



HM Railway Inspectorate Investigations Guide

January 2008 revision

HM Railway Inspectorate Investigations Guide

Contents

Introduction.....	4
The Railway Accident Investigation Branch (RAIB).....	5
Respective roles and responsibilities.....	5
Summary of MoUs	5
Notification of incidents	7
During office hours	7
Out of hours: the DfT duty officer system.....	7
Out of hours: the emergency contact officer (ECO) system.....	7
Fast stream reports.....	8
Selection and response.....	9
Criteria for selection of incidents for investigation	9
RAIB implications	9
Mandatory Investigations	9
Major incidents.....	9
Fatalities.....	10
Other incidents.....	10
Non-site investigations	10
Incidents not to be Investigated	11
Site Liaison.....	12
Permissioning duties.....	12
Evidence collection	13
Provision of technical support by HSE	13
Recording incidents on COIN.....	13
Appendix 1	
Reporting of serious incidents to HM Railway Inspectorate: guidance to dutyholders ...	14
Appendix 2	
Reporting of railway accidents under RIDDOR and RAIRR – quick reference guide	19
Appendix 3	
Fast stream reporting to senior management.....	33
Fast Rep 1 Form contents:	33
Detailed Procedure	34
Criteria for FSRs.....	35
Incidents likely to have national press interest.....	35
Appendix 4	
Mandatory incidents for investigation.....	36
MI LIST.....	36
Operational Incidents.....	36

Workforce Incidents	37
Trespass	37
Appendix 5	
Mandatory incidents not selected for investigation (or investigation cancelled) because of inadequate resources/other priorities.....	38
Review of decision not to investigate when additional information received.....	38
Appendix 6	
RAIB template letter to the bereaved, and example of HMRI letter.....	39
Appendix 7	
Evidence collection	42
Perishable evidence	42
Taking possession	43
Testing of signalling equipment	43
Records.....	44
Appendix 8	
Recording incidents on COIN.....	46
What incidents should be recorded?.....	46
How are incidents recorded?.....	46
Inquest verdicts.....	47
Appendix 9	
Investigations flowchart.....	48

Introduction

1. The purpose of this Guide is to ensure a consistent approach to investigating incidents. There is a separate procedure which covers investigating complaints
2. HMRI follows the Health and Safety Executive (HSE) Operational Procedure on Investigation (See HSE Intranet - **Operational Procedures >Investigation**). Its purpose is to provide a common, transparent procedure for operational staff to carry out investigations consistently, and to enable ORR to fulfill its duties as a regulator under the [Health and Safety at Work etc Act 1974](#) (HSWA).
3. It describes the process of investigation in a series of stages, spelling out the responsibilities of both front line staff and line managers, setting performance standards and providing links to other guidance at the appropriate place. There are three other Procedures which will be relevant to some investigations. These are: Notices, Prosecution and Enforcement Decisions.
These procedures refer to the HSE enforcement management model (EMM). RGD 2003-04 which describes how the EMM should be used and managed within HMRI has recently been updated and reissued.
4. This Guide is not intended to reproduce or duplicate the HSE guidance, but is designed to supplement it with HMRI specific information where appropriate, particularly with respect to the role of RAIB and the police.
5. The investigation of major incidents requires some particular responses, and these are described in the ORR Major Incident Procedures Manual.
6. This Guide will be periodically updated to reflect current developments, whether internal to HSE or ORR (e.g. change programme and harmonisation of procedures) or external (e.g. the advent of RAIB).
7. A hard copy will not be produced, as it is more efficient to prepare and make required updates and amendments via the Intranet. However, staff can print off sections as required.

The Railway Accident Investigation Branch (RAIB)

8. RAIB is the independent safety investigative body formed as a requirement of the European Railway Safety Directive. [The Railway Transport Safety Act 2003 \(RTSA\)](#) and the Railways (Accident Investigation and Reporting) Regulations 2005 (RAIRR) set the framework for them to investigate the root cause of accidents, and to make recommendations but without apportioning blame or liability. Nothing in the establishment of the RAIB replaces the duty of ORR as the National Safety Authority (NSA) as defined in the Directive to investigate matters relating to breaches of health and safety legislation, or that of the police to investigate the other aspects of criminal law pertinent to them.

Respective roles and responsibilities

9. RAIB's role is to investigate serious accidents and incidents that, under slightly different circumstances, may have led to a serious accident. This is mainly (but not necessarily) limited to those connected with train movements.

Summary of MoUs

10. Respective roles and responsibilities between RAIB, the police and ourselves have been agreed and are described in two Memoranda of Understanding (MoU). The first covers England and Wales, and is between RAIB, the British Transport Police (BTP), the Association of Chief Police Officers (ACPO) and ORR. The other covers the different legal position in Scotland, and is between RAIB, the Crown Office and Procurator Fiscal Service, BTP and ACPO (Scotland) <http://callisto/upload/pdf/ORR-RAIB-BTP-ACPOS-COPFS-0406.pdf> and http://callisto/upload/pdf/ORR-RAIB-BTP-ACPO_MOU_April_2006.pdf

11. The MoUs recognise that all parties have duties to perform in relation to investigating rail accidents and incidents and that each party in fulfilling these duties should appropriately take into account the respective roles and responsibilities of the other parties.

12. They set out when the RAIB investigation will take precedence and when a criminal investigation will take precedence. In effect this means that whilst no party can prevent other parties discharging their duties and functions, the exact timing and manner in which each party carries these out may be affected by another's investigation where this best serves the public interest.

13. The MoUs recognise that, in the public interest, it would require firm indications of serious criminality¹ to justify a criminal investigation taking precedence over an RAIB investigation whose results will be made public. Consequently, the success of criminal proceedings may be adversely affected but unless there are firm indications of serious criminality this is likely to be justified.

14. They provide a framework within which each party can carry out their respective roles and responsibilities, and, where necessary, carry out parallel independent investigations in cooperation with one another, in a way which achieves the best outcome for all concerned. They recognise the need for each party involved in the investigation of rail accidents and

¹ "Serious criminality" includes the crimes of murder and culpable homicide, and any criminal act which result in a terrorist incident, deaths, multiple casualties, serious injury and/or other serious consequences, e.g. derailment of a train, or a train collision. This does not include criminal offences which properly fall to be investigated by ORR.

incidents to approach their task in co-operation with one another and in accordance with the public interest.

15. The Corporate Manslaughter and Corporate Homicide Act is in force from 06/04/08, and will guide the way the police investigate certain fatal accidents.

16. Where RAIB is not investigating an incident, HMRI may undertake a technical investigation into causes where this follows our selection criteria: see below.

Notification of incidents

During office hours

17. The procedures for notifying incidents, including out of hours, are the same whether or not it could be classed as a major incident. These are drawn up and managed by the Information and Intelligence Team under the Operations Intelligence Manager(OIM). [Appendix 1](#) reproduces some guidance on the reporting of serious incidents, prepared for dutyholders, which is a useful quick reference.

18. HMRI will normally be informed of incidents by Network Rail control offices, London Underground Network Control Centre (NCC) and by responsible officers of other railway and transport systems undertakings. During office hours (09:00-17:00, Mon-Fri) these messages are passed directly to the Information and Intelligence Team. on 020 7282 3910.

19. The OIM will gather the necessary information by discussions as appropriate with: Network Rail control, LUL NCC, TOC control, responsible railway officer, BTP and RAIB. In the case of a serious accident Accident Section will also inform:

- The appropriate ATM/GM
- ORR Press Office;

RAIB co-ordinator to confirm our involvement

and, depending on the nature of the accident:

- Transport for London;
- DfT Radioactive Materials Division in the case of a nuclear incident;

20. The duty to report to RAIB under RAIRR has not affected the parallel duties to report to HMRI under RIDDOR. There are differences between the requirements. Details are given in the quick reference guide at [Appendix 2](#).

Out of hours: the DfT duty officer system

21. Between 17:00 and 09:00 the following day (Mon-Fri and during weekends and holidays), incidents are passed to the DfT Duty Officer on 020 7282 2118. This number will transfer automatically to the home based DfT Duty Officer on call.

22. The duty officers have been provided with guidance on handling railway incidents by the Information and Intelligence Team. If clarification is required as to whether an incident should be referred immediately to HMRI or not, the ECO should be contacted: see below.

Out of hours: the emergency contact officer (ECO) system

23. The ORR ECO system is administered by the Information and Intelligence Team, and consists of 20 ECOs, mainly at B5 or above. They act as the contact point for the DfT duty officer. Their role is to contact the appropriate inspector in cases where some immediate follow up is required. An updated list of available ATMs and GMs is provided to them weekly.

24. ECOs are also provided with the full confidential staff list to facilitate a wider network of contacts if required in the case of a serious/major incident.

Fast stream reports

25. In the case of a serious incident, the Operations Intelligence Manager (OIM) will draft a fast stream report (FSR) for ORR senior managers, ideally within one hour of the incident being notified. In the case of an out of hours incident, the area team manager (ATM) in discussion with senior management may draft a FSR and email to the Information and Intelligence Team at riaccident.section@orr.gsi.gov.uk for them to distribute the next working day. The detailed procedure, including the structure of such reports, is at Appendix 3.

Selection and response

Criteria for selection of incidents for investigation

26. Area Team Managers (ATM) have the prime responsibility in selecting which incidents should be investigated.

RAIB implications

27. A RAIB decision to investigate may influence at what stage HMRI starts our investigation, and the level of resource we decide to devote to the investigation. We may choose, depending on the nature of an incident, to wait for technical findings from RAIB before determining our course of action, or may run an investigation in parallel to their technical one.

28. Though contact with safety representatives should be made in any case during the course of investigations, it is particularly important to keep them informed when a non-site investigation is proposed.

Mandatory Investigations

29. It is HMRI policy to require mandatory investigation of certain incidents. The current list is given at [Appendix 4](#) and may be subject to change as priorities are reviewed.

30. Investigation of incidents within these categories can only be waived with the written agreement of the relevant General Manager (GM) where the decision is due to inadequate resources. The procedure at [Appendix 5](#) should be followed. Other legitimate reasons for non-investigation are: impracticability of investigation (for example, unavailability of witnesses, or evidence); or indications that disproportionate effort would be required, and lack of reasonably practicable precautions available for risk reduction.

Major incidents

31. The Railways Act 2005 (RA), schedule 3 paragraph 4, enables ORR to “authorise a person to investigate and make a special report on any accident, occurrence, situation or other matter of any sort ...” This power may or may not be used by the ORR Board following a major incident depending on the circumstances, but in practice will be reserved for the exceptional high public profile events. This is equivalent to the Health and Safety Commission’s (HSC) power under the Health and Safety at Work etc Act 1974 section 14(2)(a), which was used, for example, to require HSE to investigate and report following the Hatfield derailment.

32. There is no equivalent power to HSWA section (14)(2)(b) under the RA, under which the HSC could direct a public inquiry to be held with the consent of the Secretary of State. This happened following the derailments at Southall and Ladbroke Grove.

33. Incidents where HMRI is directed to investigate by the ORR Board will invariably be covered by one of the categories listed. In these circumstances the [Major Incident Procedures Manual](#) should be consulted for additional requirements.

Fatalities

34. HMRI follows HSE's procedures on contact with, and disclosure of information to, relatives of those killed. See step 4.3 of the Operational Procedure and OM 2002/105 (England & Wales) and OM 2003/105 (Scotland). But we also need to be aware of what RAIB will be doing if they are investigating.

35. RAIB has produced a standard letter (reproduced in Appendix 6) to which they attach a leaflet about the functions of RAIB rather than one specific for the bereaved. This includes a contact address for HMRI. However, because of the importance of ensuring that RAIB and the safety authority operate independently, it has been agreed that HMRI will write separately. As a consequence, bereaved families will receive three letters, including one from the police. Following OM 2002/105, a standard letter for the ATM to send has not been produced, but an example which has been used is attached at [Appendix 6](#) for guidance.

36. ORR have produced two leaflets entitled *Advice and Information for Bereaved Families*, one for England and Wales and one for Scotland. Stocks are held centrally by Communications Team, and will be supplied on request, within a pack containing other useful information for families.

Other incidents

37. The ATM decides which incidents should be investigated, depending on resources and other current priorities. RIDDOR 'over 3 day' (O3D) injury reports, National Control Centre reports and other sources (such as liaison meetings with safety representatives or media articles) may reveal incidents of interest to HMRI which are not covered by the mandatory investigation categories at [Appendix 4](#).

38. Factors to be weighed when exercising discretion include consideration of:

- The potential consequences of the incident;
- Seriousness of any possible breaches of law;
- Dutyholder's past performance;
- Actual or anticipated level of media attention;
- Resources available;
- Enforcement priorities;
- Balance between investigation and other essential work as prioritized in the Operating Plan;
- Whether the investigation will assist policy development;
- Whether the investigation will aid the development of topic guidance;
- Providing information which will help monitor trends and assist in standard setting;
- Furthering current or planned research objectives;
- Assisting in staff training.

Non-site investigations

39. Generally, incidents require a visit to site, but other approaches may be used when this is not justified. These include:

- Considering information supplied by RAIB (either at the initial stages or later when their report is published);
- Reviewing industry reports;
- A telephone enquiry, or a letter drawing attention to a particular incident or group of incidents and asking for an explanation of the circumstances and remedial action proposed or taken.

40. The reasons for selecting this method of investigation should be recorded on the COIN investigation record.

Incidents not to be investigated

41. It remains our policy that certain incidents will not generally be investigated. In addition to adult trespass and suicide these will include incidents that only come to our attention through a letter from a solicitor, insurance company or other body requesting an investigation in connection with a civil claim, unless:

- The letter reveals sufficient information to justify an investigation *and* the tests at paragraph 35 are met; *or*
- The incident appears to be within the categories set out at [Appendix 4](#) and has not been reported as required by RIDDOR.

42. Another legitimate reason for non-investigation could be if RAIB are already investigating and there is no practical benefit in us conducting our own investigation.

Site Liaison

43. As there is some overlap between the roles of RAIB and HMRI, every effort should be made to minimise duplication of effort. Contact should be made with the Duty Co-coordinator at RAIB by the most appropriate HMRI manager (as soon as practicable on being informed of an incident) in order to ensure that both agencies organise a co-ordinated response. We should ensure that we are able to supply such information as we have available about the incident and advise the RAIB of the level of response that we will be initiating.

44. Where RAIB is investigating they must be informed of HMRI's intention to enter the site, beforehand if practicable, or otherwise as soon as possible afterwards. We also need to tell RAIB what we intend to do, or have done, on the site, and must do nothing (without RAIB's agreement) that interferes with or disturbs the incident site.

45. RAIB has no legal powers other than those necessary to enable its investigations. They may issue urgent safety advice (USA), but if urgent action has to be taken to prevent a repetition or serious risk on site, this is for us to undertake in our role as National Safety Authority.

46. At the earliest opportunity, the police, RAIB and HMRI should agree a strategy for the preservation of the scene and evidence collection. Any concerns that we have with regard to any aspect of the site/investigation in respect of our enforcement role should be identified to RAIB. It is essential that good working relationships are established and that RAIB are aware of both the police and HMRI's need to adhere to the Work Related Death Protocol ([link](#)) where necessary.

47. Other details as to how evidence on and off site will be handled and shared, as well as working arrangements between all parties, is given in the MoUs, to which you should refer for more detailed information. In particular, RAIB will provide details of their findings and access to any factual technical evidence to HMRI and the police as appropriate for their respective roles. This will not include any witness evidence unless the individual chooses to share it with us.

48. There will be instances where RAIB will not be in a position to share certain elements of the information it has gathered, such as confidential information relating to an individual. In such circumstances we will need to gather this information separately if it is necessary for our investigation and cannot be gained by any other means.

49. RAIB have undertaken to fully comply with the requirements of the Criminal Procedure and Investigations Act 1996 (CPIA), so that evidence they share with us can be used in proceedings.

Permissioning duties

50. Where duty holders involved in an incident have either a safety certificates and/or authorisations, inspectors should take the opportunity to check their safety management systems in relation to their emergency response procedures and procedures for reporting, investigating and analysing accident and incidents, in order to verify the information provided in their submission. This should be done within the context of our overall delivery plan for the duty holder.

51. Where there is no safety certificate/authorisation, inspectors should consider the need for general follow up action and undertake this at a suitable opportunity.

52. Inspectors should be aware that RAIB may ask for information on a safety certificates/authorisations, or delivery plans during the course of their investigation. It is also possible that RAIB may ask us for a wider range of information about our work in relation to the incident they are investigating. Whenever RAIB ask to interview ORR staff HMRI senior management should be informed.

Evidence collection

53. [Appendix 7](#) is an aide memoire on the different kinds of evidence to be collected when dealing with a railway incident. It was originally in the Major Incident Procedures Manual, but is relevant to any serious incident.

Provision of technical support by HSE

54. The HSE/ORR The Memorandum of Understanding (MoU) <http://callisto/upload/pdf/279.pdf> enables ORR to call upon technical support should this be needed. In addition, the nature of the incident could be such that HSE will be directly involved with the investigation, because they are the enforcing authority under the Health and Safety (Enforcing Authority for Railways and Other Guided Transport Systems) Regulations 2006 (EARR 06), such as when major construction work at or near the railway is involved. In all such cases an early dialogue should be established.

Recording incidents on COIN

55. Guidance is given in [Appendix 8](#).

Reporting of serious incidents to HM Railway Inspectorate: guidance to dutyholders

1 INTRODUCTION

This note provides guidance on notifying serious incidents that are reportable under the "Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995" (RIDDOR 95).

2 REPORTING POINTS

The HM Railway Inspectorate Information and Intelligence Team is manned Monday to Friday from 09.00 hrs to 17.30 hrs. Accidents occurring during these hours should be reported on the following number:

020 7282 3910

Alternative numbers are:

020 7282 3895

020 7282 3879

020 7282 3891

020 7282 3880

020 7282 3882

Railway Network Internal Number 00-31380

Fax 020 7282 2118

Outside these hours, weekends and public holidays, serious incidents should be reported to the Department for Transport (DfT) Duty Officer on:

020 7944 2118

3 NOTIFICATION OF SERIOUS INCIDENTS

If any of the following occurs you should notify HMRI Information and Intelligence Team or the DfT Duty Officer without delay:

- a) Any accident (derailment, collision, fire etc.) to a passenger train or tram where fatalities or serious injuries occur to passengers, staff or others;
- b) Any serious accident to a train or tram (e.g. high speed derailment or head-on collision) even if there are no casualties;

- c) Any incident which seems likely to result in substantial disruption to passenger services for at least 1 hour;
- d) Any accident involving the release or combustion of dangerous goods from a train which necessitates the evacuation of railway personnel or the general public from the area affected;
- e) Any incident involving a freight train carrying radioactive materials;
- f) Any collision between a train and a road vehicle at a level crossing whether or not there have been any injuries;
- g) Any pedestrian fatality at a public road level crossing;
- h) Any fatal accident or serious injury (life threatening) to railway staff on duty;
- i) Any fall from a train door whilst the train is in motion, other than at a station;
- j) Any child (age under 16) trespasser fatally or seriously injured on the railways (see section 4 regarding notification of fatalities involving adult trespassers and suicides);
- k) Any fatality or life threatening injury to a passenger;
- l) The overturning or collapse of any crane, collapse of a high scaffold, collapse of a bridge or tunnel, failure of a structure which occurs on, or blocks, a railway;
- m) Striking of underground power cables carrying a voltage of 650 or more even where no damage or injury occurs.
- n) Any incident of a runaway:
 - Train
 - Wagon
 - Engineers Trolley
 - On Track Machinery
- o) Any incident not mentioned above which receives or is likely to receive media attention e.g. a serious near miss.

All other incidents should be reported during normal office hours within the RIDDOR timescales (e.g. written notification within 10 days of the accident occurring).

4 ADULT TRESPASSERS AND SUICIDES

Fatalities involving adult trespassers and suspected suicides need not be reported to the duty officer out of hours. Those occurring between 17:30 and 09:00 hours, weekends and public holidays should be notified immediately to the Information and Intelligence team on the next available working day.

5 DETAILS TO BE NOTIFIED

- your name, organisation and telephone number
- the date and time the accident occurred
- where it occurred
- the train involved
- what happened
- number of casualties
- whether the casualties were passengers, staff or other people
- the line/services affected and any delays to those services

When reporting a serious incident out of hours to the DfT Duty Officer, please state if you are notifying an incident to HMRI, RAIB or to both.

Also note the name of the person you spoke to you and the time you made the notification.

6 WRITTEN NOTIFICATION

A written report on the appropriate form (F2508RA/F2508B) should be completed and sent to HMRI Information and Intelligence Team within 10 days of the accident occurring to:

HM Railway Inspectorate
Office of Rail Regulation
One Kemble Street
London
WC2B 4AN

Notifications can also be faxed to 020 7282 2118 or sent by e-mail to riaccident.section@orr.gsi.gov.uk

7 FURTHER ADVICE

Full guidance on the reporting regulations can be found in the HSE guidance booklet:

"Guidance for railways, tramways, trolley vehicle systems and other guided transport systems on the Reporting of injuries, Diseases and Dangerous Occurrences Regulations 1995"
ISBN 0-7176-1022-5 Price £11.50 available from HSE Books, PO Box 1999, Sudbury, Suffolk CO10 6FS

If you require advice on any aspect of the reporting regulations please contact the HMRI Accident Section.

Related safety information can also be found on ORR's web site

<http://www.rail-reg.gov.uk/server/show/nav.1210>

Appendix 2

Reporting of railway accidents under RIDDOR and RAIRR – quick reference guide

Legislation

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (HSE regs)

RAIRR – The Railways (Accident Investigation and Reporting) Regulations 2005 (RAIB regs)

FATAL ACCIDENTS

RIDDOR

- Any death on the railway is reportable
- Death from natural causes is not normally reportable unless the cause of death was in connection with a work activity

RAIRR

- Only deaths due to train accidents and movement accidents are reportable
- Excluded are:
 - Fatalities due to non movement accidents
 - Assaults
 - Trespass and suicides

MAJOR INJURIES (RIDDOR) SERIOUS INJURIES RAIRR

RIDDOR

- Any fracture other than to the fingers, thumb or toes.
- Any amputation

RAIRR

- A fracture other than to fingers, thumbs or toes;
- Amputation

- **Dislocation of the shoulder, hip, knee or spine**
- **Loss of sight (whether temporary or permanent)**
- **A chemical or hot metal burn to the eye or any penetrating injury to the eye.**
- **Any injury resulting from electric shock or electrical burn (including any electrical burn caused by arcing or arcing products) leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours**
- **Any other injury –**
- **Leading to hypothermia, heat induced illness or to unconsciousness**
- **Requiring resuscitation**
- **Requiring admittance to hospital for more than 24 hours**

- **Dislocation of the shoulder, hip, knee or spine**
- **Loss of sight whether temporary or permanent, in one or both eyes**
- **A chemical or hot metal burn or any penetrating injury to one or both eyes**
- **An injury leading to hypothermia or heat induced illness**
- **An injury requiring resuscitation of the injured person**
- **An injury requiring admittance to hospital for more than 24 hours**
- **An injury directly leading to loss of consciousness**
- **An injury resulting from the absorption of a substance by inhalation, ingestion or through the skin that causes acute illness requiring medical treatment**

OVER 3 - DAY INJURIES AND HOSPITAL TREATMENT

RIDDOR

Over – day injuries

- **A railway employee is unable to carry out their normal work duties for more than three consecutive days. This excludes accidents which are reported as major injuries**

Hospital Treatment

- **A member of the public is taken immediately from the site of the accident to hospital. There is no distinction between a major injury and over 3 day injury for a member of the public**

RAIRR

- **Only fatalities and serious injuries as defined are reportable**

RIDDOR SPECIFIC DANGEROUS OCCURRENCES AND RAIIR SCHEDULES 1 TO 3

DO Number	Description	Schedule No	Description
49	Collision between passenger trains	1 Para 3	A collision between rolling stock on a running line which causes damage or blocks a running line that was open to railway traffic at the time of the collision
50	Derailment of a Passenger Train	1 Para 4	A derailment of rolling stock on a running line that was open to railway traffic at the time of the derailment, or which blocks a running line that was open to railway traffic at the time of the derailment.
51	Collision between non passenger trains	1 Para 3	A collision between rolling stock on a running line which causes damage or blocks a running line that was open to railway traffic at the time of the collision
52	Derailment of a non passenger train on a running line	1 Para 4	A derailment of rolling stock on a running line that was open to railway traffic at the time of the derailment, or which blocks a running line that was open to railway traffic at the time of the derailment.
53	Derailment of a non passenger line in a siding which obstructs a running line	1 Para 4	A derailment of rolling stock on a running line that was open to railway traffic at the time of the derailment, or which blocks a running line that was open to railway traffic at the time of the derailment.

HM Railway Inspectorate Investigations Guide

54	Buffer Stop Collision (excluding sidings) where damage is caused to the train	1 Para 5	A collision of rolling stock with an arrestor mechanism or buffer stop, other than in a siding, that causes damage to the rolling stock.
55	Any case of a train striking any cattle or horse whether or not damage is caused to the train, or striking any other animal where damage occurs that requires temporary or permanent repair		Animal strikes are not reportable unless the train derails
56	Any case of a train striking or being struck by any object which causes damage requiring immediate temporary or permanent repair or which might have been able to derail the train	2 Para 1	A collision of rolling stock with an object on or adjacent to a running line which under slightly different conditions might have caused a derailment, except: Those already reported as collisions and derailments If the object was an animal Where the obstruction was caused by an act of vandalism
57	Any case of a train other than one on a railway striking or being struck by a road vehicle	3 Para 6	A collision between a tramcar and a road vehicle on a part of a tramway laid along a carriageway. (Monthly Return)
58	Passenger trains dividing	2 Para 4	Any unintended division of a train or a tramcar
59 (a)	Failure of an axle	2 Para 5 (a)	Failure of an axle
59 (b)	Failure of a wheel or tyre including a tyre loose on its wheel	2 Para 5 (b)	Failure of a wheel or tyre including a tyre loose on its wheel
59 (c)	Failure of a rope or the fastenings thereof or of the	2 Para 6	The failure of a cable or the fastening

	winding plant or equipment involved working an incline		thereof of the winding plant or other equipment involved in working a railway operated by a cable haulage system.
59 (d)	Any fire, severe electrical arcing or fusing in or on any part of a passenger train or a train carrying dangerous goods	2 Para 5 (c)	a fire or severe electrical arcing or fusing, whether or not extinguished by a fire-fighting service
59 (e)	In the case of any train other than a passenger train, any severe electrical arcing or fusing, or any fire that was extinguished by a fire fighting service	2 Para 5 (c)	a fire or severe electrical arcing or fusing, whether or not extinguished by a fire-fighting service
59 (f)	Any other failure of any part of a train which is likely to cause an accident to that or any other train or to kill or injure any person	1 Para 9	An accident or incident which under slightly different conditions might have led to a death, serious injury or extensive damage to rolling stock, the infrastructure or the environment
60	Any case of a train striking a road vehicle or gate at a level crossing	1 Para 2 and 2 Para 1	An accident on a level crossing involving rolling stock, resulting in the death of a person or serious injury to a person. A collision of rolling stock with an object on or adjacent to a running line which under slightly different conditions might have caused a derailment,
61	Any case of a train running onto a level crossing when not authorised to do so	*	
62	A failure of level crossing equipment which could endanger users of the road or path crossing the railway	3 Para 1	The failure of equipment at a level crossing which reduces the level of safety on the railway (Monthly Return)

63	<p>The failure of a rail in a running line or rack rail which results in:</p> <p>A complete fracture of a rail through its cross – section or</p> <p>In a piece becoming detached from the rail which necessitates an immediate stoppage of traffic or the immediate imposition of a speed restriction lower than that currently in force</p>	3 Para 2	<p>The failure of a rail, including a rack rail, on a running line whether by a complete fracture through its cross section, or by the buckling or detachment of a piece of rail and which necessitates an immediate closure of that running line or speed reduction on that running line. (Monthly Return)</p>
64	<p>A buckle of a running line which necessitates an immediate stoppage of traffic or the immediate imposition of a speed restriction lower than that currently in force</p>	3 Para 2	<p>The failure of a rail, including a rack rail, on a running line whether by a complete fracture through its cross section, or by the buckling or detachment of a piece of rail and which necessitates an immediate closure of that running line or speed reduction on that running line. (Monthly Return)</p>
65	<p>Any case of an aircraft or a vehicle of any kind landing on, running onto or coming to rest foul of the line, or damaging the line which causes damage, which obstructs the line or which damages any railway equipment at a level crossing</p>	2 Para 3	<p>An obstruction of, or damage to, track, caused by a road vehicle encroaching onto a running line, except when the obstruction or damage occurs on a part of a tramway track laid along a carriageway.</p>
66	<p>The runaway of an escalator, lift or passenger conveyer</p>	*	
67	<p>Any fire or severe electrical arcing or fusing which seriously affects the functioning of signalling</p>	*	

	equipment		
68 (a) and 68 (b)	<p>Any fire affecting the permanent way or works of a relevant transport system which necessitates the suspension of services over any line or the closure of any part of a station or signal box or other premises for a period –</p> <p>(a) in the case of a fire affecting any part of a relevant transport system below ground of more than 30 minutes</p> <p>(b) in any other case, of more than 1 hour</p>	*	
69	Any other fire which causes damage which has the potential to affect the running of a relevant transport system	*	
70 (a)	The failure of a tunnel, bridge, viaduct, culvert, station or other structure or any part thereof including the fixed electrical equipment of an electrified relevant transport system	3 Para 3	The failure of a structure on railway property, including a tunnel, bridge, viaduct, culvert, railway cutting, embankment, station, signal or fixed electrical equipment which under slightly different circumstances may have led to a serious accident or which otherwise reduces the level of railway safety. (Monthly Return)
70 (b)	Any failure in the signalling system which endangers or which has the potential to endanger the safe passage of trains other than failure of a traffic light controlling the movement of vehicles on a road	3 Para 4	A failure in the signalling system which reduces the level of railway safety. (Monthly Return)
70 (c)	A slip of a cutting or an embankment	3 Para 3	The failure of a structure on railway property, including a tunnel, bridge,

			viaduct, culvert, railway cutting, embankment, station, signal or fixed electrical equipment which under slightly different circumstances may have led to a serious accident or which otherwise reduces the level of railway safety. (Monthly Return)
70 (d)	Flooding of the Permanent Way	*	
70 (e)	The striking of a bridge by a vessel or by a road vehicle or its load	*	
71	Passenger Congestion at Stations	*	
72	Any case where a train travelling on a running line or entering a running line from a siding, passes without authority a signal displaying a stop aspect unless the stop aspect was not displayed in sufficient time for the driver to stop safely at the signal	3 Para 5	Rolling stock passing a railway signal displaying a stop aspect, unless either the driver had been given authority to pass the signal or the signal did not display in sufficient time to enable the driver to stop safely at the signal.

No specific category in RAIRR Schedules but could be interpreted to report under:

- Schedule 1 Para 8 An accident that causes extensive damage to rolling stock, the infrastructure or the environment
- Schedule 1 Para 9 An accident or incident which under slightly different conditions might have led to death or serious injury or extensive damage to rolling stock, the infrastructure or the environment.

No railway specific category in RIDDOR but requirement in RAIRR schedules:

- Schedule 1 Para 6 An accident involving the release or combustion of dangerous goods being carried on rolling stock, that necessitates the evacuation of the area

This may be captured under DO 59 (d) - Any fire, severe electrical arcing or fusing in or on any part of a passenger train or a train carrying dangerous goods or a general DO e.g. DO 19 Explosion or Fire and DO 20 Escape of Flammable Substances

NOTIFICATIONS

Immediate notification e.g. telephone/fax/e-mail HMRI	Immediate Notification Required By Telephone RAIB
<ul style="list-style-type: none"> • Any accident (derailment, collision, fire etc.) to a passenger train or tram where fatalities or serious injuries occur to passengers, staff or others; • Any serious accident to a train or tram (e.g. high speed derailment or head-on collision) even if there are no casualties; • Any incident which seems likely to result in substantial disruption to passenger services for at least 1 hour; • Any accident involving the release or combustion of dangerous goods from a train which necessitates the evacuation of railway personnel or the general public from the area affected; • Any incident involving a freight train carrying radioactive materials; • Any collision between a train and a road vehicle at a level crossing whether or not there have been any injuries; • Any pedestrian fatality at a public road level crossing; • Any fatal accident to railway staff on duty; 	<p>All Schedule 1 Events:</p> <ol style="list-style-type: none"> 1. An accident resulting in the death of a person or the serious injury of two or more persons. 2. An accident on a level crossing involving rolling stock, resulting in the death of a person or serious injury to a person. 3. A collision between rolling stock on a running line which causes damage or blocks a running line that was open to railway traffic at the time of the collision. 4. A derailment of rolling stock on a running line that was open to railway traffic at the time of the derailment, or which blocks a running line that was open to railway traffic at the time of the derailment. 5. A collision of rolling stock with an arrestor mechanism or buffer stop, other than in a siding, that causes damage to the rolling stock. 6. An accident involving the release or combustion of dangerous goods being carried on rolling stock that necessitates the evacuation of the area. 7. An accident or incident that is likely to result in suspension of

<ul style="list-style-type: none"> • Any fall from a train door whilst the train is in motion, other than at a station; • Any child (age under 16) trespasser fatally injured on the railway; • Any passenger fatality; • The overturning or collapse of any crane, collapse of a high scaffold, collapse of a bridge or tunnel, failure of a structure which occurs on, or blocks, a railway; • Striking of underground power cables carrying a voltage of 650 or more even where no damage or injury occurs. • Any incident not mentioned above which receives or is likely to receive media attention e.g. a reported near miss involving contractors or track workers. 	<p>a railway service for a period in excess of 6 hours.</p> <p>8. An accident that causes extensive damage to rolling stock, the infrastructure or the environment.</p> <p>9. An accident or incident which under slightly different conditions might have led to a death, serious injury or extensive damage to rolling stock, the infrastructure or the environment</p>
<p>A written notification is required to be sent within 10 days of the incident for all reportable events under RIDDOR.</p>	<p>A written notification must be sent for all Schedule 1 and 2 Events within 3 working days of the incident</p> <p style="text-align: center;">Schedule 2</p> <p>1. A collision of rolling stock with an object on or adjacent to a running line which under slightly different conditions might have caused a derailment, except—</p> <p>(a) if it is notifiable under regulation 4(1);</p> <p>(b) if the object was an animal; or</p>

	<p>(c) where the obstruction was caused by an obvious act of vandalism.</p> <p>2. An accident resulting in the serious injury of one person only except if it is notifiable under regulation 4(1).</p> <p>3. An obstruction of, or damage to, track, caused by a road vehicle encroaching onto a running line, except when the obstruction or damage occurs on a part of a tramway track laid along a carriageway.</p> <p>4. Any unintended division of a train or a tramcar.</p> <p>5. The failure of rolling stock on the track caused by—</p> <p>(a) the failure of an axle;</p> <p>(b) the failure of a wheel or tyre, including a tyre loose on its wheel; or</p> <p>(c) a fire or severe electrical arcing or fusing, whether or not extinguished by a fire-fighting service.</p> <p>6. The failure of a cable or the fastening thereof of the winding plant or other equipment involved in working a railway operated by a cable haulage system.</p>
<p>A Written notification must be sent within 10 days at the end of the month for those DO's that are reported in the form of Monthly reports:</p>	<p>A written notification must be sent within 10 days at the end of the month fro Schedule 3 Events</p>

<p>DO 57 A tram colliding with a road vehicle</p> <p>DO 63 Broken Rails – <i>Note following the railway accident at Hatfield on the 17 October 2000, a temporary arrangement exists with Network Rail for all Broken Rails on NWR infrastructure to be reported within 24 hours. This is sent by e-mail to HMRI Accident Section.</i></p> <p>DO 70 (b) Failures in the signalling system</p> <p>DO 70 (e) Bridge Bashes</p> <p>DO 72 SPADs – <i>Note following the railway accident at Ladbroke Grove on the 5 October 1999, a temporary arrangement exists with Network Rail for all Category A SPADs to be reported within 24 hours. This is sent by e-mail to HMRI Accident Section.</i></p>	<p style="text-align: center;">Schedule 3</p> <ol style="list-style-type: none"> 1. The failure of equipment at a level crossing which reduces the level of safety on the railway. 2. The failure of a rail, including a rack rail, on a running line whether by a complete fracture through its cross section, or by the buckling or detachment of a piece of rail and which necessitates an immediate closure of that running line or speed reduction on that running line. 3. The failure of a structure on railway property, including a tunnel, bridge, viaduct, culvert, railway cutting, embankment, station, signal or fixed electrical equipment which under slightly different circumstances may have led to a serious accident or which otherwise reduces the level of railway safety. 4. A failure in the signalling system which reduces the level of railway safety. 5. Rolling stock passing a railway signal displaying a stop aspect, unless either the driver had been given authority to pass the signal or the signal did not display in sufficient time to enable the driver to stop safely at the signal. 6. A collision between a tramcar and a road vehicle on a part of a tramway laid along a carriageway.
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Fast stream reporting to senior management

1. This procedure sets down the arrangements for 'fast stream' reporting (FSR) to provide ORR senior staff with essential information and confirmation of facts about any serious rail incident as quickly and as accurately as possible. This 'fast stream' reporting system is intended to cover:
 - incidents that meet the reporting criteria that have in the past been agreed by ministers; and
 - incidents that are likely to have national press interest, even if they are not "reportable"
2. Where RAIB are not investigating we may use the FSR to prepare a brief for DfT. This will be at the discretion of the Chief Inspector (CI) or Deputy CI.
3. The purpose of the FSR is to enable senior managers to respond authoritatively to questions and avoid them finding out about incidents via the media. The Information and Intelligence Team will prepare and distribute to Directors Plus and the Chairman.

4. Fast Rep 1 Form contents:

Incident Report No:

1. Details of incident/accident:

Location: Railway companies involved:

Trains involved: (Time/Place of Origin/Destination) **Type of Train** (passenger/freight):

Date of incident: Time of Incident:

Source of information: Time & Date Information Received:

2. Nature of Incident:

(a) **Are there any casualties:** Yes No Not Known (Insert No's)

Public: Killed; Injured; (*Major*) (*Minor*) Still Trapped; In hospital;

Staff: Killed; Injured; (*Major*) (*Minor*) Still Trapped; In hospital;

(b) **Which Line/Services are affected:** (brief details)

(c) **Are there likely to be delays to those services:** Yes No Not Known
If known, when are services likely to resume?

(d) **Are implications likely to affect other train operators?** (details if known) Yes
No Not Known

(e) **Is the press likely to have an interest?** Yes No Not Known

(f) **Is the industry issuing a press release?** Yes No Not Known

3. **Initial estimates of significance of Health and Safety implications** (details if known)

Major Minor Not Known

4. **Initial action taken by HMRI**
5. **Sensitive issues** (if appropriate)
6. **Lines to take** (if appropriate)
7. **Any other comments**

Report made by: Name (Block capitals) Date:

Contact Telephone Number:

Location:

Detailed Procedure

5. The Operations Intelligence Manager is responsible for confirming the facts about the initial report and assessing whether the incident is reportable under any of the criteria listed below. If it is reportable, they should complete the Fast Rep 1 report form as soon as possible after an incident has been reported.
6. If the Operations Intelligence Manager is unavailable, the Information and Intelligence Team will contact a Principal Inspector, who will then be responsible for assessing the incident and completing the Fast Rep 1 if appropriate.
7. Out of hours initial incident reports will be made via DfT's duty officer to the ORR Emergency Contact Officer (ECO) who will in turn contact the appropriate available inspector. Whoever takes the call should make a judgment whether the report meets the criteria.
8. In these circumstances, an electronic copy of the Fast Rep 1 form should be completed by whoever deals with the report and be sent out to the normal distribution list at the earliest opportunity on the next working day. This is to ensure that ORR's senior management is informed and to provide a formal back-up to the out of hours telephone call.
9. The information on the Fast Rep 1 should be short, to the point. Generally, they will be one-off, standalone reports and not subject to review or updating, unless the situation is developing, eg a major incident. They will cover the known details of: what happened; the seriousness; injuries; the immediate ramifications; and information on what HMRI are doing.
10. Where readily available, the Fast Rep 1 should include brief information on:
 - any previous accidents at the same location;
 - the signal SPAD history if a SPAD was involved;
 - whether any current improvement initiatives would have had a mitigating effect.
11. If necessary, dependent on the seriousness of the incident, the Fast Rep 1 will be subsequently supplemented by further information on policy advice and lines to take.
12. In most cases a formal submission giving policy advice or lines to take will not be necessary, and for the less serious incidents senior managers are unlikely to need or want further information. For some serious incidents, however, sending the Fast Rep 1

early may mean that there is little information about casualties, service disruption, etc, and these would be shown on the form as "not known". Therefore, for incidents where the situation is developing either in terms of casualties/injuries and/or service disruption and consequences, the Fast Rep 1 should still be sent, but with subsequent updates by e-mail .

13. The Information and Intelligence Team is responsible for holding and keeping up to date the external and 'in-house' distribution lists. In most cases the Operations Intelligence Manager is responsible for completing the Fast Rep 1 form for incidents that meet the criteria.

Criteria for FSRs

14. A FSR will be required if the incident falls within any of the following criteria, and may also be necessary, depending on severity and circumstance, if it falls within the 'national press interest' categories.

- Any accident (derailment, collision, fire, etc.) to a passenger train or tram where fatalities or serious injuries occur to passengers, staff or others;
- Any serious accident to a train or tram (eg high speed derailment or head-on collision) even if there are no casualties;
- Any accident involving the release or combustion of dangerous goods from a train that necessitates the evacuation of railway personnel or the general public from the area affected;
- Any incident involving a freight train carrying radioactive materials;
- Any collision between a train and a road vehicle at a level crossing resulting in fatalities;
- The overturning or collapse of any crane, collapse of a high scaffold, collapse of a bridge or tunnel, failure of a structure which occurs on, or blocks, a railway
- .Any incident that, although minor in safety terms, will have a considerable impact on a large number of passengers - in particular on routes to and from London, or the East or West coast main lines.

Incidents likely to have national press interest

- Any major fire where a train is involved;
- Any incident in the Channel Tunnel;
- Any incident/accident that leads to all trains of that type to be inspected
- Any pedestrian fatality at a public road level crossing;
- Any fatal accident to railway staff on duty;
- Any child trespasser fatally injured on the railways;
- Any passenger fatality;
- Any incident that is topical in that it has similarities to, or occurred in the vicinity of, a recent incident that led to major press interest

Mandatory incidents for investigation

HMRI has reviewed its existing mandatory incident (MI) investigation criteria, after considering the role of RAIB. In summary, Area Team Managers should investigate all incidents listed below when any of these criteria apply:

- There has been a major incident as defined in the Major Incident Procedures Manual, which will be investigated in line with those procedures;
- RAIB is investigating an incident and evidence emerges that HMRI needs to use its enforcement powers;
- An incident is not being investigated by RAIB (either because they choose not to or it is not within their jurisdiction);
- Any other incident with the potential to lead to a similar outcome.

The process is shown on the flowchart at [Appendix 9](#), which also encompasses other incidents for possible investigation.

MI LIST

Operational Incidents

1. Any incident (derailment/collision/fire/etc) to a passenger train or light rail vehicle where fatalities, RIDDOR-defined major injuries to those at work, or passenger/other non-worker injuries requiring hospital treatment occur;
2. Any serious incident involving a train or light rail system, including a high speed derailment, head-on collision, severe buffer-stop collision, very serious signal passed at danger (SPAD) with an industry ranking of over 19, even if there are few or no casualties. For accidents on light rail systems involving collision with road vehicles, see OM 2003/103,
- 3 Any significant incident involving the carrying of radioactive materials, release or combustion of dangerous goods from a train that necessitates the evacuation of railway personnel or the general public from the area affected;
4. Any collision between a train and a road vehicle at a level crossing whether or not there have been injuries;
5. Any injury to a pedestrian resulting from being struck by a train on a public road level crossing or other authorised crossing;
6. Any fall from a train door whilst the train is in motion;
7. Any passenger fatality or serious injury involving a moving train at or close to a platform, for example a passenger dragged by power doors or falling between a moving train and the platform;

8. The overturning or collapse of any crane, collapse of a high scaffold, collapse of a bridge or tunnel, failure of a large pressure system such as a steam locomotive boiler, or failure of a structure which occurs on, or blocks, a railway, except where HSE is the enforcing authority;
9. Major fires at underground stations;
10. RIDDOR reportable embankment/cutting catastrophic failures (such as landslips)

Workforce Incidents

11. Any fatality or serious injury reportable under RIDDOR, including asphyxiations and cases of disease arising from a work activity. Serious injury includes the following, irrespective of cause: amputation of hand/arm/foot/leg; serious multiple fractures; crush injuries leading to major organ damage; serious head injuries involving loss of consciousness; full thickness burns & scold; permanent blinding of an eye; scalping;

Trespass

12. Any fatality or serious injury involving a young person (under 16 years of age) trespassing on the railway

Mandatory incidents not selected for investigation (or investigation cancelled) because of inadequate resources/other priorities

1. Where the ATM decides not to investigate an incident, which appears to meet the mandatory selection criteria, Part A of the decision recording form (DRF) <http://ornet/upload/doc/hrmri-form-drf.doc> should be used as described in the HSE Operational Procedure, step 2.3.
2. If the GM agrees with the decision, part D should be completed and sent electronically to the Accident Section.
3. If the GM disagrees with the decision, they should decide which team should conduct the investigation, complete part D and then send it with the incident notification to the team manager now assigned the investigation. They should also notify the Information and Intelligence Team.
4. Where an investigation is cancelled after being initially selected for investigation, either due to inadequate resources or developing priorities, the ATM should complete part B and then follow the procedures above.

Review of decision not to investigate when additional information received

5. Subsequent enquiries may provide significant additional information about incidents which were not selected for investigation. The ATM and GM should review the original decision in accordance with the criteria, and a new decision made.
6. If the GM agrees that the RIDDOR event should still not be selected for investigation, part C should be completed by ticking the appropriate box.
7. If the GM disagrees with the ATM decision and considers that the incident must now be investigated, part C should again be completed, and the above procedure followed.

RAIB template letter to the bereaved, and example of HMRI letter

Dear

RAIL ACCIDENT INVESTIGATION BRANCH

I am sorry that I have to write to you in these circumstances, and would like to offer you the sympathy and condolences of the Rail Accident Investigation Branch (RAIB) at your sad loss.

My purpose in writing to you is to inform you of the role of the RAIB in working to find the cause of the accident, and to make recommendations to improve safety overall; I enclose a leaflet that provides more detail.

It is not however, part of the RAIB's role to carry out any form of prosecution or enforcement action. This is usually done by the police or the relevant safety authority – in this case *Her Majesty's Railway Inspectorate*. In case you wish to contact them I have included their contact address at the end of this letter.

The inspector who is leading the RAIB investigation into the accident at [insert Location.....] on [insert date.....] is [insert name of Lead Inspector.....]. His contact details are:

Phone

Email xxxxxxxx@raib.gov.uk

Address The Wharf
Stores Road
DERBY
DE21 4BA

[insert name of Inspector.....] will shortly be in touch with you, through the police family liaison officer, to see if you wish to meet or have any form of contact with us to discuss our investigation. There is, of course, no compulsion on you to have contact with [insert name of Inspector.....] or anyone from the RAIB if you do not want to. We will however, remain available to you if you decide you do want to contact us at a later date. This is entirely your decision. After an initial meeting (or other contact) [insert name of Inspector.....] will, if you wish, contact you at key stages to keep you up to date with the progress of the investigation, and you are welcome to contact us for more frequent updates.

When the RAIB's final report is ready we will send you a draft copy so that you know what we have concluded. You may comment on the draft before it goes forward for publication if you wish. We will also send you a copy of the final report when it is published.

The RAIB always aims to provide the best possible service it can but if you have any concerns about the RAIB's work please raise them with [insert name of Lead

Inspector.....]. If he cannot resolve your issues please write to me at the address above, and I will personally do what I can to assist.

I hope that the work of the RAIB might be of some assistance to you.

Yours sincerely

Carolyn Griffiths
Chief Inspector
Rail Accident Investigation Branch

Contact address for Her Majesty's Railway Inspectorate:

The Chief Inspector
Her Majesty's Railway Inspectorate
The Office of Rail Regulation
One Kemble Street
London WC2B 4AN

Tel: 020 7282 2000

EXAMPLE OF LETTER FROM AREA TEAM MANAGER TO BEREAVED FAMILY

I am writing following the tragic death of your [father] in an accident on the railway in... I was given your name as a contact and I would be grateful if you would pass on the information in this letter to any other close family members. I would like to express my sincere condolences for your family's loss and to explain the role that the Office of Rail Regulation (ORR) will have in investigating the circumstances.

I lead the ORR team carrying out that investigation. We are cooperating with inspectors from the Rail Accident Investigation Branch (RAIB) and officers from the British Transport Police. RAIB investigates accidents and incidents on the UK's railways to improve safety, not to establish blame. The police will be making enquiries to inform the coroner.

The ORR's role is to discover what happened and whether any health and safety law has been broken. If our investigation shows that more should have been done to prevent the accident, we have powers to require action to stop it happening again and to prosecute those responsible under these laws.

I would like to arrange a date to meet with you, and any other close relatives, to explain what we are doing and to see whether anything you can tell us would help our investigation. I will aim to share with you what we know of the circumstances that lead to your [father's] death. In the meantime I enclose a pack of information about what happens when someone dies in these circumstances and hope it is some help.

Should you wish to contact me before we meet, please do so. I will do whatever I can to help you understand our role and the progress of our investigation. Until then, please accept my condolences at this time of your sad loss.

Yours sincerely

HM Principal Inspector of Railways
ATM

Evidence collection

Perishable evidence

1. RAIB have primacy, but copies of this evidence should still be obtained (as opposed to collected) by HMRI as it gives a broad understanding of events surrounding the accident and helps us decide whether to initiate enforcement action. Usually such evidence will be gathered either by RAIB or their accredited agents, the police (for drugs and alcohol) or by the Rail Incident Officer (RIO), or their equivalent for the non-main line network. Requests for this information should be made to the RAIB lead inspector who under the MoU should provide it.

2. HMRI attendance at site may be some time after the incident. Arrangements should have been made for perishable evidence to have been preserved or recorded as appropriate, and a check should be made to see that this has been done. Examples include:

- Data recordings (locomotive, rolling stock and signalling). Consider witnessing retrieval of data;
- Tyres, brake discs, brake blocks, brake pads, axle boxes (checked for temperature);
- Gauge readings air, vacuum checked;
- Position of controls (moved during crew rescue?) and switches, in the vehicle and (if appropriate) on the signalling panel recorded;
- Status of AWS/ATP/TPWS;
- Brake-block or pad position/hand brake position recorded;
- Brake isolation;
- Red/green cards/fault book(s);
- Perishable marks (such as wheel burn or climb/drop) on railhead recorded;
- Rail profile;
- Gauge/top/condition of fastenings/rail joints;
- Tyre profiles: outside limits?/recently machined?
- Evidence of loading irregularity/excess weight, uneven distribution/insecure;
- Wheel flats;
- Absence/presence of marks where they might reasonably be expected, such as wheel burn as a result of emergency brake application;
- Evidence or record of weather conditions at the time (rain/fog/snow/hot?);
- Cab temperature - windows/doors open/closed;
- Evidence of 'greasy' rail, especially at recognised sites of poor adhesion;

- Fitness of staff (medical restriction/sudden illness/alcohol/drugs);
 - Rail temperature (buckled/broken rail);
 - Position of sun at time of incident (factor in SPADs/road vehicles driving on to level crossings);
 - Signal sighting;
 - Vegetation control (factor in UWC sighting/SPADs);
 - Sighting and warning times of approaching trains (crossings/workgroups);
 - Blocking points used in possessions and condition of marker/warning boards/lamps;
 - Condition of ESR equipment (batteries/lamps);
 - Condition/set up of any ATWS equipment;
 - COSS Risk Assessment;
 - Communication (signal box/Control Room/ECR - train to shore (NRN/CSR));
 - CCTV installations in the vicinity (on- and off-rail infrastructure) - ascertain if they have recorded any of the event.
3. Some of this information will be available off-site and HMRI Silver should consider a strategy for obtaining this, especially the witnessing of the downloading of data recorders and obtaining signalling control room tapes, etc.

Taking possession

4. This is normally a RAIB responsibility, but we need to ensure continuity of evidence. If taking into possession a large piece of equipment such as a bogie, consideration will need to be given as to how it is to be secured and then transported to where it is required. The police may be able to help with security; otherwise an inspector should stay with it pending transportation. Transportation may be entrusted to the TOC if they are willing, or HSL will arrange transport. It is essential as part of this process that the correct 'taking into possession' form is issued, and also a record should be made in the infrastructure controller's log. In the event of whole carriages needing to be taken into possession, appropriate secure storage should be arranged before transportation off site – Bombardier at West Street, Crewe, has experience of HMRI requirements, having been responsible for secure storage of vehicles from the Ladbroke Grove and Hatfield incidents.

Testing of signalling equipment

5. This should be carried out by RAIB who should supply us with copies of the results on request.

Records.

6. The following is a list of examples of evidence gathered other than on site:
General issues

- Details of staff involved (medical restrictions? Competence and at-risk status of train crew? Obtain off-site evidence of training/assessment, etc.);
- Location details (layout, gradient, PSR, signalling system, mileage);
- Any emergency work in progress? If so, what?
- Any TSR/ESR?
- Known low adhesion or leaf-fall site?
- Details of any planned engineering work;
- Details of previous trains over the site

Track issues

- Patrolman's/Pway Eng inspection reports;
- Competence of patrolmen;
- Tie Bar register;
- Recognised cyclic top area?;
- Rough riding reports?;
- Fault number for work in system;
- Condition history of supporting earth works;
- 'IMPART' job bank

Train issues

- Vehicle susceptibility to derailment;
- Maintenance history;
- RAVERS data;
- PPM dates;
- Train examination;
- Train Weight (check actual against TOPS) ;
- Axle loading;
- Train/TOPS list;
- ;DG vehicles/TOPS list;
- Specialist advice/emergency plan (DG);
- Records of loading checks;
- Fleet problem history? (bearing failure, etc)

Signalling issues

- SPAD History;
- Competence of Signaller;
- Train Register Book;
- Box/Voice tapes;

Possession issues

- Competence of PICOP/COSS;

- Blocking points used - signal box;
- Published blocking points

Level crossing issues

- Crossing operation against Order/spec;
- Crossing condition);
- Previous inspections of crossing;
- Fault backlogs?;
- Risk Assessment (UWC);
- Operation of crossing phones/box entries;
- Operation of warning lights (UWC)

Route crime

- Condition of fence/access;
- Status of site (hot spots);

Recording incidents on COIN

1. This supplements the HSE OP on Investigation and ORR's COIN Buddy.

What incidents should be recorded?

2. As COIN is an operational work recording system rather than an accident database, case records for incidents should only be created where useful intelligence results because there has been some investigation. The IG makes clear that this can include enquiries other than paying a visit to the site. It would not as a rule include those incidents where enquiries are made about the circumstances before a decision to investigate is taken, and, where in the end, no further action is required.
3. A particular class of incident is fatalities/serious injuries resulting from trespass onto the railway, usually followed up by RICOs. Each case has to be judged on its merits, and it is accepted that an important part of the RICO role is to find out exactly what happened from BTP and Network Rail before deciding our response. As an example, a telephone call which reveals that a person jumped off a platform in front of the train and there are no extenuating factors for us, would not require to be recorded as a COIN case. Anything requiring any more follow up would be.
4. We need to avoid wasted effort in creating records that don't go anywhere and are closed again shortly afterwards.

How are incidents recorded?

5. Incidents should be recorded as a single case supported by a series of notes and attachments as required. Service orders are not used routinely in ORR. There is a link from several steps in the OP, for example at 1.6 and 2.2, to two useful pieces of guidance: a *quick reference guide* and *How to record a Basic Investigation*. Unlike HSE, we do not use this for recording complaints.
6. The guidance describes in detail examples of notes and attachments, both for the summary and details fields. ORR uses 4 mandatory notes:
 - Investigation details;
 - Visit report (s);
 - Contact with the family in the case of fatalities;
 - Management review.
7. Others are used where necessary. For example the decision recording form note will be used if one is produced.

8. For more complex multi dutyholder investigations you should also consult the guidance *How to record multi dutyholder/multi site interventions*. This is found at the same place as above. The basic model is:

- Cases with different customer/site combinations can be linked together – allowing us to record multi dutyholder/multi site interventions (NB not just for incidents);
- You must identify a **master case** or **trigger** to which you link all other related records;
- An example would be where an accident involved both Network Rail and a contractor or train operator.

9. Again, we do not generally use service orders. The principles of the basic model remain the same, but the exact structure will differ, depending on the particular scenario.

Inquest verdicts

10. Once the main investigation has been completed the case should be closed. It can be reopened to add information coming out of an inquest, which can be years later. A written report, either prepared by an inspector or RICO if they attended the inquest, or a report provided to us from a coroner's officer, should be added as an attachment to a note, while a simple verdict may be added as a note. This would normally be by the area team but could be by the Information and Intelligence Team if they received such a report.

Investigations flowchart

