LONDON TRAVELWATCH

SANDILANDS TRAM DERAILMENT INQUEST REPORT

SEPTEMBER 2021

1. Purpose of report

1.1 To record London TravelWatch's participation in the inquests into the deaths which occurred in consequence of the Sandilands tram derailment, and to note certain legal issues arising.

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 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) 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 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 London TravelWatch and its predecessor bodies have participated in all of the public inquiries or inquests arising from multi-fatality rail incidents which have occurred in its area since the Kings Cross Underground station fire in 1987. It therefore sought and was awarded recognition as an "Interested Person" (IP) at the Sandilands inquests. This status entitled it to submit evidence and (subject to the Coroner's agreement) call its own witnesses and question others'.

4.2 The other IPs, in addition to the seven bereaved families, 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), and the Office of Rail and Road (ORR). The London Fire Brigade was also recognised as an IP, 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 speed warning signage approaching the curve.

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 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 London TravelWatch participated in the cross-examination of witnesses at each stage, but did not seek to present any witnesses of its own, having had no prior involvement with safety issues on the

Croydon tram network. It did, however, table a note of evidence setting out the findings of research it had undertaken into the circumstances of historic accidents on British tramways which appeared to have causal similarities to the tragedy at Sandilands and which could arguably have been taken into account in the identification of risks arising on the network. Simon French stated during the course of his evidence that RAIB was *"very grateful for this"* as it *"reinforces our learning."*

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 observe 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. arising from 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 London TravelWatch noted in its submission on this issue that RAIB, in accordance with its statutory obligations, had consulted it at the draft stage on the contents of its report – both via a presentation in person and in writing. London TravelWatch had submitted a detailed reply, to which RAIB had fully responded, accepting most of the suggestions made. It followed that any shortcomings identified by London TravelWatch had already been addressed, and that there were therefore no remaining issues relating to causation on which it felt that additional evidence would be of benefit to the jury.

6.5 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 asking the attorney general to use his powers under the Coroners Act 1988 to apply to the high court for an order requiring fresh inquests to be held. Such a request was duly submitted on 4 August 2021, being justified on the grounds of *"rejection of evidence and/or irregularity of proceedings and/or insufficiency of inquiry."* The views of HMC have been invited by the attorney general's office, and she in turn has invited the views of the Interested Persons. In reply, London TravelWatch has affirmed the view it took during the course of the inquests (paragraph 6.4 above).

6.6 If the attorney general accepts the families' request, and if the court then rules 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 own submission, London TravelWatch identified three matters 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 application of the Norfolk ruling and related matters (such as the wording of a memorandum of understanding between the chief coroner and the accident investigation branches). [In practice, this suggestion has been overtaken - or at least put on hold - by the families' request for an application to the high court for fresh inquests.]
(b) The exemption of tramways from some of the regulatory requirements of the Railway Safety (Miscellaneous Provisions) Regulations 1997, the Railway Safety Regulations 1999 and the Railways and Other Guided Transport Systems (Safety) Regulations 2006.
(c) The application to tramways of section 2 of the Road Traffic Act 1988 and section 34 of the Offences Against the Person Act 1861.

8.2 All IPs were invited to submit further comments in response to the PFD submissions received. No comments were made on London TravelWatch's submissions, but London TravelWatch did respond to one suggestion in the families' submissions. This was a proposal (not developed in detail) that *"a UK tram passenger safety group should be established and funded centrally to advise the Light Rail Safety and Standards Board on passenger safety issues."* In the absence of any more detailed description of the role, composition and modus operandi of such a body, London TravelWatch took no a priori view on the merit of this idea. It did, however, take the opportunity to outline to HMC and the other IPs the nature and extent of the existing arrangements for the involvement of passenger representatives in rail (including tram) safety monitoring and policy making. These include:

(a) The role of London TravelWatch (and Transport Focus) in the handling and investigation, at the appeal stage, of users' comments, suggestions and complaints on all issues including safety.
(b) Their status as statutory consultees of both ORR and RAIB (and their close working relationship with these bodies), as well as with the Department for Transport on proposals for legislative or regulatory changes.
(c) Their engagement at working group level in the activities of the Rail Safety and Standards Board.
(d) Their long-standing membership of both the ORR's Rail Industry Health and Safety Advisory Committee (RIHSAC) and the rail safety working party of the Parliamentary Advisory Council on Transport Safety (PACTS).
(e) Regular update meetings with TfL's head of safety, quality and environment.

8.3 At the close of the inquests on 22 July 2021, HMC announced her intention of giving notice, within "about two weeks", of her decision on whether to issue a PFD report and her reasons for this. At the date of drafting this note (23.8.21) such notice had not yet been received, although confirmation had been sought by London TravelWatch (and given) that it would not be affected by the families' application for fresh inquests to be held.

9. Documentation

9.1 All documentation disclosed in connection with the Sandilands inquests (including charts, maps, photographs and video clips, plus the full transcript of the proceedings) was circulated in digitised electronic form. It has been lodged in the safety section of London TravelWatch's archives and is available for reference. It comprises 1,087 files, with a total size of 9.01 gigabytes.

10. Recommendation

10.1 That the foregoing report is received for information.

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 23.8.21