Process Safety Forum

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A failure to follow procedures

At 23:29 on Saturday 22 October 2011, 16 year-old Georgia Varley was struck and killed by the train she had left 30 seconds earlier.

Lessons from this event apply to both management and the workforce. Management should ensure that procedures reflect **all** operating circumstances and are regularly tested for understanding, efficiency and risk control. Employees and contractors should be involved in the development and review of procedures; they should ensure that they follow procedures and, if they identify that procedures are in need of refinement, they should bring this to the attention of management through appropriate channels.

The consequence of the guard's actions resulted in tragedy for the family of the deceased and also had significant life-changing consequences for the guard and his family. This should have particular resonance with employees and contractors working in high hazard industries, some of whom undertake actions each day that have the potential to end in tragedy if not carried out appropriately.

The investigation report concluded "The guard dispatched the train while Georgia was leaning against it. It is possible that he did this because he had seen her but expected her to move away before the train moved. It is also possible that he looked briefly in her direction but did not see her ('looked but failed to see' is a known phenomenon in routine, repetitive tasks). It is also possible that he did not see her because his attention was on his control panel and a large group of people on the platform."

Georgia's post-mortem toxicology report recorded a blood alcohol concentration nearly three times the UK legal drink drive limit and she was wearing high heeled shoes at the time of the accident. By the time the guard warned Georgia to stand back she had been leaning against the train for approximately eleven seconds. It is not known when the guard saw her during this time or, if he saw her, whether he delayed taking action in the expectation that she would move away. Platform video camera footage shows him warning her to stand back in the moments before the train departs and it is likely he did this because he thought that it would be immediately effective and because he had no direct and immediate way to stop the train.

Most accidents are the result of a number of factors coming together and are the cause of systemic failures rather than an individual one. The RAIB investigation discusses a number of these factors, but this was not published until after the verdict. The court ruled that the guard was guilty of manslaughter by gross negligence, sentencing him to five years in prison. It was clear that he knew the rules but chose not to follow them.

A copy of the Rail Accident Investigation Branch's Rail Accident Report can be found at:
http://www.raib.gov.uk/cms_resources.cfm?file=/121127_R222012_James_Street.pdf