FUTURE TRANSPORT LONDON

ISSUES ARISING FROM THE SANDILANDS TRAM DERAILMENT INQUESTS

NOTE FOR FTL MEETING BY JOHN CARTLEDGE

16 NOVEMBER 2021

1. Purpose of note

1.1 To record the conclusions of the inquests into the deaths which occurred in consequence of the Sandilands tram derailment, and to bring certain legal issues arising to FTL's attention.

2. The accident

2.1 The derailment occurred at 06.07 (before dawn) on Wednesday, 9 November 2016, when a two-car tram from New Addington to Wimbledon overturned on the sharp curve between Radcliffe Road (or Woodside) tunnel and the Sandilands tram stop on the Croydon Tramlink network. The tram was travelling at approximately 45 mph, the maximum permitted speed at this point being 12.5 mph. It slid for about 30 yards on its right-hand side, breaking all of the windows and dislodging several of the doors on that side. Seven passengers were killed instantly : Dane Chinnery, Donald Collett, Robert Huxley, Philip Logan, Dorota Rynkiewicz, Philip Seary and Mark Smith. All but one of the 63 other people on board (including the driver) were suffered physical injuries, 19 of these being classed as serious.

3. Timing of the inquests

3.1 The inquests were held (simultaneously) at Croydon town hall from 17 May to 22 July 2021, before HM Coroner (HMC) for South London (Sarah Ormonde-Walsh) and a jury of 11 members. In total the court sat on 35 days.

3.2 The unusually lengthy interval between the date of the accident and the holding of the inquests was due to three consecutive factors, viz : (a) the time required for the Rail Accident Investigation Branch (RAIB) to complete its investigation and issue its final report (published on 6 December 2017), (b) the time then required for the Crown Prosecution Service (CPS) to reach its decision on whether or not to lay homicide charges against any organisation or individual involved (announced - in the negative - on 31 October 2019), and (c) the impact of the coronavirus pandemic which started in early 2020 and

prevented the court from being convened in a medically safe environment, given the space available and the number of participants involved.

4. Organisations involved

4.1 Subject to the coroner's approval, "Interested Person" (IP) status entitles an organisation or individual to present evidence, call and question witnesses, and make submissions.

4.2 In addition to the seven bereaved families, the IPs recognised at the inquests were Transport for London (TfL) (which, through its subsidiary London Trams (LT), owns and maintains the infrastructure and vehicles), Tram Operations Ltd (TOL) (a subsidiary of First Group, which operates the vehicles and employs the drivers), Alfred Dorris (driver of the tram), Bombardier UK Ltd (manufacturer of the tram), the RAIB, the British Transport Police (BTP), the Office of Rail and Road (ORR), and London TravelWatch. The London Fire Brigade was also recognised, having participated in the rescue and recovery effort, but in the event it took no part in the inquests.

5. Witnesses called

5.1 The inquests were held in two stages, viz :

(a) evidence taken in relation to the causes and circumstances of the accident, to enable the jury to reach its conclusions, and

(b) evidence taken (in the absence of the jury) to enable HM Coroner to decide whether or not to exercise her power to issue a Prevention of Future Deaths (PFD) report and, if so, to which individual(s) and/or organisation(s) this should be addressed.

5.2 During stage one, nine witnesses were called. Six of these were RAIB inspectors (including the chief inspector, Simon French) who were questioned exhaustively on the findings and conclusions of the branch's report on this accident (a summary of which can be found at https://www.gov.uk/government/news/report-182017-overturning-of-a-tram-at-sandilands-junction-croydon, together with a link to the full document). Two were senior BTP officers, one of whom had been in charge of the rescue operation on site and one who had led the subsequent criminal investigation on behalf of the CPS. The ninth was a former TfL engineer who had not been interviewed at the time of the RAIB investigation and who had, it subsequently transpired, raised questions several years previously regarding the adequacy of the safety signage on the Croydon and other tram networks..

5.3 The driver (Mr Dorris) was too ill to be able to give evidence in person. He had, however, given a very full interview to the BTP in the course of its investigation, and the transcript of this was read for the benefit of the jury.

5.4 Following an interval during which HMC sought submissions - and gave her ruling - on the application of the Norfolk judgement (see section 6 below), a further six witnesses were called during stage two. These were the former chief engineer of Bombardier UK, the managing director of and the head of safety at TOL, the general manager of LT, the deputy director of rail safety at ORR, and the ASLEF trade union branch secretary for TOL (representing the company's drivers). All of these witnesses were questioned about changes made subsequent to the accident to address shortcomings revealed by it and to give effect to the recommendations made in the RAIB report. A summary of these recommendations is annexed to this note.

5.5 Counsel for the ORR, and its deputy rail safety director (Paul Appleton), both confirmed that its own inquiries remained open, and that no decision about whether or not to exercise its powers of prosecution against any organisation or individual under section 18 of the Health and Safety at Work etc Act 1974 in relation to the causes of the Sandilands accident would be taken until after the conclusion of the inquests. This remains the position, pending the outcome of the legal challenge noted at paragraph 6.4 below.

5.6 At certain stages during the inquests, a number of advocates and/or witnesses were unable to be present in person, mainly for medical reasons (primarily but not exclusively coronavirus-related). They therefore participated remotely via a video link. This was an interesting innovation in coronial practice which generally worked smoothly, even when neither the advocate putting questions nor the witness answering them was physically present. The link also allowed the proceedings to be monitored from elsewhere by a large number of (e.g.) legal and technical advisers acting for the various IPs, as well as by victims' relatives. It will be interesting to note whether this practice is continued once the pandemic-related restrictions on public gatherings have all been lifted.

6. The Norfolk issue

6.1 After the first nine (stage one) witnesses had been called, HMC paused the proceedings and invited all IPs to make submissions regarding the application to these inquests of the Norfolk judgement. This was given in 2016 in the divisional court in resolution of a dispute between HMC for Norfolk and the Air Accident Investigation Branch (RAIB's counterpart in the civil aviation industry) regarding the volume of evidence which the former was entitled to require the latter to disclose for the purposes of an inquest arising from a fatal helicopter crash in that county.

6.2 In essence, the ruling of the court was *"that there is no public interest in having unnecessary duplication of investigations or inquiries."* In concurring with this view, the (then) Lord Chief Justice observed that

"The [Norfolk coroner's] *submission reflected the tendency in recent years for different independent bodies, which have overlapping jurisdictions to investigate accidents or other matters, to investigate, either successively or at the same time, the same matter. On occasions each body considers that it should itself investigate the entirety of the matter rather than rely on the conclusion of the body with the greatest expertise in a particular area within the matter being investigated. The result can be that very significant sums of money and other precious resources are expended unnecessarily."*

He went on to say that the case being decided provided *"an illustration of what in many cases will be the better approach … Unless there is credible evidence that the independent investigation is* ***incomplete, flawed or deficient****, the better approach is for a coroner … not to investigate the matter de novo* [but] *to treat the findings and conclusions of the independent body* as *the evidence as to the cause of the accident supplemented, if necessary, by short additional evidence from the inspector."*

6.3 The Sandilands inquests were the first occasion since this judgement was given on which the principle it advanced could be tested in practice, i.e. a multi-fatality accident which had been the subject of a full investigation by an expert independent body. An important point of coronial procedure was thus involved. Having received submissions from all of the IPs, counsel to the inquests (i.e. HMC's own legal team) argued that no part of the RAIB report had been shown to be in any way incomplete, flawed or deficient, and that therefore no further evidence as to the causes and circumstances of the accident was required. Only the representatives of the bereaved families contested this view, and sought additional witnesses' evidence relating to (e.g.) TOL's management of driver fatigue, LT/TOL's approach to risk assessment, and the adequacy of ORR's regulatory oversight of tram industry safety.

6.4 HMC adopted her counsel's arguments, and ruled that no further stage one witnesses should be called. This ruling was challenged by counsel for the families, who questioned the legal force of the Norfolk ruling and contended that there were several aspects of the RAIB report which deserved to be further tested in evidence. They did not seek to halt the proceedings at that point, but gave notice of their intention to contest HMC's decision subsequently by seeking judicial review in the administrative court.

6.5 Such a challenge has now been lodged, on behalf of a relative of one of the victims, and at the time of drafting this note (19.10.21) a decision is awaited on whether the stated grounds for this action have sufficient merit for it to be allowed to proceed. In addition, a legal firm representing five of the victims has written to the attorney general asking him to consider using his powers under section 13 of the Coroners Act 1988 to apply to the high court for an order seeking a fresh inquest. They contend that it is *necessary or desirable in the interests of justice that another investigation be held*, justifying their application on the grounds of *rejection of evidence and/or irregularity of proceedings and/or insufficiency of inquiry*. HMC has tabled a robust defence of her rulings.

6.6 If either of these applications is allowed to proceed to a full hearing, and if the court was then to rule against HMC, the conclusions of the inquests would have to be set aside and the proceedings re-run with a new jury and additional witnesses.

7. The jury's conclusions

7.1 After eight days' deliberation, the jury returned a unanimous conclusion of accidental death (and thereby rejected the alternative option of unlawful killing, by the driver, which had been offered to them). They attached a narrative commentary on four contributory factors, viz :

(1) TOL's risk assessment process failed to sufficiently identify the risk of the tram overturning and crashing at the tight Sandilands curve at high speed with a probability of fatalities.

(2) TOL identified the importance of line-of-sight driving and route knowledge but failed to identify additional measures to mitigate risk.

(3) The lack of a "just" culture [within TOL] *discouraged drivers from reporting health and safety concerns.*

(4) The driver lost awareness and became disorientated ahead of the Sandilands curve, probably due to a microsleep. Following this, the driver failed to hit the braking point by which time the tram was travelling too fast to negotiate the Sandilands curve. The result was a high speed derailment, the tram overturning and seven fatalities.

8. Prevention of future deaths

8.1 HMC invited submissions from all IPs on whether they wished her to exercise her power to issue a PFD report and, if so, on what issues and addressed to which individuals or organisations. Only the families sought such action, on a list of issues which included automatic braking systems, door design, use of laminated glass in windows, the placing of speed limit signs, and ORR follow-up of RAIB recommendations. All of the other IPs which responded to the families' submission argued that the matters listed had already been fully covered by action taken in response to the RAIB's findings, and that nothing would be achieved by repeating these.

8.2 In its submission, London TravelWatch identified three matters (also raised by the families) which had emerged in the course of the inquest proceedings to which it suggested that further consideration should be given. As these related to questions of law or legal procedure, they were not necessarily appropriate to a PFD report, but it contended that this would not prevent HMC from referring them to the appropriate branches of government if she so chose. The issues were :

(a) The need for clearer guidance to coroners and IPs on the interpretation and status of the Norfolk ruling and related matters (such as the wording of a memorandum of understanding between the chief coroner and the three transport accident investigation branches), in order to limit the risk of protracted legal arguments at future inquests to which the Norfolk ruling applies regarding the nature and scope of any evidence required additional to that offered by the relevant investigation agency.

[In practice, this proposal has effectively been overtaken by the families' application for judicial review.]

(b) The exemption of tramways from certain regulatory requirements imposed on other rail operators. Specifically :

The Railway Safety (Miscellaneous Provisions) Regulations 1997 impose certain duties on operators of railway systems in relation to, inter alia, measures to prevent collisions and derailments, to brakes, and to accidents to persons at work from moving vehicles.
The Railway Safety Regulations 1999 similarly impose duties in relation to, inter alia, train protection systems.

Railway systems are defined, for the purposes of both sets of regulations, in such a way as to include reserved track sections of tramways but not those in which they are street-running.

In addition, the Railways and Other Guided Transport Systems (Safety) Regulations 2006 (commonly referred to as ROGS) govern the general system of safety regulation in the rail industry, and also apply for certain purposes to "other guided transport systems" of which tramways are a prime example. Although most of the requirements imposed by these regulations apply equally to main line railways and to tramways (e.g. those relating to the management of safety critical work, the conduct of risk assessments and the provision of safety management systems), there are some from which tramways are exempt. These include the requirement to hold a safety certificate or authorisation and to produce an annual safety report. As is the case with the 1997 and 1999 regulations, tramways are deemed to be wholly or largely street-running.

The question that has been raised is whether the exemptions applied to tramways in these regulations are appropriate.

(c) The statement dated 31 October 2019 in which the CPS announced its decision not to bring charges of manslaughter against any organisations or individuals arising from the Sandilands accident contains a list of other possible charges it had considered but rejected. These included causing death by dangerous or careless driving contrary to section 2 of the Road Traffic Act 1988 and endangering the safety of a person on the railway contrary to section 34 of the Offences Against the Person Act 1861.

In both instances the law was found to be inapplicable because it relates in the first instance, solely to highways and in the second, solely to railways. Reserved-track sections of tramways, such as that on which the Sandilands accident occurred, fall outside both categories.

The question that has been raised is, again, whether the exclusion of tramways from the scope of either or both of these statutes is appropriate.

8.3 London TravelWatch noted in its submission that these are complex issues, and that although they had arisen in the course of the Sandilands inquests they had not been explored in depth there. It took no a priori position in relation to any of them. But it felt that they were legitimate questions, properly raised (if only briefly) on behalf of the families, and that they merited further consideration. Their immediate

relevance to PFD was acknowledged to be debatable, and arguably the causal connection with this particular accident was somewhat tenuous. Nevertheless, it hoped that HMC might be minded to bring them (not necessarily in the guise of a PFD report) to the attention of the Department for Transport and the Ministry of Justice so that they could be further considered.

8.4 On 21.9.21 HMC wrote to all of the IPs involved in the inquests to advise them that she did *not consider that it would be appropriate or productive for* [her] *to suggest changes to the current criminal law or indeed to formal rail safety regulations.* [She had,] *however. decided that there are four areas where* [she] *should report to organisations with a view to preventing future deaths.*

(a) *First, automatic braking systems to prevent over-speeding. During the evidence it became clear that trains do have automatic braking systems. They are of course different from trams which are driven by "line of sight." However, it seems to* [her] *that it would be appropriate for a fresh assessment to be made of whether automatic braking systems would be appropriate for trams.* [She proposed] *to write to the Department for Transport and the LRSSB* [the Light Rail Safety and Standards Board] *with this recommendation.*

(b) *Secondly, tram doors. At least one of the seven died as a result of being ejected through the bottom of the door leaf. A recommendation was made by the RAIB that consideration should be given to the feasibility of strengthening doors, whether in current tram stock or in future tram building. Little seems to have been done since.* [She was] *minded to report both to Transport for London and Bombardier in respect of Croydon's current stock, and also to the Department for Transport to ask it to communicate with other tram door manufacturers in respect of whether tram doors can be adapted now or in the future.*

(c) *Thirdly,* [she was] *recommending that all tramway operators should consider subscribing to CIRAS* [the Confidential Incident Reporting and Analysis Service] *(or to another similar anonymous reporting scheme), and look at whether such schemes are used, and if not, why not.* [She would] *address this to the Department for Transport, to be disseminated to all tramway operators.*

(d) *Fourthly, London TravelWatch is a passenger safety group which covers all public transport in Greater London. There is scope for a centrally funded national tram safety passenger group which covers all the different operators.* [She proposed] *to recommend to the Department for Transport that consideration be given to setting up such a group.*

[It should be noted that the remit of London TravelWatch in fact embraces all issues of concern to users of the passenger transport systems within its remit – including but not limited to safety.]

8.5 These reports have been sent, as appropriate, to UK Tram, the LRSSB, the Department for Transport, TfL, Bombardier Transportation UK Ltd and Transport Focus. The addressees have until 23.11.21 to respond.

Note on status of author

John Cartledge served as London TravelWatch's advocate at the Sandilands inquests, but this paper has been written by him in a personal capacity and its content does not necessarily represent the views of London TravelWatch.

ANNEX

Summary of recommendations made in RAIB's Sandilands report

The RAIB report contained 15 recommendations, plus one "note of advice" on an issue (bus safety) thought worthy of attention but outside the branch's formal remit. Their subject matter was as follows :

- *Developing a body to enable more effective UK-wide cooperation between tramways on matters related to safety, and common standards and good practice guidance.*

- *Jointly conducting a systematic review of operational risks and control measures associated with the design, maintenance and operation of tramways.*

- *Working together to review, develop, and provide a programme for installing suitable measures to automatically reduce tram speeds if they approach higher risk locations at speeds which could result in derailment or overturning.*

- *Working together to research and evaluate systems capable of reliably detecting driver attention state and initiating appropriate automatic responses if a low level of alertness is identified.*

- *Working together to review signage, lighting and other visual information cues available on segregated and off-street areas based on an understanding of the information required by drivers on the approach to high risk locations such as tight curves.*

- *Reviewing existing research and, if necessary, undertaking further research to identify means of improving the passenger containment provided by tram windows and doors*.

- *Installing (or modifying existing) emergency lighting so that the lighting cannot be unintentionally switched off or disconnected during an emergency.*

- *Reviewing options for enabling the rapid evacuation of a tram which is lying on its side after an accident*.

- C*arrying out a review of the safety regulatory framework for tramways and the long-term strategy for supervision of the sector.*

- *Commissioning an independent review of the process for assessing risk associated with the operation of trams (e.g. collision, derailment and overturning)*.

- *Reviewing and, where necessary, improving the management of fatigue risk affecting tram drivers.*

- *Undertaking a review, informed by expert input from external sources, covering the way that the tram operator learns from operational experience.*

- *Improving processes and, where necessary, equipment used for following up both public and employee comments which indicate a possible safety risk.*

- *Reviewing and, where necessary, improving processes for inspecting and maintaining on-tram CCTV equipment to reduce the likelihood of recorded images being unavailable for accident and incident investigation.*

- *Reviewing and, where necessary, revising (i) existing tram maintenance and testing documentation to take account of experienced gained, and modifications made, since the trams were brought into service; and (ii) the processes for ensuring that these documents are kept up-to-date in future.*

- *Using the lessons learnt from the review of the containment provided by tram windows and doors to establish whether this identifies potential safety improvements applicable to buses and coaches.*

JC 19.10.21