The perfect storm
How to get it so wrong for nine years

Global level crossing symposium 2014
University of Illinois, Urbana

Aidan Nelson
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This presentation

- Explores the consequences of two pedestrian fatalities occurring in December 2014
- Considers the triggers for outrage and why mistakes were made
- Shows why the bereaved should never be underestimated
- Looks at hidden evidence and considers why the truth could be concealed
- Identifies lessons eventually learned
- Reminds others that they might have a virtual rather than a real cathartic experience
- Is necessarily a personal perspective
News on December 3rd, 2005

- New European Union states cool on budget plan
- Cricket: Brilliant Pakistan crush England
- Thousands honour George Best
- CIA flights landed in Germany
- Ukraine takes bird flu measures
- Bush voices support for death penalty
- UN to consider Burma issues
- Roadside bomb kills 19 Iraqi soldiers
- Pakistan claims Al Qaeda Abu Hamza killed
  - Two teenagers die in level crossing accident
So what happened?

- Olivia Bazlinton & Charlotte Thompson were killed when hit by a train on the Elsenham station user worked pedestrian level crossing protected by lights indicating when safe to cross and audible warning.
- They had purchased their tickets & were re-crossing the railway to board their train to Cambridge.
- They waited for their train to clear the level crossing and ran across into the path of a second non-stopping train.
- They were both killed instantly.
- Network Rail quickly claimed that the level crossing was safe if used properly and that, by extension, they had misused it.
- Extensive media coverage challenged Network Rail’s position.
Why defend the indefensible?

- A corporate culture within Network Rail founded on a belief that people died on level crossings only if they misused them
  - Those who challenged this seen as safety zealots
- HQ media handling philosophy that sought to perpetuate this belief
- In-house and retained lawyer’s arguing that it is cheaper to pay limited compensation without any admission of liability than to fix problems
- Inadequate risk assessment, specifically & more generally
- Anyway, level crossing accidents are really road accidents & no one really cares
- A corporate reluctance to endorse and invest in a holistic strategy to reduce risk arising at level crossings
  - Better in some regions than in others
The first few months

- Extensive media coverage showed that the crossing was unsafe and that Network Rail’s position was untenable
- Network Rail didn’t engage with the bereaved and local community
  - No meaningful contact with families
  - Continued rejection of the need for “expensive” engineered solutions
- First tranche of investigations in camera
  - Rail industry (led by RSSB), Regulator and newly formed independent Rail Accident Investigation branch (RAIB)
- No real recognition that Olivia’s parents were tenacious,
  - A mother who understood risk
  - A father who was a journalist with national level connections
- Let’s wait for the investigation reports
The RSSB investigation report

- The first to be published
  - Face-to-face pre-publication briefing of Olivia’s family
  - Briefing declined by the Thompson family
- Identified flawed risk assessment from April 2005
- A failure to respond to near-miss incident reports recorded in occurrence book by crossing keepers at the adjacent manually-worked public highway level crossing
- Reported that post accident assessment highlighted priority for action
  - Led to Network Rail committing to provide a footbridge
- 1989 fatality led regulator to require British Rail to install a differentiated second train coming warning
- For reasons unknown, this was not done and regulator at the time never pursued the issue
Other investigations

- **The regulator’s first investigation**
  - Did not lead to any enforcement action

- **RAIB**
  - Looked at the wider issue of station pedestrian and pedestrian gates at highway level crossings
  - Led to 10 recommendations to address findings that significant work was needed to reduce risk SFAIRP

- **Coronial Inquest**
  - Took place in early 2007
  - Packed full of lawyers representing all parties other than the bereaved
  - It exposed muddled thinking & managerial failure within Network Rail
  - Jury returned accidental death verdicts
  - The bereaved spoke-out and called for criminal proceedings against Network Rail
  - Triggered further negative media coverage for Network Rail
Civil litigation

- The vehicle available to the bereaved to expose Network Rail’s negligence
- Liability contested by Network Rail
- Expert witness reports commissioned and prepared
- Network Rail prepares documents for disclosure
- But, in November 2010 Network Rail doesn’t submit evidence to defend itself
- However, nothing addressed within a trial as Network Rail settled out-of-court before the trial could begin
- Negotiated settlement understood to be for a token amount plus funeral expenses
- The end of the road in the eyes of Network Rail
- But, in reality, just the start of a new chapter as the bereaved continue their quest for the truth

A bridge between business and the local community
David Higgins, Network Rail’s third Chief Executive since Elsenham takes over on February 1\textsuperscript{st}, 2011

In parallel, a whistle-blower within Network Rail leads to the bereaved being alerted to the existence of previously unseen documents

- Extensive media coverage ensues
- One, Part A of a May 2002 risk assessment, is found
- It had not been disclosed to any investigation hitherto
- Network Rail denied non-disclosure in context of civil litigation
- But, on appointment David Higgins says that Part B had not been disclosed
- Part B contained a proposed mitigation that would have prevented the Elsenham fatalities
- ORR decides to reopen their investigation in light of new evidence
- Network Rail’s PR machine makes matters worse by issuing a press statement that says: \textit{The families have endured many years of private grief. Network Rail urges the media to maintain its consideration in this respect.}
- David Higgins meets the bereaved families on March 4\textsuperscript{th}, 2011 and promises full disclosure
A second document emerges

In March 2011, a further non-disclosed document emerges

- The May 4th, 2001 memorandum from a Level Crossing Standards Manager correctly identifies the issues at Elsenham
- Recommends changes, including provision of a footbridge, eventually provided in 2007
- No action taken by the recipient manager within Railtrack, later Network Rail
- Intensifies hostility towards Network Rail from the bereaved and within the media
- Leads to RSSB admitting that the independently led rail industry inquiry had access to Part B of the 2002 risk assessment

Meanwhile, David Higgins:

- Asks Tina Hughes to act as a users champion for level crossing safety
- Added a national level crossing programme team
- Initiated large-scale closure of level crossings
At last, Network Rail in court

- Prosecution of Network Rail announced by the regulator
- Network Rail pleads guilty to:
  - Failing to carry out a suitable and sufficient risk assessment at the crossing
  - Failing to take steps to mitigate safety issues identified in a risk assessment
  - Failing to protect the safety of people using the railway
- Network Rail sentenced, March 15th, 2012
  - Judge sums up: *There was a narrative of culpable corporate blindness & complacency going beyond the merely inefficient or even occasional incompetence, that even entered the realms of criminal failure*
  - Fine is GBP1,000,000
  - The fine expresses a societal displeasure and is in the end paid for by UK taxpayers as Network Rail is a publicly funded body
  - Despite the changes initiated by David Higgins, further significant harm to the company’s reputation is generated
Network Rail’s moves on

- David Higgins initiated changes:
  - Provide additional funding for level crossing closures, 804 achieved by March 2014, with another 500 planned for following five years
  - Grade separation of pedestrian crossings increasingly the norm
  - New engineered solutions progressed
  - Best practice mobile photo-enforcement capability for British Transport Police
  - Improved risk assessment practices
  - 100 Level Crossing Manager posts created and filled, each responsible for about 60 crossings
  - Enhanced awareness programme
  - Recognition that having the safest level crossings, more can and must be done

- But, PR stance continues to be: *level crossings are safe when used properly*

- More negatives for Network Rail lie ahead
The parliamentary inquiry

- Transport Select Committee announces that it is to consider level crossing safety
- Evidence gathered over the summer of 2013
  - Includes evidence from Elsenham and other bereaved
- Oral hearings in October & November 2013
  - Network Rail makes a general apology for the way it has treated those bereaved through level crossing accidents
  - Network Rail accepts that it has systematically stigmatised the victims of level crossing accidents through the language used when speaking publicly: *misuse, trespass=*misuse, *safe when used properly* etc.
- Transport Select Committee report published in March 2014
  - Hard hitting, 25 recommendations & leads to further apologies from Network Rail’s incoming CEO, Mark Carne
Mark Carne said:

I wish to extend a full and unreserved apology on behalf of Network Rail to all those whose lives have been touched by a failing, however large or small, made by this company in managing public safety at level crossings and in failing to deal sensitively with the families affected.

Most recently (June 2014) Olivia’s mother, Tina Hughes, is awarded a MBE in the Queen’s birthday honours for services to level crossing safety.
Contact

Email: aidannelson@comsafetypartners.com
Telephone: +44 1904 448439
Mobile: +001 508 292 0486 (to 08/18)

is back again: www.lxinfo.org