The importance of learning from history

everyone home safe every day

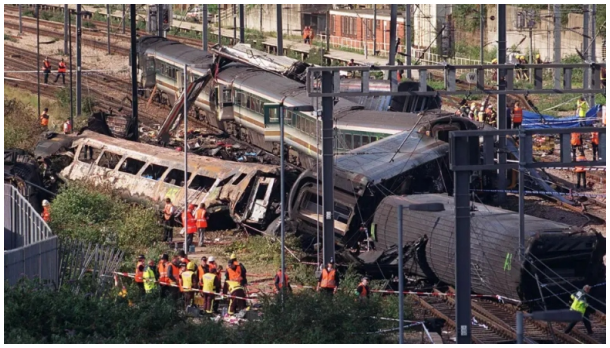
Dear all,

Rob Cairns,
Regional Managing Director

Last week, we held our quarterly regional safety meeting at our Westbury Delivery Unit. I opened the meeting by noting a few reflections since the previous review, back in September. Even now, those reflections seem unbelievable when recounting them to print in a single place in the way I do, once again, for this update.

Since the last meeting, we have experienced:

- A passenger service collision, resulting in the loss of life at Talerddig in Wales.
- An alarmingly close near-miss at Shrewsbury, involving team members being clear of a unit by a small number of seconds.
- The 25th anniversary of the Ladbroke Grove train crash within our region.
- The 20th anniversary of the Ufton Nervet Level Crossing accident within our region.
- Recently, a colleague from MTR was fatally injured on the Elizabeth Line after being assaulted whilst working at Ilford station ticket barrier.



Ladbroke Grove Junction, 5 October 1999: A three-car Thames Trains service collided with a high-speed First Great Western train

Ufton Nervet, 6 November 2004: A First Great Western high-speed train struck a car at a level crossing between Theale and Newbury

It is difficult, if not impossible, to recount these events without being taken by the sheer magnitude of their impact and how overawed you quickly begin to feel when reflecting on the profound and indelible mark each of these incidents has on anyone involved. It also becomes startlingly clear that the system within which we work involves a huge number of complex interfaces with a wide and varying range of stakeholders. This means our safety risks are highly diverse, and our systems to prevent those risks can be numerous.

Because the system within which our railway operates is so expansive, it becomes all the more incumbent on each of us to look around the very edges of what we do, and remain vigilant for those soft signals which are pre-cursors for future downstream risk. I have long since held a view that, very often, because it is in our nature to 'get stuff done', warning flags can often be seen to be yellow flags when reviewed in advance, and only become red flags when retrospectively reviewing them in the aftermath of an incident.

That is to say, our culture means we can form different views of future risks to how we view past risks – and this forms the basis for both our largest source of future risk, and also our largest defence mechanism to those same risks. This is precisely the point referred to in our regional Health & Safety strategy when stating that success and failure come from the same source. We need to focus not only on failure, but also on how everyday performance varies. Put simply, this means that it is actually our ability to interpret the risks and translate action from them amidst the many competing features of the industry, which in all other respects require quicker, faster and more urgent service levels and responsiveness from an otherwise already stretched system.

Therefore, I make this message about the importance of reflecting back, assessing what can go wrong and how it goes wrong, doing everything we can to play history forwards and try to think about those same failure modes being cast forward. Whilst we have extensive systems on which our compliance levels and risk calculations are based, this can also rely on a great deal of personal intuition in terms of being clear on what we see as the necessary precursors for drawing red lines around future risks. These such examples almost always have roots in innocuous source areas – for example, a work item which is planned late doesn't equate to it being unsafe. A work item that is planned late and then deals with change doesn't equate to an unsafe site. A work item which is planned late, is impacted by late change and then doesn't have a robust safe system of work isn't necessarily unsafe, but is highly unlikely to be as safe as it could be – and that's where intuition, and personal tolerance to risk, become foreboding for us by means of the action we take. The phrase that often gets coined is the *Swiss cheese* effect and, largely, as a metaphor, I think that works.

It's for these reasons that I am unrelenting about a small number of straightforward principles which I believe are vital deciders for maintaining future safety outcomes. Our approach, therefore, is made up of the things we do in the areas where we give repeat focus:

- Placing leadership as the primary vehicle for both the 'what' and 'how', and what levels of proactivity we deem acceptable of managers.
- The link between a safe organisation and a diverse organisation, with a deliberate move towards space being made for all viewpoints and a culture where viewpoints are upheld and respected, even if they are not agreed with or are unable to be acted upon.

- Never being overly bureaucratic or avoiding plain speaking about how we understand our responsibilities to help make sure we meet our duties.
- Our workplace being a **safe** place – by 'safe' in this context, I mean safe to take the risk to speak as we see, and have our feelings and perspectives heard, without fear of reprisal.

As ever, tell me what you are thinking – let me know what's going on. You can reply directly to me if you wish – I look forward to hearing from you.

Stay safe,

Rob

This update is provided by the Wales and Western Communications team. For any queries, please contact walesandwesterncomms@networkrail.co.uk