning.

Much work is still planned to take place in Red Zones (i.e., with unassisted lookout protection), in (unreliable) line blockages, or in questionably-separated work sites. This is because it's easier to arrange and planners lack the knowledge or authority to push for better controls. In these circumstances risk controls rely heavily on generic safe systems of work with their attendant weaknesses.

Another factor identified has been the constant numbers of late changes to planned works that consequently incorporate significant risks to the safe delivery of works. TSSA safety reps have reported that union members report an increase in this area with some 'plans' having numerous versions leading to uncertainty and confusion about the extent and accuracy of published versions.

For some time, TSSA members employed in the role of Works Planner (originally introduced around 2006) have complained about a diminishing status and excessive workload:

- On the former of these they have been pursuing a claim to professionalise the role to recognise the importance of its safety and planning function. In 2018 Network Rail recognised the need to pursue this aspiration through Role Based Competencies (after being censured for non-compliance in being able to prove competencies) and even employed an external company to report back in April 2019 - but to date nothing further has been heard;

- In terms of an excessive workload, members have reported that they often have to complete the Safe Work Packs in a rush to meet deadlines, with many taking work home to complete.

Whilst our inspection work in 2018-19 has identified local/route initiatives on improved planning, we are concerned that the forthcoming PPFF reorganisation will see the focus

on this aspect being lost. In our experience Network Rail's initiatives tend to be overly-complex and insufficiently targeted on key issues. We therefore have limited confidence in Network Rail's ability to deliver appreciable and sustained change.

4.3 Poor documentation provided to signallers.

Poor documentation provided to signallers contributes to trains being signaled into areas that are supposed to be blocked for maintenance. This relates to recommendation 2 of the 2017 Camden South RAIB report[iv] which RAIB are concerned still has not been addressed.

As with so many issues Network Rail's strategy is that new technology systems will sort it out (in this case better mapping programmes), but when they fail to be implemented, the risks continue. This would also help address the risk of wondering onto open lines as at Stoats Nest.[v] A useful recommendation would be that immediate action is needed to document each possession at the highest risk locations, i.e. complex track layouts with multiple changes.

4.4 Network Rail

Network Rail operates in an environment where decisions around efficiency savings (otherwise known as cost cutting) imposed by Government and the ORR through the five yearly Control Period process, together with the pressure in relation to improve performance at all costs strongly influences the company's direction and could be a contributing factor to the increase in near misses and line blockage incidents.

TSSA would also assert that the people who are responsible for correct processes and systems at the top of the organisation must be aware that PDSW is often not being followed but they have not decisively tackled this issue. They must be aware that there are deficiencies in the system, as illustrated above from their own research. The fact is that Network Rail continues to fail to adequately resource the planning and delivery of track work, and the current system will not work until that is addressed

When incidents occur, Network Rail's response is often to push the blame away from the organisation and director or senior manager responsibility and to scape goat a junior manager or supervisor working under the constraints imposed by those same senior leaders.

TSSA would also comment that Network Rail has been seeking to address the issue of track worker safety through the Track Safety Alliance which has been operating since 2011. One related project was the Near Miss Reduction Programme which lead to other projects such as PDSW. However, prior to the Margam incident, financial authority to progress these initiatives was being sought but has now been agreed with the formation of the Track Safety Alliance's Task Force.

TSSA would also draw attention to the RAIB's Class Investigation[vi] from 2017 which monitors Network Rail's responses to a number of safety recommendations and continues to show (at 30th July 2019) that proposed actions taken are either:

- inappropriate or insufficient to address the risk identified

- still warranting concerns.

4.5 ORR and improvement notices

TSSA would also censure ORR who have known since at least April that there are issues with track worker safety. Not only has the RAIB's Chief Inspector made the comments that he did in that organisation's Annual Report (see above, published in April 2019) but at a General Secretary level meeting between the ORR and rail trade unions, a report by ORR was presented on the issue. Yet, it took until the death of the two Network Rail track workers at Margam before improvement notices were issued in this area.

We believe that the ORR's remit is impossible to fulfil as they act as both the economic and safety regulator, effectively looking in two directions. As a result, from a safety perspective, ORR appear to be compromised when a more vigorous, unrestrained approach in this area could see real improvements.

5. How can the situation be improved?

Track workers must be protected from the risks of working on open railway lines where trains are operating, As such, TSSA is calling for:

- a system that draws the managers, planners and staff to use methods of protected working. That system needs to be simple and easy to facilitate and become the first choice when planning work. It must be the hardest option (i.e., last option) to utilise unassisted lookouts, the lowest tier on the Hierarchy of Risk Control[vii] for open line working - because that is the only way to eliminate the risk;
- track teams must be equipped with up to date mapping tools that show all the information that they need. TSSA reps have been pursuing this issue for over a decade and we are still not in a position that will provide assurances for our members that they are where they should be;
- suitably trained staff with appropriate knowledge and experience must be available to meet the needs of a railway that is a 24/7 business.

6. Conclusion

Statistics show the harsh realities of the trackworkers world. What we fail to see is that many staff, their families and friends suffer and are deeply affected by these incidents. It would be easy to fill the pages of this report with extracts from the logs or the RAIB reports showing where it has all gone wrong, but we would recommend reading the annual reports from RAIB.

In conclusion, it is hard not to disagree with the ORR observations in its consequences section, where it states, 'that workers will continue to be struck by trains and that the number of accidents could rise if the operational focus shifts to 'getting the job done' to minimize delays'[viii].

When we consider the number of near misses within the industry, it can be construed that we have been extremely fortunate that we have not been discussing much higher fatality figures given that a significant number of track workers that have 'got clear' within a few seconds or less of passing trains.

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[i] RAIB Annual Report 2018, published 30th April 2019 and available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/798651/AR2018_190430.pdf

[ii] RAIB "Report 07/2017: Track workers class investigation", published 13th April 2017 and available at: https://www.gov.uk/raib-reports/track-workers-class-investigation

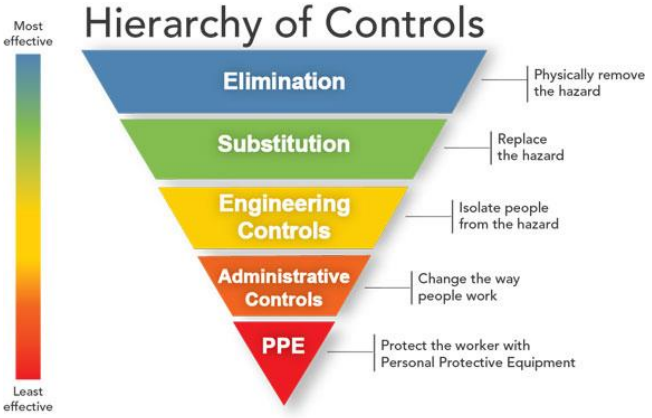
[iii] See downloadable powerpoint presentation at: https://safety.networkrail.co.uk/safety/planning-and-delivering-safe-work/

[iv] See page 37 of RAIB "Track worker near miss incidents at Camden Junction South, London, 28 February 2017" published November 2017 and available at: https://assets.publishing.service.gov.uk/media/5a182f69ed915d6665a561d7/R162017_171127_Camden_Junction_South.pdf

[v] See: RAIB Report 07/2019 "Track worker struck by a train at Stoats Nest Junction, near Purley 6 November 2018" Published July 2019 and available at: https://assets.publishing.service.gov.uk/media/5d261143e5274a592254abbf/R072019_190711_Stoats_Nest_Junction.pdf

[vi] See: RAIB "Recommendation(s) Status: Class investigation into accidents and near misses involving trains and trackworkers outside possessions" at: https://assets.publishing.service.gov.uk/media/5d3af766e5274a4012298f15/07_2017_Class_investigation_into_accidents___nr_misses_involving_trackworkers.pdf

[vii] Hierarchy of control can be illustrated by this diagram:



[viii] ORR Track Worker Safety Problem Statement 23rd April 2019 issued in papers for ORR/Trade Union General Secretaries Meeting 26th April 2019