THE SAFETY-CRITICAL ROLE OF THE GUARD

A dossier on the dangers of driver-only operation

June 2016

RMT

INTRODUCTION

BY RMT GENERAL SECRETARY MICK CASH

This dossier has been produced by RMT as part of our national fight against the introduction and extension of Driver Only Operation on Britain's railways as greedy train operating companies look to dilute the safety regime in favour of maximising their profits from the privatised network.

It sets out a range of examples from across the country which details the real consequences of axing and undermining the safety-critical role of the guard for the travelling public.

The examples are horrific but the current moves, in the wake of the government-backed McNulty report that made DOO the default option, mean that it will be the tip of the iceberg if we don't halt and reverse the drive to take out the guards.

Everyone who works on the railway knows that the Passenger/Train Interface (PTI) is the number one area of risk. That fact is accepted by the safety agencies that monitor and manage the safety regime across the rail network.

With surging demand, unmatched by rail capacity, overcrowding on trains and platforms is now endemic. The guard, working with their platform and driver colleagues, is the pivotal point in the safe management of the dangers presented at the passenger/train interface. Removing them, or downgrading their role, is a lethal gamble with passenger safety.

Only a fool, or someone motivated solely by the bottom line on a company balance sheet, would contemplate tampering with guards on Britain's crowded railways. And yet that is exactly what is happening.

This report is designed to inform and mobilise public opinion behind the union's on-going fight against Driver-Only Operation and the clear and present danger that it presents. RMT is committed to fighting in the industrial, political and public arenas to defend the guard. This report explains why.

WHAT IS DOO AND WHY IS THE GOVERNMENT AND THE TRAIN OPERATING COMPANIES PROMOTING IT?

In the three decades since Driver-Only Operation (DOO) was proposed there has been a slow and creeping introduction which has extended this operational model into around 30 per cent of our rail services.

With the model being nothing new it is right to ask the question why, if it is so safe, has it only been adopted by less than a third of the network? The answer is that it is unsafe, unpopular with the public and opposed by all of the rail unions.

RMT, and our colleagues in ASLEF, have a signed a joint agreement opposing any further extension of DOO. That agreement represented a line in the sand in terms of the industrial landscape on our railways.

But the game changer came in 2011 when the Tory-led coalition endorsed the McNulty Report into the railways that laid out, as a point of principle, that DOO would become the default mode of train operation.

RMT is in no doubt that McNulty, and the government, were acting under intense lobbying from the train operating companies whose core objective is to maximise the financial returns from their franchises. Axing and downgrading guards is part of a wider scorched-earth policy that includes closing ticket offices, cutting maintenance, hacking back on catering and reducing station and platform staffing, all in the name of profit.

RMT believes that the train driver has enough to do with driving trains safely and needs to be able to concentrate on the track and signalling systems in-front of them to ensure passenger safety. The union is clear that there is and always will be a case for a guard working in tandem with the driver.

This dossier is broken into two parts. In the first part it concentrates on a series of significant incidents at the platform train interface in which passengers either boarding or alighting from trains suffered serious and in some cases life-threatening injuries.

In the second part we concentrate on a series of incidents on the railway in which the role played by the guard has had a significant and positive impact on the post incident management of a safety event. This is a small snapshot of events that are played out on a daily basis by the dedicated staff who operate our trains every day of the year.

WHAT IS THE 'ROLE' OF THE GUARD?

The role of the guard could not be more "safety-critical". As well as being the eyes-and-ears of the rail network at that crucial Passenger/Train Interface they are currently trained to comply with the railway Rulebook which equips them to deal with numerous safety and key operational functions on our railway. In the case of emergencies or difficulties they can step in to make sure the public are safe when travelling on the railway.

These skills and knowledge include an understanding of the risks associated with working on electrified lines, track safety, dealing with a train accident or train evacuation, failed trains, managing incidents, single line working, signalling systems and signalling regulations, station duties and train despatch, speeds, track possessions, train defects, on train equipment, dealing with fires, dealing with suspect packages, route indications - these are only a sample of the 35 areas of safety responsible duties they perform.

When there is an emergency the guard can take charge especially if the train driver is incapacitated.

Of course it is not just safety. There are those public-facing jobs that help provide a better journey for train passengers; as well as checking tickets, guards can help passengers get the best value ticket and give them travel information and expert advice about a passenger's journey. They are also not just trained and forgotten about, every two years guards have to sit periodic exams to ensure that they have retained these skills and knowledge and remain competent to carry them out.

There have been numerous safety incidents on DOO services and RMT believes that the public is safer with a fully safety-trained guard on board who knows how the railway operates. Passengers know this - thousands have already opposed the government and the rail operator plans to de-skill and scrap guards. The campaign has been backed by numerous local councillors, transport bodies, passenger groups, disability groups and MPs.

With many stations having no staff on them how will disabled people, those in wheel chairs or with reduced mobility access train services if there is only a driver aboard? The railway should be easy to access for all people yet DOO threatens the limited improvements we have seen made in recent years. It makes a mockery of the Disability Discrimination Act.

At a time of increasing security threats and growing anti-social behaviour, which is reflected in growing levels of racially motivated abuse, violence and sexual assault, the presence of the guard is of growing importance not less. Some police and crime commissioners have also expressed concern about plans that could leave passengers on trains on their own - apart from the person actually driving the train. Passengers, and particularly women, should not feel scared of travelling on our railways.

Guards fill that important role in helping to moderate behaviour on trains. Many services, particularly during evenings and weekend have become little more than 'bars on wheels' and have seen a dramatic increase in drunken behaviour.

BTP resources are being increasingly focused around major stations and many stations and the vast majority of trains will never receive a visit from a BTP officer on any day of the year.

This leads, in an emergency, to the police being called upon and they too are facing real pressure and the threat of further cuts. If there is a guard aboard they can often manage the situation without further assistance. But when operating in DOO mode this cannot happen. Only a fool would suggest that a driver can drive a train while sorting out drunken behaviour in the carriages behind them.

The case for retaining and valuing Britain's train guards is overwhelming. This dossier provides the hard evidence that backs up that statement.

PASSENGER/TRAIN INTERFACE [PTI] INCIDENTS

Since January 2011 there have been 10 serious incidents at the Passenger/Train Interface [PTI] that have been or are subjected to investigation by the UK's National Investigation Body the Rail Accident Investigation Branch [RAIB].

80% of these incidents have involved services being operated in Driver Only Operation [DOO] without a second on-board safety critical worker, a guard or train manager.

RMT believes the rail industry is hell bent on extending DOO operation to all parts of the network and we further believe that this is done at the detriment of passenger safety and only to increase profits for the Train Operating Companies and therefore dividends for share holders.

The list of RAIB investigations is as follows:

Event date	Event location	Description	Operation type
28.01.2011	Brentwood Station	Passenger fall between train and platform	DOO
10.10.2011	King's Cross Station	Body part trapped in door, passenger dragged along	DOO
22.10.2011	James Street Station	Fatality. Fall between trains and platform	Non-DOO
12.04.2012	Jarrow Station	Body part trapped in door, passenger dragged along	DOO
24.11.2012	Charing Cross Station	Passenger fall between train and platform	DOO
05.06.2013	Newcastle Central Station	Body part trapped in door, passenger dragged along	Non-DOO
03.02.2014	Holborn Station	Passenger clothing trapped in door, dragged along	DOO
12.03.2015	Clapham South Station	Passenger clothing trapped resulting in fall between train and platform	DOO
10.04.2015	West Wickham	Passenger backpack trapped resulting in fall between train and platform	DOO
25.07.2015	Hayes and Harlington	Passenger bodypart trapped in door. Dragged along	DOO

BRENTWOOD STATION – 28.01.2011; A passenger alighting from the last coach of a train at Brentwood station fell, head first between the side of the train and the platform. Another passenger saw the incident and was able to grab one of her legs. The driver of the train did not see the incident on the CCTV display provided for train dispatch and the service departed as normal.

The passenger was assisted back on to the platform by other passengers. She received minor injuries including cuts and bruising. Had there been no other passengers on the platform the consequences for the injured party could have been fatal. There was no guard on-board the train. There were no platform staff on the platform.

KINGS CROSS STATION - 10.10.2011; A passenger attempting to board a service to Royston got her hand trapped between the doors of the train and was dragged along for a distance of approximately 20 m. The passenger managed to stay upright and pull her fingers free. She was given first aid by station staff and later visited a hospital near her home where her fingers were found to be badly bruised but not broken. There was no guard on-board the train. The dispatch of the train was covered by a process involving a dispatcher and the driver.

JAMES STREET STATION – 22.10.2011; A young woman was struck and killed by the train she had just alighted from. Her hands were touching the train as it started to depart and when the guard saw her fall he stopped the train by which time the passenger had fallen through the platform edge gap onto the track and sustained fatal injuries.

JARROW STATION – 12.04.2012; A passenger became trapped in one of the train doors at Jarrow station. She had arrived on the platform as the doors were closing and had placed her arm in the path of the closing door. Even though the door was not fully closed the train started to leave the station with the passenger forced to run alongside it.

Another passenger on the train activated the emergency door release allowing the passenger to free herself. She fell to the platform but then left the station. It is not known whether she sustained any injuries. There was no guard on-board the train and no staff on the platform.

CHARING CROSS STATION – 24.11.2012; A passenger who had just arrived at Charing Cross station on an in-bound train fell between the platform edge and a train departing to Dartford. It is not clear why she walked towards the train on the adjacent platform. As a result of the accident the passenger suffered life-changing injuries.

The train was dispatched by a member of platform staff who completed his duties before the passenger approached the train.

NEWCASTLE CENTRAL STATION - 05.06.2013; A passenger was dragged by a train after she tried to board the train while the doors where closing. The passenger remained upright and suffered from severe bruising to her wrist. The train's brakes were activated either by automatic application after a passenger operated the emergency door release handle or the driver responding to an emergency signal from the conductor [guard].

HOLBORN STATION - 03.02.2014; A passenger was dragged about 10 m along the platform by a departing Piccadilly Line train after her scarf became caught between the closing doors of one of the carriages. As the passenger approached the closing doors of the train she stopped but her scarf swung forward and got trapped by the closing door. Consequently she was dragged along the platform.

A member of platform staff assisted the passenger by catching hold of her as she fell to the ground which resulted in the scarf being forcibly removed by the forward movement of the train. The passenger suffered injuries to her back and neck but the action of the member of platform staff may have saved her from being more seriously hurt.

CLAPHAM SOUTH STATION - 12.03.2015; A passenger's coat became trapped between the closing doors of the train. The doors had already closed and then opened due to one set of doors encountering an obstruction. The injured passenger found the crowded carriage too much and had stepped back onto the platform to wait for the next train.

As the train started to depart the passenger was dragged along and fell into the gap between the train and the platform. The passenger suffered injuries to her arm head and shoulder and was taken to hospital.

WEST WICKHAM STATION – 10.04.2015; A passenger was dragged along the platform at West Wickham after her backpack became trapped in the doors of the departing train. The backpack strap became trapped when the train doors closed unexpectedly as she was exiting the train. As the train moved off she fell into the gap between the train and the platform edge suffering life changing injuries. She was assisted by a member of the public.

HAYES AND HARLINGTON – 25.07.15; A passenger trapped her hand in the last door of a train departing the station. The passenger was dragged for a distance of 8-10 m before falling to the ground. The passenger suffered bruises to her hand and head. Had she fallen between the platform edge and the train her injuries could have been more severe.

RAIB is still investigating this incident and has not yet published a report into the accident. They have however issued an Urgent Safety Advice to Train Operating Companies and trade unions with train driver members. The Urgent Safety Advice is available on the RMT website.

RAIB believe there is a common misconception amongst train drivers that it is not possible to obtain door interlock and for a train to depart if a persons hand or other object of a similar size is trapped in the door of a train. In fact the standard for door interlocking is 25-30 mm wide.

RAIB's advice is that train drivers responsible for the dispatch of their trains must perform a thorough final safety check after the door interlock light has been obtained and should not place sole reliance on the illumination of the door interlock light. If, having performed such a check, they are still not satisfied that it is safe to move the train, they should implement company procedures for dealing with such a situation.

RMT has argued that the advice contained in the Urgent Safety Advice does not go far enough.

The CCTV pictures reproduced in the Urgent Safety Advice are of relatively good level but there is much variation in quality of CCTV available to drivers to see the real situation behind them. Even with the relatively good quality pictures in this incident it would be very hard to distinguish between a person trapped as opposed to a person banging on the window to be let in to the train after the doors have closed, or shaking their fist at the door in frustration for missing their train.

RMT believes that if there is any doubt when performing pre-departure safety checks that it is safe to dispatch the train then drivers should perform a visual check and not rely solely on CCTV, stepping out onto the platform if necessary.

Significant railway accidents where the role of the guard made a difference to the post-incident management of the incident.

RAILWAY ACCIDENTS WHERE THE ROLE OF THE GUARD MADE A DIFFERENCE

TRAIN DRIVER RECEIVING A SEVERE ELECTRIC SHOCK AT SUTTON WEAVER, CHESHIRE 23RD SEPTEMBER 2014

A train driver received a severe electric shock at Sutton Weaver, Cheshire. He had stopped his train having seen damaged overhead power supply wires ahead of it. Following a call to the signaller, he left his train and came close to, or made contact with, an electrically live wire which had broken and was low hanging. The train driver suffered serious injuries.

Before inspecting the track the driver called the train manager (guard) to the driver's cab. After the incident the train manager called Virgin Control and when it was confirmed the power had been switched off the train manager went to assist the driver. The train manager summoned the emergency services and then went back to the train where he used the train's PA system to ask if there were medically qualified people on board. When a doctor came forward escorted him to the driver where they made sure the driver was comfortable until the emergency services arrived.

COLLISION BETWEEN A TRAIN AND A CAR AT BEECH HILL LEVEL CROSSING, NEAR FINNINGLEY 4TH DECEMBER 2012

A passenger train service from Lincoln to Doncaster, struck a car on Beech Hill automatic half barrier crossing between Gainsborough and Doncaster. The impact caused extensive damage to the car. One of the occupants, died later in hospital and the car driver was seriously injured.

The train driver stopped an approaching train on the adjacent line by deploying his red flag. The train conductor came to the driver's cab to report that there was fuel leaking and what appeared to be smoke rising from beneath the train. The driver and conductor decided to evacuate the passengers as quickly as possible as they believed that there was a risk of a fire.

Passengers were removed from the immediate vicinity of the train and when Network Rail staff arrived they were taken to an adjacent crossing. Both the guard and the driver were commended by RAIB for their exemplary actions.

PASSENGER TRAIN DERAILMENT NEAR EAST LANGTON, LEICESTERSHIRE 20TH FEBRUARY 2010

A train derailed but remained upright following an axle failure. On hearing a fire alarm the guard interrogated the trains on-board system and sent two staff to investigate the report of a fire in the fourth vehicle. Once the train had come to a stop, the gaurd went to the driver's cab to tell him about the fire.

The environment on board was difficult for both passengers and crew as they awaited rescue, because the train's power supplies had to be shut down due to the fire risk, leaving no facilities for flushing toilets or making hot drinks.

The guard and other on-board staff then made arrangements for the welfare of the passengers and communicated developments to them.

COLLISION BETWEEN TRAIN 1C84 AND A TREE AT LAVINGTON, WILTSHIRE 10TH JULY 2010

This event involved a FGW HST which was involved in a collision with a tree but did not derail. The driver was initially incapacitated and the guard applied track circuit clips to protect the train within two minutes of the train coming to a stand. The guard observed smoke coming from underneath the leading passenger coach and extinguished a small fire.

He then advised passengers of what had happened. He informed Control that the situation on board for the passengers was tolerable and despite being on board for five hours after the collision kept his passengers fully informed of developments. Throughout this period, witnesses indicate that the train manager communicated effectively with the passengers, ensuring that they were aware of steps being taken to get the train moved.

ACCIDENT AT FALLS OF CRUACHAN, ARGYLL 6TH JUNE 2010

The derailment of a Scotrail train at the Falls of Cruachan occurred after the train struck a boulder and resulted in the leading vehicle hanging down a steep embankment. There were 64 passengers and three crew on the train. Eight of the passengers were taken to hospital with minor injuries.

The conductor assisted by a passenger extinguished a small fire. He then called Control and the emergency services and assisted the passengers in the rear of the train. The crew then led all passengers to the nearby station where they were met by the emergency services.

The conductor and the other train crew all received a British Transport Police Area Commander's Commendation.

EXTRACT FROM GLASGOW EVENING TIMES, 2 DEC 2010

"Three rail workers who helped lead 60 passengers to safety after a train from Glasgow derailed and hung over a 50ft embankment have been honoured for their heroism. Drew Hinde, a 38-year-old steward from Glasgow, received a British Transport Police Area Commander's Commendation from Chief Superintendent Ellie Bird at an awards ceremony at the City Chambers. Train driver Willie Dickson, 60, from Grangemouth, and conductor Angus MacColl, 54, of Oban, were also honoured. They showed their bravery after a Glasgow-Oban train derailed at the Falls Of Cruachan, Argyll, on June 6. Eight people suffered minor injuries following the incident, which left the train precariously balanced over the embankment. A 1000 tonne crane was needed to lift the train's carriage a week after the accident."

BRIDGE STRIKE AND ROAD VEHICLE INCURSION ONTO THE ROOF OF A PASSING TRAIN NEAR OXSHOTT STATION , 5TH NOVEMBER 2010

A 25.6 tonne concrete lorry crashed onto the railway landing on the roof of a Southwest Trains service. One passenger and the lorry driver received serious injuries and a further five passengers received minor injuries. The guard informed the driver that the bridge appeared to have come down on the train, re-assured his passengers and contacted Control.

The guard then obtained a ladder from the train's cab and assisted passengers in coaches 5, 6 and 7 to leave the train in order to move forwards to the front four coaches which were undamaged. An off-duty police officer, who was a passenger on the train, assisted the guard and the seriously injured passenger who remained trapped.

DERAILMENT IN SUMMIT TUNNEL, NEAR TODMORDEN, WEST YORKSHIRE 28TH DECEMBER 2010

A Trans Pennine Express train derailed in Summit Tunnel after striking a large build up of ice that had fallen from one of the tunnel ventilation shafts. Once the train had stopped the conductor tried to speak to the driver using the train's cab to cab intercom but got no answer, so he went to the front cab. He found the driver standing in the cab.

While the driver went to the nearest signal to make contact with control the conductor got off the train and placed track circuit operating clips on both lines. The conductor was concerned about the driver's welfare, but he got back on the train, and went through it to check that the passengers were all right and to let them know what was happening.

The Network Rail mobile operations manager and emergency services then went with the driver back to the train, where they found out from the conductor that there were no passenger injuries.

Derailment of a passenger train near Dryclough Junction, Halifax 5th February 2011

A Northern Rail service derailed after striking debris from a fallen wall the conductor assisted the driver who was in a state of shock, maintained contact with Control and assisted the passengers.

The conductor went through the train to check that the passengers and driver were uninjured. The conductor then maintained contact with the controller on the train radio while the driver checked the damage to the train and confirmed with the Halifax signaller that protection was in place.

The driver and conductor then stayed with the passengers until the Network Rail incident officer arrived to take charge of the accident site. The passengers on the train were transferred to another train brought alongside the derailed train and were taken away from site safely.

DERAILMENT AT GRAYRIGG, 23RD FEBRUARY 2007

The derailment of a Virgin Trains Pendolino at Grayrigg resulted in the death of one passenger and injury to 86 others. The guard contacted Virgin Control and provided information to the emergency services about the train and the number of passengers on board. They then assisted the passengers and the emergency services, although none of them was able to move fully throughout the train, and the customer service assistant was seriously injured.

DERAILMENT OF A PASSENGER TRAIN NEAR KEMBLE 15TH JANUARY 2007

A FGW service derailed after striking debris from a landslip and came to a halt at the mouth of Kemble Tunnel. The guard kept passengers informed about the situation and the arrival of the emergency services and the plans for the evacuation. The FGW crew and the Fire Brigade evacuated the passengers through the tunnel to Kemble station.

DERAILMENT IN HOOLEY CUTTING, NEAR MERSTHAM, SURREY 13TH JANUARY 2007

A Southern service from Bognor Regis to Victoria derailed at the site of a landslip just north of Merstham Tunnel. No one was injured in the accident but 413 passengers had to be evacuated. The guard checked all passengers for injuries and assisted in the evacuation.

OTHER SIGNIFICANT RAILWAY ACCIDENTS WHERE THE ROLE OF THE GUARD MADE A DIFFERENCE TO THE POST-INCIDENT MANAGEMENT OF THE INCIDENT.

Event Date	Event location	Description	Operating Mode
17.10.2000	Hatfield	De-railment 4 deaths, 70 injured	Non-DOO
05.10.1999	Ladbroke Grove	SPAD followed by train collision. 31 deaths, 520 injured	Non-DOO
19.09.1997	Southall	SPAD followed by train collision. 7 deaths, 139 injured	Non-DOO
08.08.1996	Watford	SPAD followed by train collision. 1 death, 69 injured	Non-DOO
07.12.1991	Severn Tunnel	Train collision.185 injured	Non DOO
04.03.1989	Purely	Train collision. 5 deaths, 88 injured	Non-DOO
12.12.1988	Clapham Junction	Multiple train collision. 35 deaths, nearly 500 injured.	Non-DOO

MORE RECENT INCIDENTS WHERE THE ROLE OF THE GUARD MADE A DIFFERENCE

22ND MAY 2015, PASSENGER TAKEN ILL ON-BOARD, LARBET STATION.

The guard was advised of an unwell passenger who appeared to be slipping into unconsciousness, an off-duty nurse assisted the guard to look after the passenger. The guard then contacted the emergency services. By this time the passenger was unconscious and the guard and the nurse lowered her to the floor of the train where the nurse commenced CPR.

The guard moved other passengers away from the scene to preserve the passenger's dignity.

18TH MAY 2015, FIRE ON A TRAIN AT RUSCOMBE

A potentially serious incident was averted at Ruscombe just east of Twyford when a fire on board a train was put out – by a guard.

The incident – that led to suspension of some services in and out of Paddington – was tweeted by the Network Rail Great Western twitter feed – with the swift action and professionalism of the on-board crew heavily emphasised. Inexplicably, Network Rail have now removed those tweets, which said that the fire had been identified and put out by train crew prior to the arrival of the Fire Brigade.

CHILD LEFT ON TRAIN, FALKIRK HIGH

The guard was subjected to abuse and harassment from a group of drunken football fans who alighted at Linlithgow. The guard was alerted by passengers that a young child had been left on the train. The guard took the child and two female passengers into the empty 1st class carriage.

The guard obtained the child's father's phone number and called him to say his daughter was alright. The father was following the train in a taxi. The parents, when reunited with their daughter, where found to have been amongst the group who had previously been abusing the guard.

27TH JULY 2015, PASSENGER FALL FROM PLATFORM, HUDDERSFIELD

As the train entered the station the conductor was positioned at the local door and was able to observe a passenger with a bicycle catch the side of the train and fall between the train and the platform. The conductor immediately pressed the Emergency Stop button and brought the train to a stand. Due to this prompt action the passenger escaped with no noticeable injury.

First Trans Pennine Express stated "Without the exceptional vigilance and prompt action by the conductor a far more serious outcome may have resulted – well done and thanks to all involved."

8TH JULY 2015, PASSENGER FALL FROM PLATFORM, HAMILTON SQUARE

A member of the public was injured when she tried to board the train after the door closure procedure had commenced when the door closing alarm was sounding. The individual concerned received a number of injuries after falling between the train and the platform. The guard, by following the training he has received from the company, was instrumental in assisting the train driver in isolating the electrical supply to the third rail by placing the short circuit bar on the running and conductor rail. The guard then lowered himself between the platform edge and the train and offered assistance and reassurance to the member of the public until the emergency services arrived.

National Union of Rail, Maritime & Transport Workers
39 Chalton Street
London NW1 1JD

www.rmt.org.uk