

REMEMBERING THE LESSONS OF THE HIDDEN REPORT

Introduction

“At 8:10 a.m. on the morning of Monday, 12 December 1988, a crowded commuter train ran head-on into the rear of another which was stationary in a cutting just south of Clapham Junction station. After that impact the first train veered to its right and struck a third oncoming train. As a result of the accident 35 people died and nearly 500 were injured, 69 of them seriously.”

This is how the official “Investigation into the Clapham Junction Railway Accident”¹ report summarised the accident.

Led by Antony Hidden QC, the report attributed the immediate cause of the accident as that of an incorrectly wired circuit that had not been checked and was able to give a misleading aspect to a signal which should have been at danger.

However, Hidden also looked more deeply into the causes for that error, and produced a report that found failings in BR’s safety culture, including in the contribution which employee numbers, pay, terms and conditions made to delivering a safe railway.

In this Bulletin we will be looking at some of the Inquiry’s findings and ask the question about how today’s Government and railway industry may have lost sight of these issues in its pursuit of cost cutting measures.

BR’s Safety Culture in 1988

At the time of the Clapham disaster, British Rail was publicly committed to what it called “absolute safety” and “zero accidents.”

Hidden, however, criticised the approach, saying this was “not enough” and that “[t]here must be proper organisation and management to ensure that actions live up to words”. His firm view was that: “Management systems must ensure that there is in being a regime which will preserve the first place of safety in the running of the railway.”²

For Hidden, one of the central issues was what he called “The funding of safety through the workforce” and which, at Paragraph 14.41 he said required:

“The acquisition and retention of a high quality workforce which is imbued with a respect for proper working practices, trained to carry them out on all

¹ Available to download from: <https://www.jesip.org.uk/uploads/media/incident>

[reports_and_inquiries/Clapham%20Rail%20Crash.pdf](#)

² Paragraph 13.2, Hidden Inquiry Report

occasions, and motivated by a desire to do the best job possible to attain the objective of "zero accidents" has clear funding implications. Basic wage rates, overtime payments, and training costs are obvious examples."

Implicit in his deliberations was that of having sufficient staff to be able to safely carry out the required work.³

However, he also recognised that this call came at a time when the Conservative Government of the day was directing British Rail "to develop proposals both to improve the service, to the customer and to reduce operating costs through improved efficiency." This involved specific objectives that required "a significant grant reduction" in the funding for the organisation (Network SouthEast) sponsoring the work that was being carried out and which led to the accident.⁴

This is a point we will come back to again later when we consider the parallels with today's railway.

Hidden Recommendations

The Clapham Junction Investigation made a series of wide ranging recommendations that not only changed the way BR's S&T department operated but also affected issues more broadly across the railway, the most well known one being that of restricting working hours because of issues of fatigue.

One recommendation that this Reps Bulletin wishes to highlight is Number 20⁵ under the title of Recruitment and Retention which said:

"BR shall monitor and forecast wastage and recruitment of skilled S&T staff and take urgent steps to ensure that sufficient numbers of skilled staff are retained and recruited to match work requirements safely."

The recommendation is written about BR's S&T department but the principle of sufficient staff to match safe work requirements is applicable for all those engaged with safety critical work.

The question we would pose is whether this lesson is still uppermost in the minds of those who are seeking to cut large numbers of staff out of today's railway industry to fulfil cuts to Treasury funding?

British Rail Privatisation

Since Clapham, Britain's railways have been through privatisation which taught many lessons – lessons that the trade unions and others had warned about.

Not the least of those learnings was that the profit priority, introduced in private sector firms like Railtrack and its contractors, could easily undermine any safety culture. In Railtrack's case, standards of track maintenance were allowed to slip in order to make cost savings to enhance profits. As a consequence, accidents like Hatfield (17th October 2000, killed four people and injured 70 others) and Potters Bar (10th May 2002, killed seven people and injured 76) occurred.

One of the consequences of the Hatfield derailment – following on from previous catastrophic accidents at Southall (19th September 1997, 7 deaths, 139 injured) and Ladbroke

³ Paragraph 14.46 of Hidden Report

⁴ Paragraph 14.8 of Hidden Report

⁵ Page 169 of Hidden Report

Grove (5th October 1999, 31 killed and 417 injured) - was that Railtrack was put into railway administration and then replaced by the publicly owned Network Rail in 2002.

Following the Potters Bar accident, Network Rail decided in 2004 to take inhouse the privatised track and signal maintenance work.

Cullen Inquiry

Prior to Railtrack's demise, a two part inquiry under Lord Cullen was set up to look into the Ladbroke Grove collision as well as the management and regulation of UK railway safety. From Cullen's recommendations, the Railway Safety and Standards Board (RSSB) was created in 2003 followed, in 2005, by the Rail Accident Investigation Branch (RAIB).

Separately, in April 2006 the Railway Inspectorate (HMRI), now known as the Safety Directorate, became part of what is the Office of Rail and Road.

Much work has been done within Britain's railways to ensure new procedures and practices have been developed, implemented and refined, often adopting a risk assessment process, and in order to make sure health and safety stays as a priority. The result is that between 2015 and 2019, the UK's railways were assessed as having a passenger and workforce fatality rate well below the European average.⁶

In its latest Annual Health and Safety Report (AHSR),⁷ the RSSB:

- point to travel by train being the safest form of transport when compared to other modes (bus, coach, cycle, pedestrian, motorcycle);
- illustrates that between 2007 (Grayrigg derailment, 23rd February, 1 death and 88 injured) and 2020 (Carmont derailment, 12th August 2020, 3 killed and 6 injured) no passengers or staff died in a train crash
- stressed the fact that whilst Britain's railway has a proud safety record, Carmont teaches that there is no room for complacency, especially as the industry faces a period of change.

Much more could be said about safety on Britain's railways, particularly in relation to:

- near misses (eg, Wootton Bassett (7th March 2015) that had the potential to have been a multi fatality incident);
- workforce fatalities, injuries and near misses, especially among track workers. 12 railway employees have died at work since 2016/7, including six people employed as track workers. In 2020-21 alone, five railway staff lost their lives, including the driver and conductor on the derailed train involved in the Carmont accident.

⁶ Figure 17, Page 26, RSSB Annual Health and Safety Report 2020/21: Railway Safety in Context available at: <https://www.rssb.co.uk/en/safety-and-health/risk-and-safety-intelligence/safety-performance-reports>

⁷ 2020-2021 AHSR, available to download from: <https://www.rssb.co.uk/safety-and-health/risk-and-safety-intelligence/safety-performance-reports>

- Comments in several RAIB railway accident reports⁸ about how “Some of the lessons from the 1988 Clapham Junction accident are fading from the railway industry’s collective memory.” This was said in connection with issues similar to the immediate causes of the Clapham disaster but remains a point that must be borne in mind about other issues identified by Hidden.

Change to the railway industry

The Covid-19 Pandemic affected all areas of UK life including the railways in Britain which saw the number of passengers steeply decline, with the consequent impact on revenue.

One of the UK Government’s measures was to provide additional financial support to the TOCs and Network Rail to the tune of £800m a month. In January 2021, however, the Department for Transport announced a recovery plan and set up the Rail Industry Recovery Group (RIRG) as a way to identify changes that would significantly reduce the levels of support.

The announcement of the RIRG’s plans in June 2021 came just weeks after the publication of the long awaited and renamed “Williams Shapps Plan for Rail.”⁹

⁸ Cardiff East Junction, Report 15/2017, October 2017 and Collision at Waterloo, Report 19/2018, November 2018

⁹ Available at: <https://www.gov.uk/government/publications/gre-at-british-railways-williams-shapps-plan-for-rail>

It is hard to credit that the huge level of change that is coming from the estimated £2bn of cuts imposed by HM Treasury on Network Rail and the passenger train operators (via the recovery plan) are separate from the establishment of Great British Rail (GBR).

For instance, we know that:

- £650m of the £2bn of cuts are aimed at reducing the number of staff in the industry;
- The Williams Shapps Plan for Rail continues to require that Network Rail meets its CP6¹⁰ efficiencies of £3.5bn over the five year period;
- Network Rail has also decided to achieve an extra £0.5bn of ‘efficiencies’ during CP6;¹¹
- GBR will also be required to realise an additional £1.5bn of efficiencies¹² a year after five years and on top of existing efficiency plans.

As a result of these so called efficiencies, we are aware (so far) that:

- In Network Rail alone, 1019 management staff and approximately 500 Bands 5-8 (or equivalent) employees have left the company under the terms of the Special Voluntary Severance Scheme;
- As the sole recognised trade union for Bands 1-4

¹⁰ Control Period 6, 1st April 2019 to 31st March 2024

¹¹ See: <https://www.networkrail.co.uk/wp-content/uploads/2021/05/Our-CP6-Targets-and-Financials-May-2021-update.pdf>

¹² Page 36, Williams Shapps Plan for Rail

management staff in Network Rail, TSSA is involved in consultations that are aimed at cutting a further 905 management grade jobs;

- Proposals are also on the table that could see as many as 2,600 jobs lost in Network Rail's Maintenance function.

Will there be an impact on safety?

It is clear from the Hidden Report that having insufficient staff to carry out safety critical work has a potentially fatal effect on rail safety – for most of us, it is a self evident factor.

Of course, no one wants there to be any chance of rail safety being compromised but the impact of so many job losses caused by a determination to cut costs, come what may, calls into question whether sufficient thought has been given to their safety implications.

History teaches us through the Hidden Report what can be the effect of not having enough staff to carry out work safely and it is for this reason that TSSA wrote to the Office of Rail and Road in February 2022 expressing our misgivings and asking for their opinion.

TSSA's message is clear: We will not compromise on health and safety.

Network Rail – like any other railway company that comes under the requirements of the ROGS¹³ legislation – has to consider whether the changes are sufficient to impact on its Safety Management System (SMS), as well as their Safety Authorisation which they may have to renew. The process they adopt is to look at the level of

change which may lead to the application of the CSM RA¹⁴ legal requirements and an assessment of the risk of changes.

Reps Action

TSSA reps should be involved in consultation on job changes and one area that most look at is the safety implications of what is proposed. Such issues may not be immediately apparent and for this reason we are stressing the need to ask members affected to identify potential hazards caused by proposed changes to jobs, procedures and working practices.

This can help reps put forward counter proposals as well as in hazard identification which forms a significant part of the CSM RA process. Reps should be involved in that process.

For guidance on CSM RA, please see TSSA Reps Bulletin H&S129, November 2019, "Safely Managing Change and the Common Safety Method Risk Assessment."

Our key message to reps is: be vigilant and make sure your voice is heard.

Acknowledgments

This Bulletin has been produced from the material available in the footnotes. If you have trouble in obtaining any of those documents, please contact jenksr@tssa.org.uk

¹³ Railways and Other Guided Transport Systems (Safety) Regulations 2006

¹⁴ CSM RA is the Common Safety Method Risk Assessment