DEPARTMENT FOR TRANSPORT

ESTABLISHING A RAIL ACCIDENT INVESTIGATION BRANCH

A RESPONSE BY THE ASSOCIATION OF PERSONAL INJURY LAWYERS

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Any enquiries in respect of this paper should be addressed, in the first instance, to:

Annette Morris
Policy Research Officer, APIL
11 Castle Quay
Nottingham
NG7 1FW

Tel: 0115 9388710
Fax: 0115 958 0885

E-mail: Annette@apil.com

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1. The Association of Personal Injury Lawyers (APIL) was formed in 1990 and represents more than 4900 solicitors, barristers, legal executives and academics whose interest in personal injury work is predominantly on behalf of injured claimants. The aims of the association are:

- To promote full and prompt compensation for all types of personal injury;
- To improve access to our legal system by all means including education, the exchange of information and the enhancement of law reform;
- To alert the public to dangers in society such as harmful products and dangerous drugs;
- To provide a communication network exchanging views formally and informally.

2. In summary, APIL welcomes the establishment of a specialist investigation body for rail accidents, as already exists in relation to air and marine accidents. APIL has, for many years, been concerned about the way in which we respond to major disasters in the UK. Whilst the Rail Accident Investigation Branch (RAIB) will address some of those concerns, we urge the Government to take a step further and ensure that safety is firmly on its agenda. APIL calls for the establishment of a Director of National Safety.

3. For some time, APIL has been concerned about the way in which we respond to major disasters in the UK. In the last 15 years or so, there have been a large number of disasters involving major loss of life and injury, as the following list demonstrates:

<u>Train crashes</u>

Clapham
Southall
Paddington
Hatfield
Potters Bar

Air accidents
Manchester
Kegworth
Lockerbie

Marine accidents
Herald of Free Enterprise
Marchioness

Other
Kings Cross fire
Bradford stadium fire
Hillsborough
Shipman

We believe that the multiplicity of accidents demonstrates in itself that something is wrong with the current system.

4. APIL's general concerns have been as follows:

- Following a major disaster, several investigations are likely to be necessary. The HSE, a specialist investigation body such as the MAIB, the police and the chair of any public inquiry are all likely to become involved. There are also likely to be several legal proceedings following a disaster, such as criminal prosecutions, HSE prosecutions, inquests and civil claims for damages. APIL is concerned about the lack of coordination of the many possible investigations and legal proceedings. Bodies have in the past, therefore, duplicated much time and effort in obtaining and recording evidence and witnesses have had to undergo the stresses of providing the same evidence on several occasions.

- In the past, criminal prosecutions have seriously delayed the progress of investigations into the causes of an accident. This happened, for example, following the Southall train crash.

- There is also, on occasion, confusion and delay surrounding whether a public inquiry is going to be held. For example, in relation to Shipman, a public inquiry was initially refused, but a successful judicial review of this decision led to a full public inquiry. In the case of the Marchioness, the public inquiry commenced ten years after the disaster. We do, however, appreciate that the Labour Government ordered this inquiry shortly after it came into power.

- Important lessons have not been learnt because of a failure to implement recommendations made following a major accident. The Government is not duty bound to implement recommendations of an inquiry and may choose for political or financial reasons not to do so. There is, however, little or no public scrutiny of these decisions. For example, the Hidden report, published after the Clapham train crash, recommended the installation of the automatic train protection system (ATP). This was not done. It has been argued that ATP would have prevented the Southall and Paddington train crashes. Generally, each inquiry produces a long list of recommendations designed to prevent a further recurrence of the accident. This list is not publicly reviewed at regular intervals. Nor is there any transparency in relation to actions taken following an accident. For example, the Bowbelle, the gravel dredger that sank the Marchioness, was quietly banned from the Thames without any public announcement some years after the sinking. The Bow fleet of dredgers had had a history of accidents, such as ramming bridges, prior to the Marchioness disaster. They were too large to manoeuvre on the upper Thames.

- The public must rely on voluntary statements from ministers or replies to questions from members of Parliament. We accept, however, that the Government has been committed to the implementation of Lord Cullen's recommendations made in the context of the Ladbroke Grove inquiry.

- No body or individual is responsible in this country for monitoring the development of advanced safety systems in public transport and other areas.

- There are a variety of specialist bodies investigating accidents but there is no coordination between them. The result is that they do not, as of course, learn from each others' experiences and develop best practice together.

5. APIL welcomes the proposal to establish an independent rail accident investigation branch. It is vital that the Government, rail regulators and the rail industry can understand why accidents happen, so that they can be prevented in the future. In achieving this, we think it is sensible to establish a body that reflects the specialist investigation branches already in place in relation to air and marine accidents. We are extremely pleased to see that the way in which the RAIB will operate will go some way to addressing the concerns that we have expressed above. For example:

    - Witness statements taken by the RAIB may be passed on to other authorities where the witness is happy for them to do so. This will not only prevent duplication by the various bodies involved in the aftermath of a disaster, but will also allow a witness to reduce the stress of providing evidence as much as possible.

    - Interim reports promulgating urgent safety lessons can be published, despite the existence of criminal proceedings, allowing important lessons to be learnt before the resolution of those proceedings.

    - The RAIB, in considering industry reports and identifying possible safety problems will have a continual focus on 'prevention'.

    - It is recognised in the consultation paper that it will be vital for the RAIB and other bodies conducting parallel investigations to cooperate and to be coordinated. It is suggested that protocols should be developed to achieve this – a suggestion that APIL wholeheartedly supports.

- The RAIB will be as open as possible and will keep all relevant people informed of the progress of its investigations.

6. Whilst we welcome the proposals as set out in the consultation paper, and particularly, the aspects outlined in detail above, we do not believe that they go far enough for the following reasons:

   - Whilst it is recognised that it would be useful to have protocols in place to help the RAIB to develop effective working partnerships, there is no suggestion that similar protocols should be developed in relation to the MAIB or AAIB.

   - The RAIB is to focus on prevention by examining industry investigation reports to determine whether there are matters of local or national importance which should be brought to the attention of the industry, for example, if a number of accidents or near-misses suggest a significant trend. It does not appear, however, that it will have powers to require the rail industry to take action.

   - The suggested coordination to be achieved through the proposed protocols, applies to investigations only. The Government has still not addressed the need for coordination of the various legal proceedings that usually follow a major disaster.

   - Monitoring of the implementation of recommendations made in the context of a public inquiry or other investigation will fall to a rail industry safety body. This will allow the industry to monitor its' own progress on safety issues – this is something that has led to problems in the past.

- There is no proposal for the RAIB to coordinate with and learn from the practice of the AAIB or MAIB and vice versa. Each independently reports to the Minister for Transport.

- There is still a gap in the system – there is no body to step in when a disaster occurs which is not related to the rail, air or marine industry e.g. Hillsborough, Kings Cross fire and Shipman.

- There is no proposal for the national coordination of safety standards.

- There is still to be no pro-active body responsible for monitoring and implementing best practice in public safety standards around the world. The RAIB and other bodies will react only after a disaster occurs.

7. The central tenet of our concerns, outlined above, is that the approach to safety and the way in which we deal with disasters will still be fragmented, despite the establishment of the RAIB. In response to this, APIL proposes the creation of a Director of National Safety. The heads of the RAIB, MAIB, AAIB and HSE would report to the director, who would have some administrative assistance.

8. Such a director would have two main roles:

- To secure improvements in public safety in rail, air, marine and other sectors;
- To ensure a satisfactory response to any major disasters.

9. In securing improvements in safety across all sectors, the director would:

- Examine industry reports on accidents and near misses to identify trends and require the relevant industry to take appropriate action;

- Monitor the implementation of any recommendations made within the context of a public inquiry and report publicly on progress;

- Produce and revise a national safety strategy annually. This would include monitoring safety developments around the world;

- Submit a report to the relevant minister, following liaison with the relevant bodies, such as the HSE, RAIB, MAIB or AAIB, if, following research, the director considered that a safety procedure should be adopted;

- Hold regular meetings with the heads of the RAIB, MAIB and AAIB to ensure that their procedures are, so far as possible, consistent with each other and ensure that each branch learns from the successful practice of other branches.

10. In ensuring a satisfactory response to a major disaster, the director would:

- Be responsible for developing the suggested protocols for liaison between all relevant investigatory bodies and prosecution authorities in relation to rail, air, marine and other accidents. The protocols would outline suggested coordination procedures in relation to both the variety of likely investigations and legal proceedings.

- Be consulted on whether, and if so what, criminal charges should be made following a major disaster.

- Liaise, when a disaster occurred, with all relevant bodies and produce an inquiry strategy for responding to that particular disaster. In doing this, the director would seek to minimise duplication and delay in all necessary investigations and legal proceedings.

- Make a recommendation to the relevant minister as to whether a public enquiry is necessary, applying publicly available criteria.

11. In essence, by drawing the various investigation bodies together and overseeing the responses to major disasters, the stress caused to the injured and bereaved would be reduced and important safety lessons would not be lost within a fragmented system. The public could also feel more confident that the Government was putting public safety firmly on the agenda. Such a director would, of course, have to be accountable. We suggest that he should produce an annual report for the relevant minister. The report should deal with the progress of implementation of safety recommendations submitted to the minister by any inquiry report. The director should address the appropriate select committee of the House of Commons. Accountability for safety issues could not, however, stop there. Where the director had made safety recommendations to a minister, that minister should be required to make a statement to Parliament outlining progress made on implementation and explaining why any of those recommendations had not been followed, where that was the case.

12. In conclusion, whilst APIL supports fully the establishment of the Rail Accident Investigation Branch, it is concerned that the Government's approach to safety, and to responding to major disasters, will remain fragmented. For this reason we call for the appointment of a Director of National Safety.