PARLIAMENTARY ADVISORY COUNCIL ON TRANSPORT SAFETY

TRANSPORT SAFETY COMMISSION INQUIRY :
UK TRANSPORT SAFETY - WHO IS RESPONSIBLE?

Further note submitted by John Cartledge

This note deals with two matters : the application of the Health & Safety at Work etc Act 1974 to the rail industry, and the possible role of coroners' investigations.

(1) Health & Safety at Work etc Act 1974 (HASWA)

In its written evidence to the Commission, the RAC Foundation has quoted extensively from a paper entitled *Transport safety : is the law an ass?*, published by Dr Chris Elliott in 2009. It includes a paragraph casting doubt on the fitness for purpose of HASWA as a framework for regulating safety in the rail industry. A number of the quoted extracts are reproduced below *in italics*, followed in each case by a comment from the author of this note.

HSWA is the legal basis for most railway safety law. This is somewhat illogical, since it regulates rail companies in their capacity as employers, not as transport operators.

Railways are unusual in that, unlike most places of employment, the public at large has relatively free access to their premises and equipment. But the provisions of the Act (as signalled by the term "etc" in its title) are not limited to the duties of employers and employees towards each other. It also requires "every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety." A similar duty is placed on persons in control of premises, so that (e.g.) preserved railways run by volunteers are still within its scope, even if they are not employers and have no employees.

The extent to which, if at all, this duty towards "other affected persons" encompassed passengers (or, indeed, neighbours or passers-by) was the subject of some dispute in the course of the public inquiry into the Kings Cross Underground fire in 1987. The inspector who conducted the investigation (Desmond Fennell QC) concluded in his report that this term should be construed literally and widely, so that it embraced anyone whose health or safety might be affected.

In 1990 the sponsorship of HM Railway Inspectorate was transferred from the Department of Transport to the Health & Safety Executive (HSE) established by HASWA, and any continuing legal uncertainty was resolved by the enactment of section 117 of the Railways Act 1993, which brought all previous rail safety legislation within the scope of the Act (and therefore of the HSE). It further provided, for the avoidance of doubt, that the general purposes of the Act included "securing the proper construction and operation of transport systems" and "protecting the public (whether passengers or not) from personal injury and other risks arising from the construction and operation of transport systems." The "transport systems" in question are listed as "any railway, tramway or trolley vehicle system; or …any transport system using any other mode of guided transport."

In 2006 HSE's responsibilities vis-à-vis railways passed to the Office of Rail Regulation, which is now the enforcing authority for HASWA in respect of this industry.

That approach is appropriate for the safety of workers and passengers within a workplace (carriage, maintenance depot) but not for regulating a system because it does not address interactions between players.

The potential for safety risks to arise at the interfaces between operators of different elements within the main line rail system was recognised at the time of the restructuring which accompanied its privatisation in the 1990s. It was addressed by the introduction of a system of "safety cases", which all operators (whether of trains or infrastructure) were required to draw up and submit for approval as a precondition of receiving an operating licence. In order to bring it into compliance with the EU's Rail Safety Directive, this system was revised in 2006 and re-enacted by the Railways & Other Guided Transport Systems (Safety) Regulations, made under HASWA and known colloquially as ROGS. These in turn were updated in 2011. "Safety cases" have been replaced by safety certificates and authorisations, which are subject to acceptance by ORR. One of the elements which these must include in order to satisfy the regulator is an explicit identification of the interfaces with other operators, and an explanation of the arrangements for managing these. In addition, all operators are required by their licences to conform with the system of Railway Group Standards (one of which is the Rule Book) which exists for the express purpose of applying common safety procedures in respect of all risks which are not under the exclusive control of any individual duty holder.

Also, it is uncertain and subjective.

Any uncertainty or subjectivity in the wording of the Act which might hamper its interpretation has been addressed in a guidance document issued by the ORR entitled *Assessing whether risks on Britain's railways have been reduced SFAIRP* (i.e. "so far as is reasonably practicable") – see http://orr.gov.uk/what-and-how-we-regulate/health-and-safety/guidance-and-research/risk-management. In addition to this formal advice from the industry's safety regulator, RSSB (formerly the Rail Safety & Standards Board) has provided detailed guidance on "good practice" in its publication *Taking safe decisions* – see http://www.rssb.co.uk/about-rssb/case-studies/taking-safe-decisions.

There are further difficulties with applying HSWA to a hybrid public/private structure, such as the question as to whether affordability is relevant to reasonable practicability.

The law applies uniformly to all railway employers irrespective of their ownership, so the fact that the rail industry may have what is described as "a hybrid public/private structure" has no bearing on its scope. The ORR's guidance is clear as to whether affordability is relevant, because there is a duty to implement safety measures "so far as is reasonably practicable". The test of this is set by the judgement in the (pre-HASWA) case of Edwards v National Coal Board (1949), in which it was held "that duty holders have only discharged their health and safety duties when the costs incurred in implementing a control measure are grossly disproportionate to the risk involved, i.e. the risk being insignificant in relation to the sacrifice". This means that it is an offence to fail to implement any safety measure unless it can be shown that the cost of doing so would be "grossly disproportionate" to the safety benefits it would bring. These benefits accrue to everyone who may be at risk, not purely to the operators (and their passengers) which bear the direct cost of delivering them – so it is appropriate that in practice it is society at large that is funding a large proportion of them, by virtue of the fact that a major share of the industry's costs are underwritten by the state.

The guidance from ORR and RSSB elaborates the meaning of gross disproportion, and provides a method for quantifying the value of preventing injuries of varying severity. In practice, the industry has not limited itself to adopting measures which satisfy this test, and has often made

safety improvements for which, in narrow economic terms, there is no justification. In some instances this has been done in order to comply with a specific obligation laid upon it by law, e.g. the introduction of the train protection and warning system (TPWS, which mitigates the risk of signals being passed at danger) or of centralised train door controls. In others, there has been seen to be a commercial benefit from doing so, particularly when they are an integral part of an investment in new technology or operating systems aimed primarily at improving service performance and/or efficiency.

HSWA was the product of the Robens Report in 1972, which specifically recommended that its otherwise highly effective principle that duty holders must each do all that is reasonably practicable should not apply to transport, 'Provisions for the safety and health of those engaged in flying aircraft, driving trains, lorries and so on clearly cannot be considered in isolation from a whole complex of special considerations such as the constraints imposed by the design of transport vehicles, the circumstances in which they operate which include many eventualities beyond the control of an employer'. The section on 'Transport workers' concludes that the proposed general occupational safety and health provisions should extend to '...all transport workers except whilst they are directly engaged on transport operations'. Robens never intended that the legislation that he was designing should be used to regulate passenger safety.

It is true that Robens foresaw difficulties in applying the principles underpinning HASWA in the context of the transport industry – and it may be that his reservations have continuing force in the context of the roads where there is commonly no identifiable employer on whom the duties enshrined in the act can be placed. But despite his reservations, in the event the railways were not exempted from its provisions, and subsequent legislation (cited above) has expressly confirmed them to be within its scope. Whatever the intentions of its original author, the HASWA regime has in practice been successfully applied to this industry, and the best test of its fitness for that purpose has been the (steadily improving) trend in the railways' safety record over subsequent decades.

(2) The role of coroners' investigations

A member of its secretariat has indicated informally that the Commission is interested in the possibility that in the absence of an independent accident investigation body for the roads equivalent to those which now exist in other transport sectors, the system of coroners' investigations might be adapted and developed for this purpose. Comments on this suggestion have been invited.

As an advocate on behalf of the official rail users' representative bodies, the author participated in two inquests into multiple-fatality incidents on the rail network – the derailment at Potters Bar in 2002 and the level crossing collision at Ufton Nervet in 2004. He has acted in a similar capacity at a series of public inquiries into other such events, including the Kings Cross Underground station fire (in 1987) and the collisions at Clapham Junction (1988), Southall (1997) and Ladbroke Grove (1999). He is not, however, an authority on coronial law and practice, and the following comments should be treated in that light.

In England and Wales, all violent or unnatural deaths, and those whose cause is unknown, must be reported to the coroner for the area in which they occur, and the coroner must determine whether their circumstances merit investigation which may, in turn, lead to the convening of a formal inquest. The primary purpose of this is to ascertain how a death occurred, though "how" may be interpreted more broadly as encompassing the surrounding circumstances. Inquests must be held if a post mortem examination concludes that the cause of death was violent or unnatural. Such fatalities occurring on the railway are generally found to be the result of suicide, accidental death or (very exceptionally) unlawful killing.

Coroners have power to require the production of evidence and to summon witnesses, and a duty to report "actions to prevent future deaths" (PFD) to any person or organisation who they believe may have the power to take them. Although such a report may recommend that action is taken to eliminate or reduce the risk of other deaths from similar causes, it cannot stipulate what that action should be. Any person to whom such a report is addressed must respond to it within 56 days and must include a timetable for any action they intend to take.

Local authorities have a duty to provide whatever staff are needed by coroners to carry out their functions. But coroners do not have their own teams of specialist investigators to call upon, or large budgets with which to fund such work, and they are heavily reliant upon evidence gathered by other agencies. In the case of individual rail fatalities, this is generally provided by the British Transport Police.

Inquests must be held in public unless "the interests of justice" or considerations of national security dictate otherwise. Lengthier and more complex inquests, such as those arising from major railway accidents, are held with a jury and may result in narrative conclusions (previously known as verdicts) amplifying what they consider to be the principal issues that have emerged. The conclusions of an inquest can be challenged in the High Court by or under the authority of the Attorney General, and the court has power to order a fresh investigation.

Prior to the establishment of the Rail Accident Investigation Branch, major rail accidents were investigated by the industry's safety regulator (then the HSE, now ORR). On some occasions, the level of public and political concern led to the convening of a public inquiry, such as those cited above. On others, a formal investigation was conducted internally by the regulator leading to a published report – e.g. the derailments at Watford South Junction (1996), Great Heck (2001) and Hatfield (2000). In most, but not all, of these instances, the circumstances of the accident also gave rise to a criminal trial, of either the rail operator or a member of its staff, or both. They were charged either with offences under HASWA or with manslaughter, or both. And there have been other, more recent trials, typically arising from level crossing accidents, e.g. those at Elsenham (2005) and Moreton-on-Lugg (2010)

In the instances in which a public inquiry was held, an inquest was still necessary under coronial law, but the proceedings were usually brief and amounted to little more than a formal legal footnote. Where there was no such inquiry, e.g. at Ufton Nervet and Potters Bar, the inquests were more prolonged and the scope of the evidence taken was wider, as they assumed some of the characteristics associated with public inquiries. In particular, they gave representatives of the victims an opportunity to hear and challenge the expert witnesses, and to present additional evidence from other sources.

The interaction between trials, inquiries and inquests can give rise to difficulties regarding sequencing and timing. Whichever is held first, the other proceedings can be delayed. If an inquest is held first, there is a risk of prejudicing a subsequent trial (if the defendant/s plead/s not guilty), and on occasion it has been necessary to give inquest witnesses qualified immunity, so that they can give evidence freely without fear of self-incrimination. Because of a series of complicating factors (relating to the trial arising from the Hatfield accident, and the specific circumstances of the subsequent Grayrigg derailment), the inquest into the Potters Bar accident was adjourned until eight years after the event – though the Chief Coroner now has a duty to keep a register of investigations lasting more than twelve months and to take steps to reduce unnecessary delays.

Most – but not all - of the provisions of the Coroners and Justice Act 2009 were brought into force in 2013. This Act has brought about a number of important changes in the work of coroners, not least the creation for the first time of the post of Chief Coroner, whose holder provides leadership to and

sets standards for the whole of the coroner service. A guide to its effects can be found at https://www. judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/. Where relevant, these changes have been reflected in the contents of this note.

The Rail Accident Investigation Branch was established in 2006 in fulfilment of a recommendation of part 2 of the Ladbroke Grove rail inquiry ("the Cullen report") and gave effect to one of the requirements of the EU's rail safety directive. By removing from the ORR the responsibility for investigating the causes of safety incidents, it ended the previous situation in which the regulator could on occasion find itself called upon to reach judgements about the contributory part played by its own past actions and policies. RAIB does not hold public inquiries, but it is required to liaise closely with victims of accidents and their families during the course of its investigations, and to take their concerns into account. Its findings as to cause are central to the evidence given at any subsequent inquest, and it has discretion to delay their publication until other legal proceedings arising from the same event have been concluded.

ORR also has power to conduct public inquiries (termed "investigations") under the Railways Act 2005, as does the government under the Inquiries Act 2005. But the former power has not yet been exercised, and the latter has never been exercised in relation to a rail safety incident. It is difficult to envisage a situation in which this would now be likely to happen, but if it does, an inquest may simply conclude that any consequential deaths occurred in a "disaster which is the subject of a public inquiry", leaving it to the inquiry to explore the full circumstances and make recommendations.

If the Commission is minded to pursue further the possibility that coroners' investigations might be used in the case of road accidents in a manner similar to those of RAIB on the railways, a number of factors would need to be taken into account. Amongst these are that :

(a) Coroners only have a power to inquire into fatal accidents. RAIB is obliged to investigate serious accidents involving the derailment or collision of rolling stock, which includes those which cause at least one death or five serious injuries or extensive damage. But it also has power to investigate any other incidents occurring on railway property where it believes that there are significant safety lessons to be learned, and fortunately the infrequency of fatal derailments and collisions has meant that most of its investigations are of this type.

(b) Coroners operate separately within defined geographical areas. The RAIB is a single organisation with a nationwide remit.

(c) The RAIB has a permanent staff of investigators, whose expertise covers the entire field of railway technology and operation, and can additionally call in the services of specialist external advisers. Coroners do not have equivalent technical and professional resources at their disposal.

(d) The ORR, as the railways' safety regulator, has a specific duty to oversee action resulting from RAIB recommendations (though not automatically to accept them), and to satisfy itself either that appropriate action has been taken or that there are valid reasons for this not to have been done. It is not clear on whom an equivalent duty would rest in the case of road safety.

(e) Coroners are required to have appropriate legal or medical qualifications. They are not required to have any specialist knowledge of either civil or mechanical engineering, or of the human factors that play a part in driver and pedestrian safety. Their PFD reports are necessarily couched in fairly general terms, and do not contain detailed recommendations for action.

A fuller and more authoritative commentary could be sought from the Chief Coroner's office.

In Scotland, a role broadly equivalent to that of coroners in England and Wales is performed by the procurators fiscal, who conduct fatal accident inquiries. Since 2010 they have been provided with expertise and specialist advice by the Scottish Fatalities Investigation Unit (SFIU) – see http://www.copfs.gov.uk/media-site/media-releases/244-lord-advocate-launches-new-scottish-fatalities-investigation-unit. It is described as having "been established with the intention of ensuring that all death reports are prepared according to the highest possible standards; that policy and practice in the investigation of deaths is applied consistently; and that appropriate and timely decisions are taken throughout the life of these cases. The unit will oversee and provide advice and support to local specialist deaths investigators in procurator fiscal offices around the country. In particular, the unit deals with more complex non-criminal cases, including providing guidance in all cases where a fatal accident inquiry is to be held."

Prima facie, it appears that Scottish practice in the investigation of "sudden, suspicious, accidental and unexplained deaths" may offer a more fruitful model for the Commission's consideration than that of coroners in England and Wales. The Crown Office and Procurator Fiscal Service (COPFS) will no doubt be willing to provide further details.

In this connection, it may be worth mentioning that the investigation of work-related deaths (a topic of interest to the Commission at its hearing on 3.7.14) is the subject of a detailed protocol for liaison between the HSE, the Association of Chief Police Officers Scotland, the British Transport Police and COPFS – see www.hse.gov.uk/scotland/workreldeaths.pdf. It should be noted that the wording of the protocol reflects the institutional arrangements that were in force at the time it was drawn up, and that it predates both the transfer of the safety regulatory oversight of the rail industry from HSE to ORR (2006) and the abolition of the Health & Safety Commission (2008). In other respects, however, the principles and procedures it outlines remain in force.

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