The burden of remembrance: confronting difficult histories

Dear all,

Rob Cairns,
Regional Managing Director

I wanted to build on last week's message where I discussed the events at Eastleigh and the features we already know are critical to a healthy and safe culture.

- **Incidents affect everyone;** safety failures have wide-ranging, lasting emotional impacts.
- **Emotions drive safety;** trauma leaves deep emotional memories, shaping safety culture.
- **Decency builds safety;** leaders must foster commitment through honesty and respect.
- **Diversity & integrity matter;** representation changes must uphold core values and open communication.
- **Honesty prevents blindness;** open feedback and diverse views are essential for a safe culture.

Remembering past railway accidents, especially those that directly impacted us or those close to us, is a complex and often deeply triggering process. While moving forward with hope is vital, ignoring or suppressing these histories, whether as a society or a company, has severe consequences.

This creates a difficult cultural balance we must address. We all want to look ahead. However, choosing to forget causes serious problems. It dismisses the suffering of those involved and risks repeating the same mistakes.

Future safety isn't simply about avoiding new hazards. It's about meticulously connecting past risks to present practices, preventing known failures, and building a safer future on hard-earned lessons. This principle is crucial in infrastructure and operations, where **corporate memory is paramount**. For those who plan, operate, and maintain our essential systems, remembering past lessons is a moral duty, not just record-keeping. Losing this knowledge is dangerous, impacting lives and eroding trust.

In UK railway history we have stark examples of past incidents that we must not forget.

• Southall (1997) - inadequate Automatic Warning System implementation highlighted the need for robust signalling and automatic train protection.
• Ladbroke Grove (1999) - a train running a red signal in our region underscored the importance of driver training, signal visibility, and TPWS.
• Potters Bar (2002) - faulty points on Eastern regions East Coast route led to derailment, demonstrating the need for stricter maintenance and inspections.
• Ufton Nervet (2004) - a level crossing collision in our region highlighted the risks and spurred the development of better safety technology.
• Grayrigg (2007) - poorly maintained points exposed maintenance and inspection weaknesses.
• Clapham Junction (1988) - signalling errors in Southern region emphasised the need for thorough testing and verification.
• Purley (1989) - a collision caused by driver error in poor visibility emphasised the importance of clear operating procedures and driver training in adverse conditions.
• Moorgate (1975) - a train entering Moorgate station at high speed, without slowing, resulted in a severe collision and highlighted the need for automatic train protection and enhanced driver monitoring.

These events demand acknowledging past wrongs, understanding their root causes, and learning from the consequences. This is challenging, evoking strong emotions. It's not just about rules and reports. It's about remembering the people who were hurt and understanding how things went wrong. This helps us make the railways safer and treat everyone fairly, with decency and respect.

We build corporate memory by:

- **Documenting and sharing**
  Keeping good records, listening to staff stories, and using databases to track safety.

- **Building a strong safety culture**
  Encouraging everyone to care and speak up, respecting diverse views, and challenging ego bias that might dismiss concerns. A diverse organisation is more likely to create open conversations around these issues, making them easier to overcome.

- **Preventing Memory Loss**
  Avoiding hiding mistakes, updating outdated systems, and managing staff turnover, whilst actively combating selective memory that might downplay past failures.

- **Promoting transparency and learning**
  Thorough training, openly discussing risks, and documenting both successes and failures, whilst guarding against truth blindness that can ignore warning signs.

And here's where all of us come in; even if a risk seems small, we need to talk about it. We can all play a vital role by discussing the implications of these risks, no matter how unlikely they seem. By openly discussing 'what if' scenarios, and learning from the past, we can help prevent future accidents. We must make sure that no voice is diminished, and that no one is afraid to mention a potential danger, even when facing pressure from ego-driven individuals.

In safety-critical places like our region, honesty, responsibility, and decency are key. We must be vigilant against behavioural risks, such as ego bias, truth blindness, and selective memory, which can cloud our judgement and lead to tragic consequences. A diverse organisation is better equipped to overcome these risks due to the breadth of perspectives and experiences brought to the table

As always, please feel free to reply to me and let me know your thoughts.

Stay safe,
Rob