

TRANSPORT FOR LONDON

SAFETY, HEALTH AND ENVIRONMENT ASSURANCE COMMITTEE

SUBJECT: LONDON UNDERGROUND RAIL GRINDER INCIDENT

DATE: 1 DECEMBER 2010

1 INTRODUCTION

- 1.1 This paper provides the Committee, and the Rail and Underground Panel whose Members will attend the Committee meeting for this agenda item, with an update on the Formal Investigation Report (FIR) for the runaway Rail Grinding Unit (RGU) incident on the Northern line which occurred on 13 August 2010.
- 1.2 The Committee is asked to note the paper.

2 STATUS OF THE INVESTIGATION

- 2.1 The FIR was reviewed by the London Underground Executive Committee (LUEC) on 16 November 2010. The LUEC considered the report, which makes 12 recommendations addressing the root causes of this incident, to be comprehensive and thorough. Implementation of these recommendations will be monitored by the LUEC and will be summarised in LU's Quarterly Health, Safety and Environment (HSE) Performance Report to the Committee.
- 2.2 The Rail Accident Investigation Branch (RAIB) investigation into this incident continues. It is not known when this investigation will be completed, as the RAIB does not give target dates for its investigations, but when it is completed LU will review it and act on its recommendations as appropriate. Normally, LU FIRs and RAIB investigation reports have very similar findings and recommendations, but any that are significantly different will be reported to the Committee.
- 2.3 The Office of Rail Regulation (ORR) continues to conduct its own investigation into this incident. Again, and for similar reasons, no timescale for this investigation is available and there is a possibility that ORR may, in due course, decide to take further action against LU on this matter.

3 WIDER CONSIDERATIONS

- 3.1 As reported to the TfL Board at its meeting on 22 September 2010, LU has work in progress to consider the wider underlying lessons from this and other recent significant incidents. This work is being incorporated as an enhancement to the existing HSE Improvement Programme and focuses on the following three topics:
 - (a) systematically searching for and, if reasonably practicable, correcting any previously undetected weaknesses in LU's major accidents risk models and controls;

- (b) analysis to determine whether underlying cultural, organisational or similar human factors played a role in the occurrence of these and previous such incidents, which are around five times less frequent than they were a decade ago; and
 - (c) integrating the results of the above work streams into LU's HSE Management System (HSEMS) so that any weaknesses identified are systematically addressed.
- 3.2 By its nature, this work is evolving as it progresses and updates will be provided to the Committee on a regular basis as a part of LU's Quarterly HSE Performance Reports.

4 PUBLICATION OF THE REPORT

- 4.1 Shortly after this incident occurred LU made a commitment to publish its FIR. This commitment was reiterated at the meeting of the TfL Board on 22 September 2010. The FIR will be published once finalised.

5 RECOMMENDATION

- 5.1 The Committee is asked to NOTE this paper.

6 CONTACT

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