MAYOR OF LONDON

TRANSPORT FOR LONDON
EVERY JOURNEY MATTERS

Agenda

Meeting: Audit and Assurance Committee

Date: Tuesday 3 December 2019

Time: 2.00pm

Place: Conference Rooms 1&2, Palestra, 197 Blackfriars Road, London, SE1 8NJ

In accordance with section 100(B)(4) of the Local Government Act 1972, the Chair has agreed to accept the following as an item of urgent business on the grounds that the information was not available at the time of publication.

Copies of the papers and any attachments are available on tfl.gov.uk How We Are Governed.

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Further Information

If you have questions, would like further information about the meeting or require special facilities please contact: Sue Riley, Secretariat Officer; telephone: 020 7983 4392; email: SueRiley@tfl.gov.uk

For media enquiries please contact the TfL Press Office; telephone: 0845 604 4141; email: PressOffice@tfl.gov.uk

Howard Carter, General Counsel
Monday 25 November 2019

Supplementary Agenda
Audit and Assurance Committee
Tuesday 3 December 2019

9 Audit of Tram Operations Limited Fatigue Management (Pages 1 - 4)

Director of Risk and Assurance

The Committee is asked to note the paper.

Audit and Assurance Committee

Date: **3 December 2019**

Item: **Audit of Tram Operations Limited Fatigue Management**

This paper will be considered in public

1 Summary

1.1 The purpose of this paper is to inform the Committee about the audit process for audit 17 780: Management of Fatigue in Tram Operations Limited (TOL), which was commissioned in May 2017. This paper also details the provision of an incomplete copy of audit 13 744; Competence and Fitness of TOL Tram Operators, in response to Mayor's Question 18/1314. This report was commissioned in June 2014 and pre-dated the Sandilands tragedy by two years and four months. Questions have been raised concerning these two separate audits by the London Assembly.

2 Recommendation

2.1 **The Committee is asked to note the paper**

3 Background

3.1 Internal Audit 17 780 on management of fatigue in TOL was initiated in May 2017 in response to a request from Surface Transport Management. The audit was carried out at a time when several external investigations, including the BTP, ORR and RAIB, were taking place into the tragic Sandilands tram crash in November 2016. However, the audit was not itself directly related to Sandilands.

3.2 TfL undertook to provide a copy of the audit report to the RAIB once the audit was complete, but due to an oversight this did not happen even though the Safety, Sustainability and Human Resources Panel had been informed that the report had been provided to RAIB. Once this oversight was identified the report was provided to RAIB on 12 February 2019. RAIB subsequently updated its report and made reference to the audit report stating that '*the TfL audit report identified no evidence of additional factors, beyond those already discussed*' and '*the conclusions of the TfL audit are consistent with its own findings that, at the time of the accident, TOL's management of fatigue risk was not in line with published industry practice, and that there was significant scope for improvement.*'

3.3 As part of its investigation into Sandilands the London Assembly has raised questions about the reasons why the Audit Report was not initially provided to ORR and RAIB, and broader questions about the audit process that was followed, particularly as regards review of the draft audit report prior to it being issued.

3.4 This paper provides further information about the audit process followed by TfL Internal Audit, with particular reference to the audit report review process.

4 Audit Process

Overview of process

4.1 The scope, objective and timeframes for an audit are agreed in advance, in writing, with key stakeholders, including the primary person that will receive assurance from the audit.

4.2 After completion of the fieldwork an audit report is drafted, and a closing meeting is held with the managers responsible for the area under review. The purpose of this meeting is to agree the findings, the management response and action owners, and gives an opportunity to provide additional evidence where the accountable manager believes the findings to be incorrect. Other staff/ managers involved in the audit are also provided with the opportunity to comment on the factual accuracy of the audit report. However, any revisions to the report are at the discretion of the audit team. Senior Officers are not involved in drafting, reviewing or revising the report. If circumstances were to arise in which the audit team believed they were coming under undue pressure to change a report this would be escalated through the Director of Risk and Assurance.

4.3 Final reports are circulated to those involved in the audit, accountable managers, risk owners, and senior managers including the Director accountable for the business area or activity being audited. This may include Chief Officers should the subject area or findings of the report warrant it.

4.4 The process followed is in line with standard practice for Internal Audit functions as defined by the Chartered Institute of Internal Auditors (IIA). In accordance with IIA requirements TfL Internal Audit has been subject to external quality assessment review every four to five years – most recently in March 2017 (reported to the July 2017 Audit and Assurance Committee meeting) – and there have been no adverse comments regarding its approach to reporting.

Audit IA 17 780: Management of Fatigue in Tram Operations Limited (TOL)

4.5 In the specific case of audit IA17 780, this originated as a request from Surface Transport senior management, who highlighted some specific areas for consideration, which the internal audit team included within the scope and objective for the audit.

4.6 Following completion of the audit fieldwork, the draft report for IA 17 780 was distributed within Internal Audit for review prior to issue outside of the department as is usual.

4.7 This was an audit of TOL's processes, and the draft report was issued to TOL management for their review and comment. The draft report was shared with the TfL Director of Trams and the Senior TfL HSE manager for their awareness immediately prior to issuing it to TOL. However, they were not requested to

comment on the report and they did not do so.

4.8 A closing meeting was held with TOL and TfL management to discuss the draft report and TOL subsequently provided comments on the report in writing. In response to concerns raised by TOL the audit team decided to remove the audit conclusion of 'requires improvement' from the report. This was, in part, because a system of classifying audit reports that is internal to TfL was not directly relevant to an external organisation. In addition, TOL had noted that the required improvement conclusion was by reference to ORR good practice guidance rather than the contractual requirements against which TOL operated. Some other changes, revisions and reordering were made to the wording of the draft report for accuracy and to reflect additional information provided by TOL, but the evidence and recommendations were not changed. They were clearly set out in the final audit report.

4.9 No Surface Transport Directors or the Managing Director of Surface Transport were included in the review process for this report. They were, at no stage, asked to comment on the report and they did not do so. The Director of London Rail and the MD Surface Transport were included on the distribution list for the final report when it was issued but did not have prior sight of it.

5 Response to MQ 2018/1314 regarding the 2014 Audit 13 744

5.1 A question to the Mayor dated 21 June 2018 requested a copy of audit 13 744 Competence and Fitness of TOL Tram Operators. This report was commissioned in June 2014 and pre-dated the Sandilands tragedy by two years and four months. A copy was provided in response and was published on the GLA website 26th June 2018. It was identified in September 2019 by a GLA member that the copy of 13 744 published in response was incomplete, consisting of 8 not 12 pages. A full copy was provided on 15 October together with an apology, an explanation for what had happened and a description of the contents of the four missing pages (one page of audit report, three pages covering audit scope, meeting dates and distribution list).

5.2 The mistake arose when the audit report was converted from a word document to a pdf file for storage by the Internal Audit Team. The version saved was incomplete and this version was used to answer the MQ. It would not have been immediately apparent that there were further pages to the report because page eight ends cleanly at the end of a sentence and paragraph. However, the contents page at the front clearly indicates it is a 12 page document and audit reports don't end abruptly in that way.

5.3 There has been a suggestion that this is evidence of a pattern of dishonesty at TfL regarding this tragic accident and in relation to safety more generally but this is not the case. The full 12 page report was circulated within TfL and to TOL in 2014 and TfL provided the full report to the RAIB investigation in November 2016. There can be no suggestion that TfL did not provide the RAIB with the full report in a timely way. The partial conversion of the document was an accident and no one meant that to happen or was aware that the error had occurred until it was pointed out by the Assembly Member.

6 Lessons learned

6.1 The audit team have reviewed the background to this audit and the process followed and have identified some lessons learned to take forward. These are summarised below.

Timing of the audit

6.2 The audit was carried out at a time when investigations into Sandilands were in progress by TfL, RAIB, BTP and ORR. This allowed a perception to arise that the audit was part of the Sandilands investigation and that its findings were intrinsic to informing the RAIB's investigation, whereas in fact the audit was unconnected to the Sandilands investigations. In future we will consider whether audits may have relevance to other issues in addition to those specifically addressed in the report.

Audit conclusion

6.3 The first draft of the audit report shared with TOL included a 'requires improvement' conclusion. In the course of the review process, as described more fully in paragraph 4.8 above, the audit team decided to remove the conclusion from the report. Although the issues and recommendations in the report remained the same, the removal of the conclusion has led to suggestions that the report had been watered down.

6.4 It would have been preferable to have given more consideration at the outset of the audit to the appropriateness of using an internal TfL audit conclusion. Going forward we will not use TfL audit conclusions on audits of external third parties.

Liaison with regulatory bodies

6.5 Since the incident TfL has transformed the existing HSE team into a new organisation under a new TfL Chief Safety, Health & Environment Officer post. The new structure contains a position with specific accountability to provide information to regulators.

List of appendices to this report:

None

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