Clapham 30 Years on:

Learning from History

Facilitator Guidance

This guidance has been created to assist facilitators to deliver a session to remember and reflect on the Clapham rail disaster which happened 30 years ago, 12 December 1988.

This guide contains images of the slide deck, additional accident information plus speaker notes to help run a session where members of the audience can discuss, share learning and drive improvements.

The full pack of materials will allow you to add events that maybe relevant to task or location to enhance local discussion and debate.

**The objective** of the session will be to revisit Clapham disaster, learn from history and take the opportunity to ask “what you can contribute to keep railway safe.”

**The session:**

* Should last one hour maximum
* allow audience to hear from Andrew Haines, our CEO, possibly for first time
* give everyone the opportunity to contribute no matter what role or experience
* give you chance to add local content.

**The Full Pack includes**

* Facilitation guide (this document)
* Main Presentation deck
* Two Andrew Haines films- main and close.
* Appendix A - Other accidents.
* Appendix B - Fatigue Improvement Programme
* Appendix C -Drugs and Alcohol
* Rail Magazine- Learning from History article
* RAIB reports into Cardiff 2016 and Waterloo 2017.
* IP signalling Clapham Safety Hour.

**Before you Begin**

* 1. Familiarise yourself with the slides and read this guide for recommended facilitation points in Red, and additional information you may wish to have at your side.
  2. Ensure that accompanying two Andrew Haines film clips are downloaded/embedded in the correct places in the presentations. <https://www.wikihow.com/Embed-Video-in-PowerPoint>
  3. Familiarise yourself with “swiss cheese” accident model (slide 11)
  4. Slide 17 choose an example or 2 of other major accidents that are maybe applicable to you and the team- either geographical, task related, or similar root causes that may apply to incidents team may have had experience of- and embed into the main deck. More details of other accidents are available in the Rail Magazine article.

**Running the session**

**Slides MUST be shown in “slideshow” mode (f5, or slideshow toolbar or icon bottom right of screen).**

These sessions work best with your own thoughts and experiences as well as asking audience for theirs

**Please note Clapham,** and other rail accidents will carry different meanings to each person in the business. Some unaware, some around at the time, some personally involved or affected- so please be mindful of your audience**.**

**Network Rail has many services available to anyone who may be affected by stories or memories.**

**Validium ‘time to talk’ service is available to all 24 hours a day 0800 358 4858**

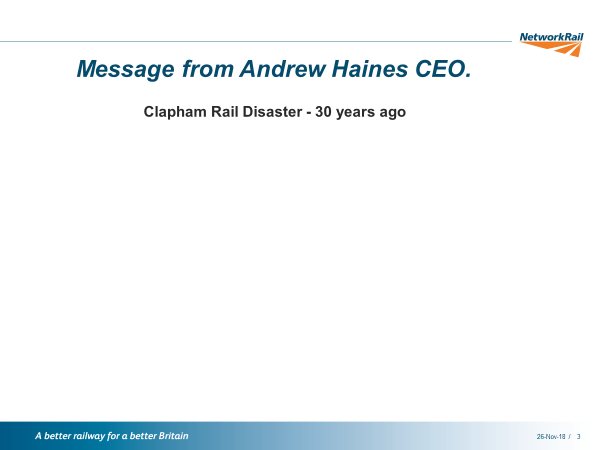
**Slide 2 - welcome & scene setting**



**FACILITATOR INSTRUCTIONS**

* Introduce yourself, and how session will take around 60 minutes, and would like audience thoughts, experiences and points of view.
* Nearly 12 years since last passenger fatality- and with 30 years since landmark Clapham accident, we would like to take this chance to reflect, remember other relevant accidents, take the opportunity to talk about the improvements and how it can only take a moment of taking eye of the ball and history could repeat itself.
* Useful at this stage to ask audience if anybody/family members involved, and to make sure they are ok hearing.
* **Final point is key- ask audience question… and to consider answer for the end of the session when we will revisit.**

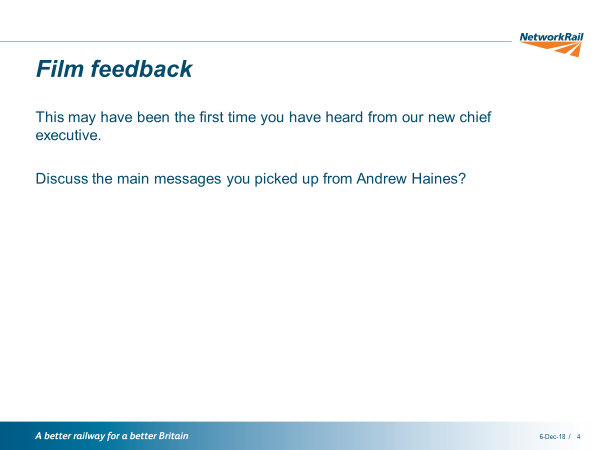
**Slide 3 – Andrew Haines**



* Insert Andrew Haines filmed opening message will appear here will last approx. 2 mins Instruction on how <https://www.wikihow.com/Embed-Video-in-PowerPoint>-

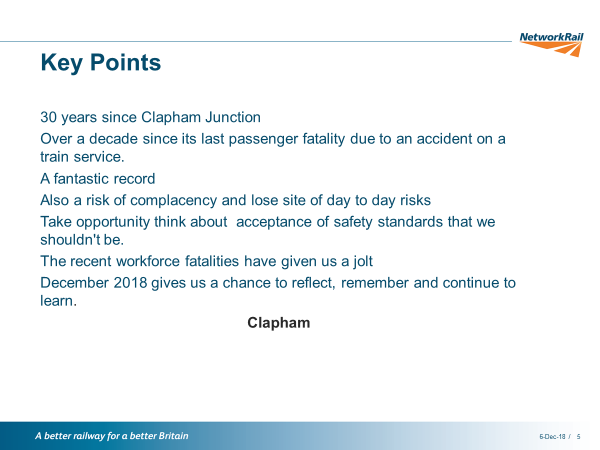
**Slide 4 Film Feedback**

* Maybe the first time audience has heard from Andrew- ask audience how it landed/resonated?

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**Slide 5- Key points**

General points from Andrew, audience should have these points. Then reinforce why everyone is here. Clapham

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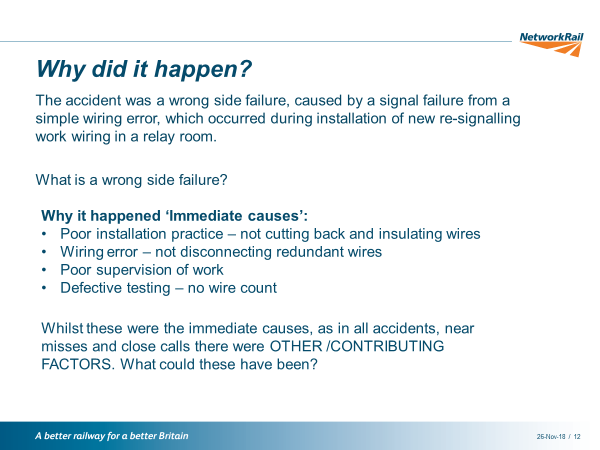
**Slides 6-11 – Clapham Disaster**



**Points to say:**

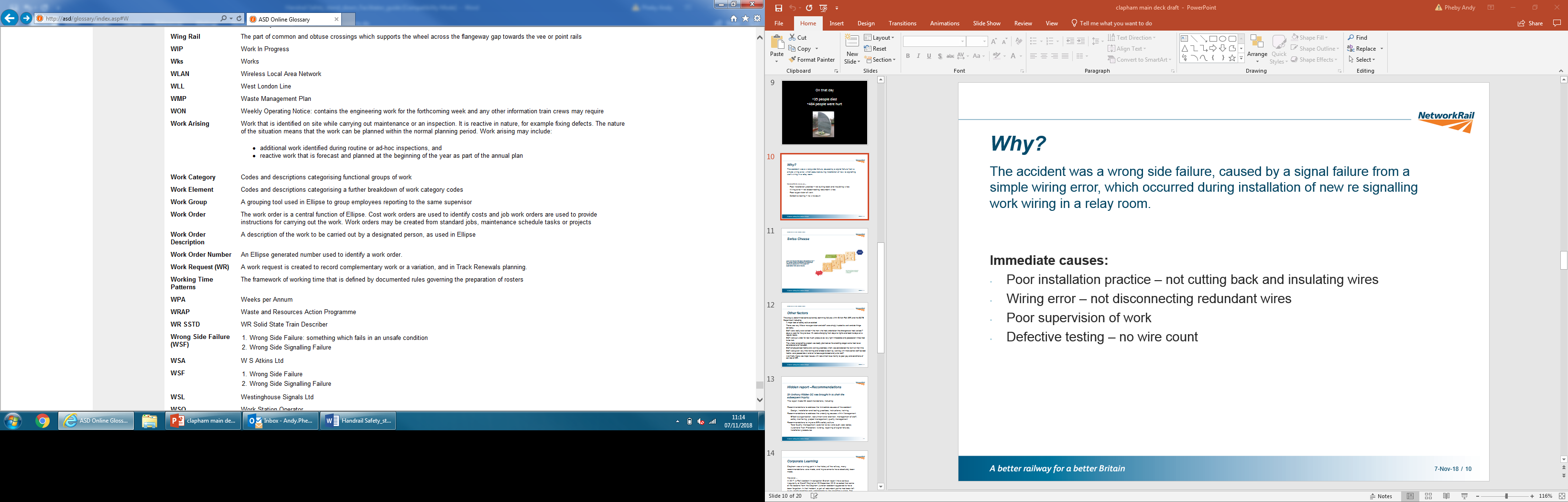
* **THESE SLIDES MUST BE SHOWN IN SLIDESHOW MODE** These slides are woven together and contain the facts
* **AND CLICK THROUGH**
* These slides **should not** need any commentary from you- click through at a suitable pace
* There maybe a few images upsetting to any one personally involved ie may bring back supressed thoughts from the past and not necessarily Clapham.

**Slide 12 – Why did it happen**



This slide will need to be clicked through to get all the above content

* Ask - What is a wrong side failure? We are asking as phrase used a lot in the railway but how many people know what it means.



**Next click**

* the trains were on the same line
* it happened due to a simple wiring error causing signal failure
* **These are the Immediate Causes of the Clapham accident.**

**2nd Click**

**Facilitation-**

**Whilst these were the immediate causes, as in all accidents, near misses and close calls there were OTHER /CONTRIBUTING FACTORS.**

**QUESTION- ask the group to discuss (small groups where possible) what these could have been?**

**Get feedback and facilitate a discussion on key points.**

Slides 13 and 14 can be switched around depending on your style/how comfortable you are

**Slide 13 – Swiss Cheese Model**



Brief overview of Swiss Cheese model- which highlights how it’s possible for a combination of factors to come together and lead to an accident. This model is equally applicable in passenger and workforce accidents.

For reference -This model should be well-known and across the business and has been used frequently. [Think Where Safety Starts](https://safety.networkrail.co.uk/safety/prevention-through-engineering-and-design/) talks about Swiss Cheese in previously produced safety presentations, allows the viewer to look at the railway system and how decisions not only effect those around them but others in the railway system

Ask the audience if they have seen this before? and to explain

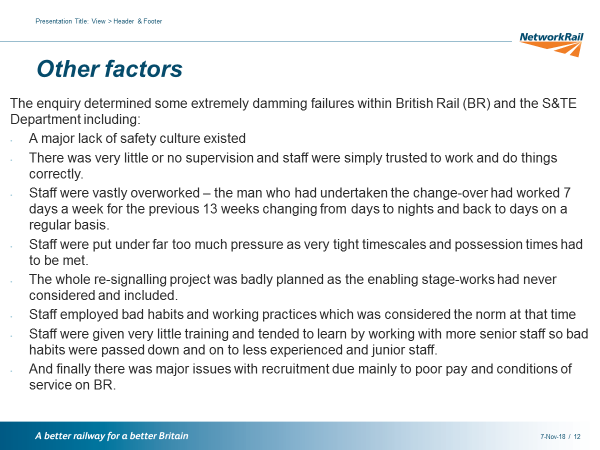
But put simply-

* in any work/task there are many elements involved (layers of cheese)
* where there are gaps in process/planning/ culture/procedures etc in an element (illustrated by a hole in the cheese)
* an accident/incident will take place if all holes align.
* A barrier can be formed at any stage by a process/planning/challenge/procedure correctly followed- this barrier will stop the accident from happening.

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**Slide 14 – Clapham Other Factors**

**This version of slide gives greater detail of the other factors identified and is slightly different to version shown on main deck- you can use this slide detail for more context.**



These are the holes in cheese that could have prevented the accident.

Facilitation

Compare these factors to those identified.

Which of these are still recognisable 30 years on?

What do we do individually/what as an industry we have in place now to mitigate against these recognisable factors?

Give group time to discuss and feedback- (keep slide in view for reference)

**Slide 15 (16)– The Hidden Report**

**The slide in this guidance gives more detail than the one on slideshow- it is hidden and you can show if you wish**



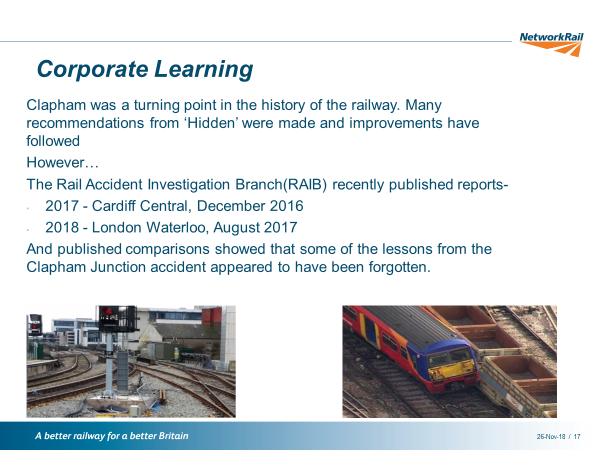
This slide gives the audience the outcomes from the formal investigation into the accident produced by Sir Anthony Hidden

‘Hidden’ is known across the industry and usually associated with Fatigue- which addresses the tighter control or working hours.

However, 93 recommendations in total were made.

Did your feedback recognise any of these recommendations?

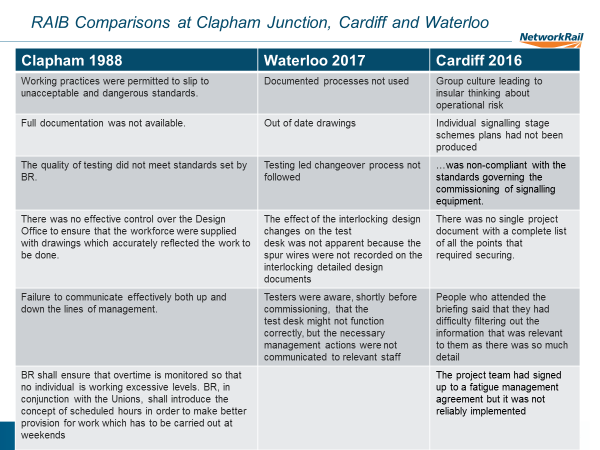
**Slide 17 – Corporate Learning**



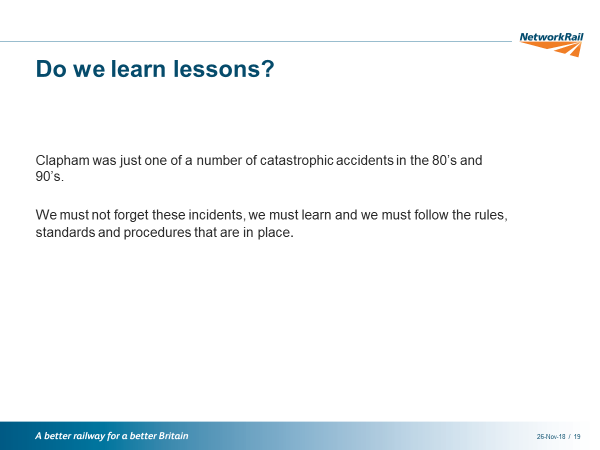
2 RAIB reports in last 12 months have cited similarities to Clapham-

Slide 18 gives a table of a summary of similarities taken from Waterloo RAIB Report -taken form page 51 of the full report- found on link and is also part of the pack of supporting documents

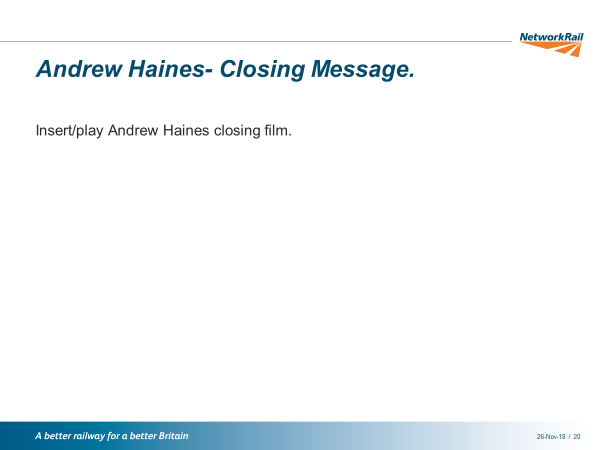
<https://assets.publishing.service.gov.uk/media/5bf28782e5274a2aeeae93bb/R192018_181119_Waterloo.pdf>



Slide 19

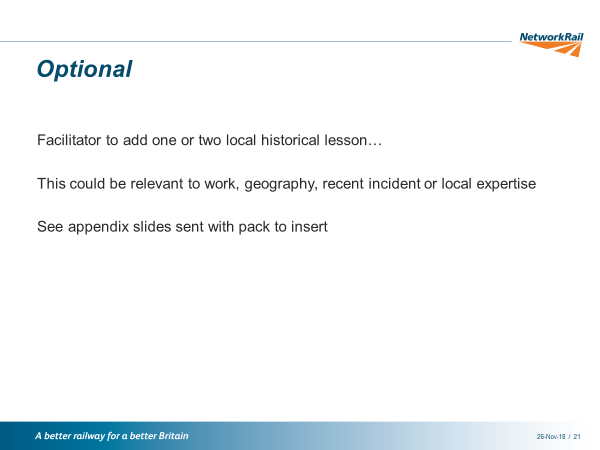


Slide 20



Insert Andrew Haines closing remark lasts 1 min. <https://www.wikihow.com/Embed-Video-in-PowerPoint>

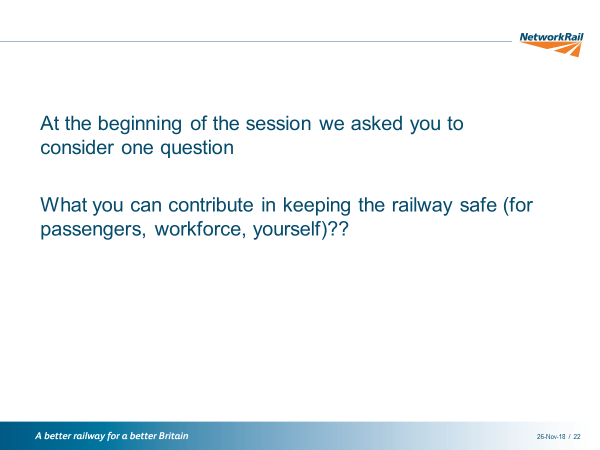
Slide 21



We strongly recommend using 1 or 2 stories from the Appendices to add a local, or to find out more about improvements in Fatigue a key Hidden recommendation.

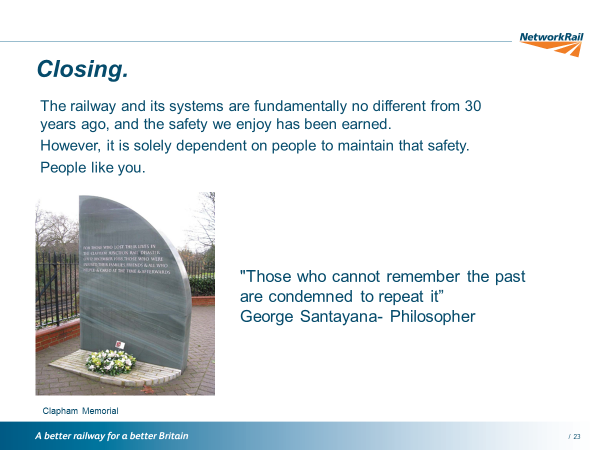
Facilitation

Slide 22- questions asked at beginning



Facilitate responses

Final Slide



This is the final slide

We have processes, we have standards, we have rules- but it’s up to the human to apply them.

We have an enviable safety record, but only takes a moment for that to change.

30 years ago it went wrong. It mustn’t happen again.

Thank you