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Learning Brief: #021

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Irregularity (near miss) at Balham - Safety Critical Communication

This learning brief is shared in order to promote learning and improve safety. You should seek appropriate guidance regarding the relevance, accuracy, and completeness of this alert to your circumstances prior to implementation.

Theme

Culture
Human Factors and Procedures
Management Systems

Summary of Learning

At around 19:05 on the 20th April 2019, a tamper made an un-signalled and unauthorised move of about 600 metres, passing over Balham Junction, and entering Platform 3 at Balham station.

A railway "tamper"

The tamper could have collided with a passenger train, which had travelled over the same junction in the opposite direction around 75 seconds earlier.

Description

The incident occurred at the boundary of an engineering possession. Moving out of the possession area required the tamper, which had been working on one line, to cross over to the other whilst still inside the possession boundaries.

The crossing move did not take place, and the tamper left the possession on the wrong line.

The junction at Balham

Witness evidence (including from voice recordings) show that several of those involved in the incident felt embarrassed to use correct Safety Critical Communication methods, both when conversing with colleagues they knew and those they did not.

- The Person in Charge of Possession's during the day provided inaccurate information about the position of the tamper
    - The tamper driver and conductor driver did not query the instructions provided by the Person in Charge of Possession during the day
    - Two signallers on the line did not query instructions provided by the Person in Charge of Possession during the night
- The failure of two signallers on the line to query instructions, may indicate there were gaps in their fundamental understanding of the instructions.

The standard of safety critical communications throughout was well below that expected, resulting in no party having a clear understanding of the location of the tamper or the actions to be taken.

The Person in Charge of Possession's working environment may have resulted in distraction and the loss of paperwork – they were working from home.

The Rail Accident Investigation Branch (RAIB) identified that over the last 20 years agreed standard Safety Critical Communications had not been embedded as standard practice in the rail industry. This is due to several factors, including competence and training, monitoring and social and cultural issues.

Many staff had not adopted the necessary protocols, and some staff still felt 'socially embarrassed' by using formal methods of communication.

There is also a risk that individuals do not feel empowered to comment and/or challenge instructions given.

Learnings

These “social inhibitors” were also prevalent within the aviation industry prior to the 1990’s.

- Following several accidents and incidents, aviation has adopted a new strategy, and developed its communication protocols.

- This has resulted in a change in competence assessment, supported by a robust monitoring and enforcement regime.

- The aviation industry has worked to establish a culture in which standard protocols in communication are almost invariably used.

- Not using appropriate safety critical communication methods is now seen as an *abnormal* practice.

The offshore industry has suffered from individuals who have not felt empowered to challenge instructions. Several initiatives were introduced:

- Time Out – Anyone on an offshore installation can stop a job they deem it unsafe, and positive encouragement from management to do this.

- Monitoring to see how many jobs were being stopped, to praise those who have done so

- In the event of an incident, a line of questioning, where relevant, to investigate why nobody stopped the job.

- Every job (with more than one person involved) starts with a Toolbox Talk to ensure that everyone understands the work scope. The team walk through the job with a focus on critical interfaces with others. This is particularly important where trades are mixing, and with people who have not worked together.

Businesses should consider the safety critical tasks that they carry out, and where Safety Critical Communications are essential to minimising the risk from these tasks. This should include ensuring terminology is understood and consistently applied across the business(es).

Further reading

RAIB Rail Accident Report - Serious operational irregularity at Balham

Process Safety Leadership Group Final Report – Appendix 5, *Guidance for the management of operations and human factors*

UK Health and Safety Executive (HSE) – Safety Critical Communications