

Workshop: Improving Railroad Safety through Understanding Close Calls

Aidan Nelson Presentation:

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experience



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History or reality today?



Has anything changed ?

"Engine drivers constantly complain of the way in which signals are placed; but it is only in rare cases or after an accident has actually occurred.... that improvements are introduced"

"On several occasions the author has examined signals where drivers have made mistakes, and in every case has found that the true cause was the defective state or position of the signal"



Company or the individual?

“Accidents constantly occur through the defective system of working adopted by the companies, but whatever the system, when the accident causes the death of a person, the railway servants are liable to a charge of manslaughter”



Blame them not us?

"It has always been the custom, whenever an accident happens, for the companies to try to place all the blame on some servant, in order that he may be punished , and the responsible officers who are really to blame for neglecting to provide proper appliances may escape scot free"



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Source:

Safe Railway Working by Clement Stretton

Published: 1893



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Experiment to
national system



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Rapid change in level of commitment

- Summer 1999

- A growing level of volunteer company interest

- Industry conference – support in principle but funding generally not in business plans

- Autumn 1999

- Catastrophic rail accident

- Parliamentary interest

- All Railway Group now committed



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Developing the national system

Broadly based industry steering group led and facilitated by RSSB predecessors managed the process

Concerns as to cost led to engagement of "newcomers" being conditional on there being a competitive procurement strategy

Core service provider contracted nationally, regional centres funded by a levy on number of staff enrolled



Some problems on the way

The transition from academically provided to commercially provided service was not without pain

IPR issues led us to a new taxonomy and reverse fitting historic data to it

Issues of trust and confidentiality led to the creation of a trust to own the taxonomy, the data itself and to license use of system

Creative counting of staff to be enrolled



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Commitment has to be underpinned

Railway Group Safety Plan

Railway Group Standard directly mandates enrolment of safety critical staff employed by Network Rail and train operators (The Railway Group)

Supply chain to Railway Group members has to be handled within contractual framework



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But we have an open safety culture

Some organisations still feel they don't need CIRAS

However the nature of the reports into the system illustrates that there is still a widely held concern that "blame" is alive and well in management thinking

Watch for local managers keeping the supply of CIRAS forms under surveillance



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Why report to CIRAS?

Quite a few early reports are to test the system, in particular that it really is confidential

Because when I reported an issue openly nothing was done and we know that the CIRAS system guarantees a response

CIRAS operates across organisational boundaries



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Quality of response

Too often the managerial response to a CIRAS report is defensive

This often reflects that the responding manager feels that self justification is necessary within the organisation

Independent peer review of responses raises quality considerably



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Our role in CIRAS



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Governance

We facilitate, fund and act as managing agent for the CIRAS Trust

Our nominated trustee chairs the Trust

We facilitate the independently chaired industry steering group on which we have membership

We fund the independent chair of the industry steering group



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Management

We fund the core CIRAS facility and recover the costs from the general funding of RSSB

We provide procurement services

We undertake the annual census of enrolled staff

We undertake research to review the effectiveness of the system – e.g. CIRAS journals



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We too are members of CIRAS

All our staff are within the scope of the system

We also provide the lead managerial response on issues related to ambiguity in and /or the interpretation of the Rule Book and other Railway Group Standards



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RSSB CIRAS Committee (1)

Newly formed, operates in the context of our safety leadership role within the rail industry

Works principally from CIRAS national report cross referenced with wider industry safety performance data and intelligence

Will request additional analysis from the CIRAS core facility as requires

RSSB CIRAS Committee (2)

Determines necessary RSSB action:

- Identify issues for further research

- Key issues monitored within quarterly and annual safety performance reports or generates a requirement for special topic reporting

- Influence Railway Group Safety Plan, national initiatives and standards

- Identify sources of risk for discussion at the RSSB risk review forum

- Initiate topic based workshops

Monitors progress / close out of actions



In conclusion:



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In short

Don't underestimate the management challenges in creating a high integrity confidential reporting system

Don't see it as a "bolt on", rather See it as an integral component of your wider human error management programme

Champion and lead development from within the industry to create ownership and minimise scepticism



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