Recommendation(s) Status: Accidents involving a wheelchair rolling onto the track at Southend Central and a pushchair rolling onto the track at Whyteleafe

This report is based on information provided to the RAIB by the relevant safety authority or public body.

The status of implementation of the recommendations, as reported to us, has been divided into eight categories:

Key to Recommendation Status

Open **(replaces Progressing and Implementation On-going)**	Actions to address the recommendation are ongoing.
Closed **(replaces Implemented, Implemented by alternative means, and Non-implementation)**	ORR consider the recommendation to have been taken into consideration by an end implementer and evidence provided to show action taken or justification for no action taken.
Insufficient response:	The end implementer has not provided sufficient evidence that the recommendation has been taken into consideration, or if it has, the action proposed does not address the recommendation, or there is insufficient evidence to support no action being taken.
Superseded:	The recommendation has been superseded either by a newer recommendation or actions have subsequently been taken by the end implementer that have superseded the recommendation.
Awaiting response:	Awaiting initial report from the relevant safety authority or public body on the status of the recommendation.

RAIB concerns on actions taken by organisations in response to recommendations are reflected in this report and are indicated by one of the following:

Red – RAIB has concerns that no actions have been taken in response to a recommendation.

Blue – The blue triangle shows recommendations where the RAIB has concerns that the actions taken, or proposed, are inappropriate or insufficient to address the risk identified during the investigation.

White – The white triangle shows recommendations where the RAIB notes substantive actions have been reported, but the RAIB still has concerns.

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Report Title	Accidents involving a wheelchair rolling onto the track at Southend Central and a pushchair rolling onto the track at Whyteleafe
Report Number	17/2014
Date of Incident	28/08/2013

Rec No.	Status	RAIB Concern	Recommendation	RAIB Summary of current status
17/2014/01	Closed - I	None	The intention of this recommendation is to reduce the risk of pushchairs and wheelchairs rolling off platforms. Network Rail and Station Facility Operators should implement processes for managing the risk of wheelchairs and pushchairs rolling onto the track. These should include: l the inclusion of platform slopes as a factor to be considered when assessing the risk to passengers on platforms; l guidance to risk assessors on factors likely to exacerbate any risk of roll away (such as the presence of ticket machines, help points and shops/kiosks where people are more likely to release their hold on pushchairs and wheelchairs); l consideration of measures to manage the risk (taking account of the work arising from the implementation of recommendation 3 in the short-term and recommendation 2 in the longer term); l specific consideration of the impact on platform slopes of any works that are to take place at the station and methods of ensuring that those works will, as a minimum, not worsen the slope (and reduce or eliminate it if	A. ORR has reported that Network Rail and Station Facility Operators have reported that they have taken actions in response to this recommendation. ORR proposes to take no further action unless they become aware that the information provided becomes inaccurate.

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			reasonably practicable to do so); and l the sharing of information concerning any residual risk at the conclusion of works (paragraphs 73a and 75c).	
17/2014/02	Closed - I	None	The intention of this recommendation is for the rail industry to understand the point at which a slope becomes sufficiently steep for it to be more likely than not that an occupied wheelchair or pushchair without a brake applied would roll away. The work should consider the most appropriate methods of influencing the behaviour of passengers to minimise the risk. Network Rail in consultation with the Association of Train Operating Companies, RSSB and the Department for Transport, should (as part of the national strategy for managing the platform train interface risk) arrange for work to be undertaken to determine when a slope towards the railway could become a significant hazard, and ways of mitigating the risk. The scope of the exercise should consider: l all slopes on platforms including those that have been installed intentionally (for example to accommodate changes in level along the platform length); l at what point a slope towards the railway makes it more likely than not that a wheelchair or pushchair without brakes applied could roll away, taking account of modern designs of such equipment; and l other factors such as how individuals perceive a slope hazard, the most appropriate way to highlight the hazard, appropriate methods to influence public behaviour, and other ways of mitigating the risk. Once the work is complete the industry should publish appropriate	REC 2 and 4 appear to mitigate the risk of further reoccurrence. ORR has reported that (Dutyholder name) has reported that it has completed actions taken in response to this recommendation. ORR proposes to take no further action unless they become aware that the information provided becomes inaccurate. .

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			guidance, including consideration of standardisation in the contents of signage, announcements, etc (paragraphs 73b and 73c).	
17/2014/03	Closed - I	None	The intention of this recommendation is for the Association of Train Operating Companies to consider the most appropriate ways of influencing the behaviour of passengers travelling with a wheelchair or pushchair, pending the outcome from recommendation 2. As an interim measure, pending the outcome of the research identified in recommendation 2, the Association of Train Operating Companies should, in consultation with passenger groups including those representing the interest of disabled passengers, review the findings of this report and seek to understand the ways in which the risk of wheelchairs and pushchairs rolling onto the track can be more effectively managed by operators. This review should include consideration of: l locations where passengers may need to remove both their hands from a pushchair or wheelchair because of the nature of another task to be performed (eg at a ticket machine or shop/kiosk); l reference to any existing good practice in this area; and l measures that could most effectively influence the behaviour of passengers using wheelchairs and pushchairs on station platforms. The output of the review should be consolidated into suitable guidance for train operators (paragraphs 73b, 73c and 75c).	ORR has reported that Association of Train Operating Companies has reported that it has taken actions in response to this recommendation. ORR proposes to take no further action unless they become aware that the information provided becomes inaccurate.
17/2014/04	Closed - IA	None	The intention of this recommendation is for the rail industry to capture, share and use information relating to roll-off events with a particular emphasis on identifying where platform slopes were a causal factor so	ORR has reported that (Dutyholder name) has reported that it has completed actions taken in response to this recommendation. ORR proposes

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			that it has a better understanding of the causes of roll-off events and the associated risk. Network Rail, in consultation with Station Facility Operators and RSSB, should implement a process to improve the investigation and recording of roll-off incidents and the way in which data is shared. Particular attention should be paid to the following areas: l improvements in capturing and recording incidents involving roll-off type events, including the identification of the key factors that caused the roll-off such as the presence of a slope towards the railway on the platform; l a review of previous roll-off incidents and accidents (covering at least the last five years) to identify those that may have been solely attributed to 'user error' or 'trespass', including establishing whether there may have been other causal factors such as a slope at the location concerned; and l a review of how intelligence on roll-off incidents should be shared within and between SFOs and Network Rail as an input to decisions on the nature and content of improvement works at stations (recommendation 1 also refers) (paragraphs 73b and 74).	to take no further action unless they become aware that the information provided becomes inaccurate.