

1. PURPOSE

The purpose of this procedure is to specify the management process for the reporting and subsequent investigation of unplanned events.

An unplanned event includes work-related injuries, occupational illnesses, damage to plant and equipment, damage/contamination of the infrastructure, nuisance complaints, road traffic collisions and any event that has the potential to cause any of the aforementioned events, widely known as close calls and near misses. From this point forward, 'event' means any of the above.

The implementation of the process associated with this procedure will ensure that corrective actions can be taken to reduce the chance of reoccurrence. It will ensure VolkerRail's legal and moral duties within various legislation are complied with and that the specific client requirements are addressed, i.e. Railway Group and Network Rail Standards, Transport for London etc.

This procedure includes references where applicable to the ORR-Risk Management Maturity Model RM3 and BS ISO 45001:2018 to show a correlation with the requirements of each.

2. SCOPE

The procedure is mandatory and applies to all VolkerRail (VR) staff, agency staff, contractors, their supply chain and visitors.

It applies to all VR activities, those who are working on our behalf, and those within our undertaking, on all infrastructures, static or transient sites, within VR offices and depots.

Joint Venture and Alliance procedures may supersede the requirements of this procedure. However, all arrangements for reporting and investigation must be agreed with the **VR HSQES Director**.

3. REFERENCES (INPUTS) / RELATED DOCUMENTS
Client Standards

- London Underground Cat 1 Standard 1-558 Formal Investigation of Incidents
- London Underground Cat 1 Standard S1556 Incident Reporting and Investigation
- Network Rail NR/L2/INV/003 Accident and Incident Reporting and Investigation
- Network Rail NR/L3/OHS/0046 The Reporting, Investigation and Recording of Safety and Sustainable Development Events and Close Calls within Infrastructure Projects
- Network Rail NR/L3/INV/3001 Reporting and Investigation Manual and associated modules 900 – 905
- Network Rail NR/L2/ENV/015 Environment and Social Minimum Requirements for Projects – Design and Construction
- Network Rail Environmental Incidents and Close Call Guidance Note. Version 2.0

Legislation

- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- Health and Safety at Work etc. Act
- The Railways (Accident Investigation and Reporting) Regulations
- The Railway and Transport Safety Act
- The Railways and Other Guided Transport. Systems (Safety) Regulations
- The Construction (Design and Management) Regulations Environmental Damage (Prevention and Remediation) (England) Regulations (as amended)
- Environmental Damage (Prevention and Remediation) (Wales) Regulations (as amended)
- Environmental Liability (Scotland) Regulations (as amended)
- Regulatory Enforcement and Sanctions Act

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Railway Group / Industry Standards

- Rail Industry Standard RIS-8047-TOM Reporting of Safety Related Information
- Rail Industry Standard RIS-3119-TOM – Accident and Incident Investigation
- Rail Industry Standard RIS-2273-RST Post Incident and Post Accident Testing of Rail Vehicles
- BS ISO 45001:2018 – Occupational Health and Safety Management
- ORR – RM3 Risk Management Maturity Model
- GEGN8613 - Application of human factors within safety management systems

VolkerRail Procedures

- ENV08 – Management of Environmental Incidents
- ENV09 – Management of Protected Sites and Species
- PER03 – Disciplinary Procedure
- PER25 – Absence Management
- QUA05 – Management of Non-Conformance
- QUA10 – Document Retention Schedule
- SAF07 – Safety Critical Certification Suspension, Withdrawal or Reinstatement
- SAF13 – Recording of Safety Critical Communication
- SAF16 – Drugs Alcohol and Medication
- SAF40 – Emergency Response and Management
- CMS16 – Competence Development Plan

Systems

- EcoOnline – Safety Software Accident Incident Reporting Software Web-based System platform. Allows the capture of Accident, Incident, Close Call and Audit information as well as dashboard and reporting tools.
- SMIS - Safety Management Intelligence System, also known to many as 'SMIS', is the rail industry's online enterprise safety and business intelligence software, incorporating the national database for recording safety-related events that occur on the rail network in Britain.

4. DEFINITIONS

Definition	Meaning
Accident	An unplanned, uncontrolled event giving rise to death, ill health, injury or loss
EcoOnline	VR's approved accident and incident reporting and investigation event management system
Eco Report	A preliminary investigation to establish the facts and preliminary causes of the event and whether there is a need for further investigation
Assault	Any event in which a person is physically assaulted, subjected to verbal abuse or threatened with violence, whether or not there is injury.
Close Call	An unsafe act or condition that could result in personal injury or damage
Corrective Actions	Required to address failing/s that led to root cause(s). These are mandatory and must be completed

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Definition	Meaning
Designated Competent Person (DCP)	<p>The person nominated to have overall responsibility for the management of investigations.</p> <p>L1DCP – Level 1 Investigation Designated Competent Person L2DCP – Level 2 Investigation Designated Competent Person</p> <p>The DCP shall meet the following requirements:</p> <ol style="list-style-type: none"> 1. Must have successfully completed an investigation course/refresher in the last 3 years 2. Must hold IOSH Managing Safely or hold NEBOSH General Certificate (or equivalent) 3. Must be a member of a professional body in accordance with their specific discipline 4. Must maintain their CPD in accordance with their professional body (e.g. IOSH/ICE) 5. Specific to the Environment and Sustainability discipline, they must hold IEMA Practitioner Membership (or equivalent - minimum may be achieved through a Certificate in Environmental Management) 6. Specific to the Quality discipline, they must hold a minimum of Practitioner level with the Chartered Quality Institute, working towards full Chartership and have at least 5 years' experience in a senior quality role with a Lead Auditor qualification.
Design Close Call	<ul style="list-style-type: none"> • A design condition or situation (including errors and omissions) which could have been identified earlier in the design review / verification process, or; • Something which has been signed off and subsequently found to have the potential to cause harm or injury to people or the environment, or; • A design which harbours a latent hazard which has the potential to cause harm or injury to people or the environment. This may be the result of design assumptions or option decisions which have not been adequately tested, managed, or communicated, or; • A set of parameters which places staff under sufficient stress or pressure to endanger or damage their wellbeing or compromise their ability to fulfil their role effectively; this is likely but not necessarily the result of pressure to deliver on time. However, there are other potential causes of stress, which could be design or individual specific, e.g., having to design to a bare minimum clearance.
Employee	Directly paid employees paid monthly, weekly or hourly. This does not include agency or any other labour-supplied persons.
Environmental Close Call	An event that could have resulted in potential harm to the environment. This may include the unexpected find of contaminated soils, protected species, archaeological find, etc, but in all circumstances, the find must not have been disturbed, damaged, killed, injured or destroyed.
Environmental Incident	An unplanned or uncontrolled event with negative environmental consequences may require immediate response to minimise the impact. An environmental incident can (but not always) result in a quantifiable loss, e.g. of fuel, or as a result of a breach of an agreed practice or process, e.g. conditions of a consent, licence, permit or primary legislative requirement.
Fatality	Any injury or condition that results in the death of a person. Death from natural causes is not reported unless it can be demonstrated that there is reason to suspect the death arose in connection with work.

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Definition	Meaning
High Potential	The term 'High Potential' is used as a means to highlight events with actual or potentially serious consequences that arise because of a failure of VR controls. In identifying these, actual and potential consequences of each event are considered and assessed against the likelihood of the consequences based on frequency, using historical data.
Immediate Cause	As defined by the HSE within HSG245: The most obvious reason why an adverse event happens, e.g. the guard is missing, the employee slips; there may be several immediate causes identified in one adverse event, i.e. the thing that had to be there at that moment in time for the accident to happen
Incident	An unplanned or uncontrolled event has resulted in damage or loss to property, plant, materials or the environment or a loss of business opportunity. Incidents do not include those events that are categorised as Operational Close Calls.
ISO 45001	International Standard Organisation – Health and Safety Management System
Investigation lead	A competent person by virtue of their knowledge, expertise or experience appointed by the DCP to lead and manage the investigation. The Investigation lead shall also meet the following requirements: <ol style="list-style-type: none"> 1. Must have successfully completed an investigation course / refresher in the last 3 years 2. Must have completed IOSH Managing Safety training or hold NEBOSH General Certificate (or equivalent) 3. Must hold IEMA Practitioner Membership (or equivalent - minimum may be achieved through Certificate in Environmental Management) specific to the Environment and Sustainability discipline 4. Must have completed EcoOnline training
Level 1 investigation	An investigation of an event for which a Level 2 investigation remit is not required
Level 2 Investigation	A formally structured investigation of an event led by VR's DCP or client, i.e. Network Rail, Transport for London, etc.
Near Miss	An unplanned and/or uncontrolled event involving a train or rail-mounted plant which has the potential to cause personal injury. A Near Miss is an outcome of an Operational Close Call.
Non-workers	Members of the public, visitors, passengers
Operational Close Call	An unplanned or uncontrolled event which occurs on the operational railway and has the potential to cause injury or damage (known previously as Irregular Working)
OTM	On Track Machine
Public	Invited or uninvited (trespasser) members of the public
Probable	Means that although it is considered highly likely that the factor applied, some small element of uncertainty remains
Possible	Means that although there is some evidence that supports this factor, there remains a more significant degree of uncertainty

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Definition	Meaning
Quarantine	Removing a piece of equipment from service and keeping it separated/isolated until an investigation is carried out.
Reportable	Those events defined under RIDDOR as having to be notified to the ORR, HSE or Local Authority
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrence Regulations
RM3	Risk Management Maturity Model
Road Traffic Collision (RTC)	A road traffic collision is an incident involving a vehicle on a road or other public area which causes injury to any persons in the vehicle, 3rd party injuries, damage to an animal, damage to another vehicle or damage to property construction/fixed structure.
Root Cause	As defined by the HSE within HSG245: An initiating event or failing from which all other causal or failings spring. Root causes are generally management, planning or organisational failure.
SPAD	Signal Passed at Danger, meaning any occasion when any part of a train progresses beyond its authorised movement to an unauthorised movement. See RIS-3119-TOM for further definition.
SMART	This mnemonic refers to SMART actions/recommendations that are S pecific, M easurable, A chievable, R elevant and T ime-bound.
Underlying Cause	As defined by the HSE within HSG245: The less obvious 'system or organisational reason' for an adverse event happening, e.g. pre-start-up machinery checks are not carried out by supervisors. The hazard has not been adequately considered with a suitable and sufficient risk assessment; production pressures are too great, etc.
VRCC	VolkerRail Control Centre, which operates on a 24/7 basis
SMIS	Safety Management Intelligence System is a system for supporting rail industry parties in carrying out their responsibilities for health, safety and environment management.

5. PROCESS

5.1 General Responsibilities

All employees have a legal duty within the Health and Safety at Work etc. Act to cooperate with their employer so far as is necessary to enable their employer to ensure that their legal duties can be complied with. This includes compliance with the requirements of this procedure in relation to reporting and cooperation with any investigations that arise.

Investigators shall be selected by their Line Manager and approved by the **Designated Competent Person** (DCP). The Line Manager shall complete the Suitability Assessment for Investigators form (SAF04F12) and Role and Conduct of Employees and Investigation Team Declaration (SAF04F18) and forward them to the **Training Coordinator**, who will arrange training following successful DCP approval, where applicable.

For further guidance about the role and conduct of employees and the investigation team, please refer to SAF04G06.

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The investigation team shall cooperate with the Investigation lead to achieve the objectives of the remit and shall not disclose any information to any other parties whilst the investigation is underway without the authority of the Investigation lead.

5.1.1 Employees / Contractors

Any **VR employee or sub-contractor** who sustains an injury from an accident at work or is involved in any of the events listed in SAF04G01 is responsible for reporting the event within two hours. For further details, refer to Section 5.2.

5.1.2 Line Managers

Line Managers are responsible for ensuring all staff under their area of responsibility are briefed on the requirements of this procedure. This should form part of the Company Induction process.

If there is a requirement to suspend any / all competence(s), then Line Managers should refer to SAF07 – Safety-Critical Certification Suspension, Withdrawal or Reinstatement.

For anyone affected by the SAF07 process, a care support programme will be initiated where there is reasonable evidence to indicate that this may impact the individual's performance or mental wellbeing. Implementing this programme will be the responsibility of the Line Manager, who is to liaise with the individual(s) regularly. How often this will happen will be determined by both parties.

The Line Manager will inform the individual(s) that any communications between them will be recorded using the Mental Wellbeing / Performance Review document (SAF04F19).

The Line Manager is responsible for forwarding completed copies of the Mental Wellbeing / Performance Review document to the Investigation lead. These will be stored securely in the post-incident file located in the investigation folder.

Where the programme is deemed insufficient in managing the individual's performance or mental wellbeing, the Line Manager will contact VR's Human Resources and Occupational Health department for further guidance.

This process can be utilised if witnesses have observed scenes described as being traumatic and can affect an individual's mental wellbeing or performance.

5.1.3 VolkerRail Control Centre

The **VRCC Duty Controllers** are responsible for the following:

- a) Recording an accurate and concise account of the event within the EcoOnline system
- b) Arranging assistance / support by initiating any specific emergency response procedures (i.e. Oil Spill response) as per SAF40 Appendix B
- c) Maintaining contact with the Site Supervisor or equivalent and H&S On-Call to ensure updates are received
- d) Escalation of information in line with the emergency command structure, client control centres and enforcing authorities
- e) Instigating actions as a result of the discovery of any protected sites and / or species during the work in line with VR Procedure ENV09.

5.1.4 Health & Safety / Quality / Environmental Advisors and Managers

The **Health & Safety / Quality / Environmental Advisors** and **Managers** are responsible for the following:

- a) Supporting the businesses with the investigation process
- b) Advising where specialist knowledge is required to support, i.e. ecologist, asbestos contractor
- c) Maintaining the EcoOnline system to close events
- d) Providing updates to the client within 24 hours in the format agreed with the client
- e) Ensuring the notification of RIDDOR events to the enforcing authority within the timescales required

5.1.5 Designated Competence Person (DCP)

For Level 1 Investigations, the DCP (L1DCP) will be:

- a) Head of H&S and Senior H&S Managers

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- b) Head of Quality Systems
- c) Head of Environment & Sustainability
- d) Discipline-specific Professional Head
- e) Or any of the above's nominated deputies (provided they meet the competency requirements for a DCP)

For Level 2 Investigations, the DCP (L2DCP) will be:

- a) HSQES Director
- b) Engineering Director
- c) Professional Head of Train Operations
- d) Alternatively, any of the above's nominated deputies (provided they meet the competency requirements for a DCP and with the authority of the HSQES Director)

The DCPs are responsible for the following:

- a) Issuing a remit (the investigation matrix in SAF04G04 offers guidance on what unplanned events require remits and Level 2 investigation)
- b) Managing and supporting the investigation process
- c) Appointing competent investigators to lead investigations
- d) Identifying the investigation team
- e) In conjunction with the Line Manager, taking the decision to suspend any / all competence(s) in line with the requirements of SAF07
- f) Liaising with the Client's DCP

5.1.6 Investigation lead

The Investigation lead is a competent person by virtue of their knowledge, expertise or experience appointed by the DCP to lead and manage the investigation.

They are responsible for the following:

- a) Nominating appropriate members to assist with the investigation process, including the collation of evidence and any other supporting information required
- b) Ensure investigation panel members have read and agreed to the Roles and Conduct of Employees and Investigation Team Guidance document (SAF04G06) by signing the Roles and Conduct of Employees and Investigation Team Declaration (SAF04F18) before engaging with the investigation. The document is to be submitted to the **Rail Investigation Administrator**
- c) Arranging meetings to review the draft investigation report with the panel members and any other interested persons and agreeing to the final content of the report
- d) Ensuring that the investigation achieves the requirements of the remit
- e) Recommending and agreeing with corrective actions, areas for improvement and other appropriate actions with the action owners
- f) Maintaining the original documentation that supports the investigation and EcoOnline system throughout the process and handing it over to the Rail Investigation Administrator once the report has been issued
- g) Verifying that the evidence provided to deem a corrective action or recommendation arising from the investigation as completed satisfies its intent. This will be managed through the EcoOnline system
- h) The Investigation lead must complete the Investigation Quality Checklist (SAF04F20) and email it to the **Rail Investigation Administrator** when the final report has been published. The **Rail Investigation Administrator** will upload all required information to the Microsoft Teams folder

5.1.7 Rail Investigation Administrator

The **Rail Investigation Administrator** is responsible for the following:

- a) Storing completed Roles and Conduct of Employees and Investigation Team documents within Microsoft Teams
- b) Monitoring the status of investigations and identifying any overdue timescales to the DCP, Director of Major Projects and Director of Specialist Businesses Supporting the Investigation leads with the administration of the investigation file
- c) Completing Fair Culture Tracker with the Investigation lead

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- d) Maintaining an Investigation filing system in conjunction with the EcoOnline log
- e) Entering Corrective Actions from Investigations to the EcoOnline system
- f) Producing reports and statistics for key performance indicators associated with the process.
- g) Checking that the required information is uploaded into Microsoft Teams before using the investigation quality checklist (SAF04F20) before further review is completed
- h) Distribution of the Investigation Reports, to individuals nominated by the Investigation lead. For Level 2 Investigations, as a minimum, this includes the HSQES Leadership Group

5.1.8 Data and Reporting Analyst

The **Data and Reporting Analyst** is responsible for the following:

- a) Managing the recording of events into SMIS in line with the Rail Industry Standard RIS-8047-TOM Reporting of Safety Related Information
- b) Assisting the Health & Safety, Quality or Environmental Advisors and Managers with the report to the Enforcing Authorities
- c) Preparation of data and analysis from the EcoOnline system to support the DCP Conference Calls and Rail Investigation meetings

5.1.9 IMS Coordinator

The **IMS Coordinator** is responsible for the following:

- a) Issuing a Flash Alert within 48 hours of a high potential event occurring based on the initial known facts that may require the business to take immediate actions, i.e. stop work / do something different
- b) Issuing a Shared Learning document based on the lessons learned from the investigation

5.2 Reporting Requirements

All accidents (including assaults), occupational ill health disorders / conditions, close calls, operational close calls, incidents and environmental incidents that occur on VR premises managed depots or involve VR employees, their contractors, members of the public and those within our undertaking must be reported to VRCC immediately by the person involved or the Site Manager / Site Supervisor.

The following details must be provided as a minimum:

- a) Date and time of the event
- b) VR business unit
- c) Project or contract name and number
- d) Location where the event has occurred
- e) Description of what has happened
- f) Any reported injuries or damage
- g) Immediate actions taken.

For complete guidance on the reporting of these events, refer to SAF04G01. This document also clarifies the escalation requirements where VR are or is not the Principal Contractor for the works related to the event.

5.2.1 Timescales

Immediately:

- Immediate response and preservation of evidence exercise instigated.
- Initial report to VRCC

Within two hours:

- Further updates provided to VRCC.
- VRCC to escalate to all interested parties (on-call, Network Rail SCO247, ORR, Regulatory Authorities, etc)
- VRCC to have completed the 'Initial Review' stage of EcoOnline.

For events that happen on a specific client infrastructure, refer to the relevant standards for reporting guidelines and requirements.

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5.2.2 Visits from Enforcing Agencies

All visits and communication (e.g. ORR, HSE, Environment Agency, Local Authority, police, etc) must be reported to VRCC. VRCC will record the necessary details required within the EcoOnline. VRCC will notify the HSQES Director.

5.3 Information Gathering

All business units and their associated projects must, on reporting an event, nominate a single point of contact to VRCC, who will be responsible for the facilitation of the preservation of evidence and confirming that the immediate actions required have been taken.

Evidence collection should be recorded using the initial Evidence Checklist (SAF04F17).

As a minimum, this will include:

- a) Photographs
- b) Witness accounts/statements
- c) List of persons present
- d) Sketch plan
- e) Perishable evidence

All items should remain in quarantine until the investigation is complete and an agreement has been reached with the Investigation lead to remove them from quarantine. Under no circumstances should items be removed/used during the investigation process and during quarantine.

Priority should be given to perishable evidence, interviewing personnel / obtaining statements using form SAF04F03, taking photographs and making sketches of the scene.

For OTM-related incidents, the OTM Crew Manager will complete an OTM Incident Report (SAF04F02) to serve as part of the information-gathering process and to establish any specific details relating to OTM incidents. This will be submitted to the OTM Business Manager for review within 24 hours of the incident occurring.

5.4 Agreeing the Level of Investigation

The level of investigation will be agreed after consultation with those detailed in paragraph 5.4.1 and using the event severity matrix as soon as possible.

5.4.1 Event Severity Matrix

The purpose of the event severity matrix is to determine the level of investigation required.

The process requires an element of judgment used by the DCP with input from the Professional Head and other key organisation members as deemed appropriate.

SAF04G04 provides guidance on how to rank events using the potential severity matrix facility in EcoOnline to help determine the actual and potential severity, the potential of the event reoccurring and the action that should be taken following such an event.

Using a combination of professional experience, historical knowledge of previous events, internal and external, an evaluation of the barriers that should have been in place, and an understanding of forthcoming work activities of a similar nature, the potential severity of the event may be increased.

Investigation Level
Low Potential – EcoOnline report only
Medium Potential – Level 1 investigation
High Potential – Level 2 investigation

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5.4.2 Initial Event Review

For any event identified as having an actual or potential severity rating of high, an initial event review must occur as soon as possible or within four hours after the event occurred. An initial event review will occur on Monday morning if the event occurred over the weekend. The initial event review aims to complete an early assessment of the event to capture the circumstances. At the same time, still recently, making sure that preservation of evidence on-site and off-site is being undertaken, the required immediate actions have been taken, and the next steps and resources required for the investigation. The initial event review must be recorded using the recording function within Microsoft Teams. The record of this call and SAF04F11 will form part of the evidence file.

The projects **H&S, Quality or Environmental Advisor / Manager** or relevant **Professional Head** will facilitate the call. It is mandatory that the **Project Manager**, a subject matter expert / **Professional Head**, Single Point of Contact, **VRCC Duty Manager, Training & Competence Manager** and others, as required, attend the initial event review. The structuring of the SAF04F11 must be followed, and the relevant sections must be completed.

5.4.3 DCP Call

Following the initial event review, if it is deemed that a DCP call is required, the call will take place as soon as possible (within 24 hours). Mandatory attendance will include the DCP, **Business Director, Business Lead, Head of H&S, Quality or Environment and Head of Performance Improvement and Strategy. The H&S, Quality or Environmental Advisor / Manager or Relevant Professional Head** will present the information from the initial event review at the DCP call and propose an investigation level and an investigation lead.

Additional information / evidence obtained between the initial event review and the DCP call will be discussed during the DCP call.

The items that will be discussed are:

- a) **Initial Findings** – identify what the initial findings are and what immediate corrective actions have been taken.
- b) **Immediate risk to business** – understanding the immediate risks to the business operations, employees or supply chain and agreeing on actions to restore normal working.
- c) **Cooperation** – Identify who VR will need to cooperate with to enable effective two-way communication and cooperation.
- d) **Communication needed:**
 - **Internal** – Agree if a Flash Alert needs to be issued (within 48 hours based on the initial known facts which may require the business to take immediate actions, i.e. stop work/do something different)
 - **Client** – Agree on how the client HSQES representative will be notified of the level of investigation, who is leading / should be the point of contact and potential interfaces required between VR and the client in order that the investigation can be completed in line with the agreed remit
 - **Industry / External / Enforcing Agency** – Agree if there are any legal reporting requirements and if urgent safety-related advice needs to be raised via the NIR3350 or NIR8250 system
 - **Level of Investigation** – Agree if the investigation will be a Level 1 for medium potential events or Level 2 for high potential events. Those on the call will identify the investigation lead and subject matter experts to support

5.4.4 Circumstances where a Level 2 Investigation may not be required:

There may be circumstances whereby the **HSQES Director**, in consultation with the enforcing authorities or Infrastructure Manager, determines that a Level 2 investigation is not required, providing that VR can demonstrate that:

- a) An external organisation's investigation will enable the Infrastructure Manager or VR to meet the objectives and purpose of this procedure
- b) A VR-led investigation would duplicate effort in terms of the investigation remit that has been set, the costs and the impact on individuals, which would exceed the benefits of a VR investigation.

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5.5 Investigation Report Templates
5.5.1 EcoOnline report

The EcoOnline system record will be used for events not requiring a level 1 investigation. It should be completed in full and finalised with any necessary details once the investigation is complete.

5.5.2 Level 1 Investigations

All Level 1 Investigations must be completed using SAF04F14.

5.5.3 Level 2 Investigations

All Level 2 Investigations must be completed using SAF04F06.

5.5.4 Network Rail Level 1 Investigations

Network Rail Level 1 Investigations must be completed using either the Network Rail Level 1 template or with prior agreement of the Network Rail DCP, VR's Level 1 SAF04F14.

For all Category 1, 2 and 3 environmental events the Network Rail Preliminary Report and Investigation Form (Level 1) NR2072P is to be used. If the event is a Category 4 (Negligible) environmental incident a Network Rail Level 1 template is not required. An EcoOnline report shall be issued instead to the client to correct any information provided within the first 2-hour reporting process. Refer to SAF04G01e for guidance on the classification of environmental incidents.

5.5.5 Use of other clients, joint ventures or alliance templates.

Other Clients, Joint Ventures or Alliance templates may be used, providing that they provide VR with the same level of information that is contained in the EcoOnline system and investigation reports.

5.6 Investigation Timescales

The following table gives an outline for the investigation team to follow to ensure timely completion of the investigation. There may be deviation depending on influencing factors that are specific to each investigation in all cases should be agreed with the DCP.

For Network Rail Investigations, the timescales are per the current standard requirements, nationally and locally. However, the requirements to update the EcoOnline system are the same.

Action	Action Owner	Level 1 Target Date	Level 2 Target Date
Quarantine plant/equipment	Investigation lead	Incident + 0 day	Incident + 0 day
Conduct Initial Event Review Call	H&S, Quality or Environmental Advisor / Manager or relevant Professional Head	Incident + 4 hours	Incident + 4 hours
Conduct a DCP Conference Call	DCP	N/A	Initial Event Review + 24 hours
Obtain VRCC voice-tapes	VRCC Duty Manager	Incident + 1 day	Incident + 1 day
Visit accident/incident site (record / collect evidence if site visit not already completed)	Investigation team	Incident + 2 days	Incident + 2 days
Issue Initial Flash Alert – (<i>What we know – What are the immediate actions</i>)(where applicable)	Investigation lead	Incident + 2 days	Incident + 2 days
Set dates for interviews.	Investigation team	Incident + 3 days	Incident + 5 days

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Action	Action Owner	Level 1 Target Date	Level 2 Target Date
Gather, review and analyse evidence: <i>interviews, statements, site paperwork, competencies, photographs, laboratory test results, procedures, standards, D&A screening results, etc.</i>	Investigation team	Incident + 5 days	Incident + 7 days
Review/transcribe interview voice recordings with evidence.	Investigation team	Incident + 6 days	Incident + 9 days
Draft STEP/Causal Analysis	Investigation team	Incident + 7 days	Incident + 16 days
Draft Barrier Analysis	Investigation team	Incident + 9 days	Incident + 18 days
Draft investigation report	Investigation lead	Incident + 12 days	Incident + 21 days
Issue draft investigation report, STEP, Causal and/or Barrier Analysis for DCP review	Investigation lead	Incident + 14 days	Incident + 28 days
Consult with the Fair Culture Panel	Investigation lead	Incident + 16 days	Incident + 32 days
Consult with action owners to agree on corrective actions	Investigation lead	Incident + 18 days	Incident + 35 days
Review period for draft investigation report comments/feedback	Investigation team, Directors and DCP	Incident + 21 days	Incident + 42 days
Inform the client of any known delays that may impact meeting the required timescales for submitting the final report.	Investigation lead	Incident + 21 days	Incident + 42 days
Finalise investigation report and appendices and issue for signature (Discuss with DCP whether Share Learning is required)	Investigation lead	Incident + 24 days	Incident + 49 days
Issue final investigation report and Appendices B to Rail Administrator.	Investigation lead	Incident + 27 days	Incident + 55 days
Distribute Shared Learning and investigation reports.	Rail Investigation Administrator	Incident + 28 days	Incident + 56 days
Transfer investigation files to EcoOnline and update analysis fields	Rail Investigation Administrator	Report Issue + 2 days	Report Issue + 2 days
If DCP mandates Shared Learning, issue to the IMS Coordinator for publication	Investigation lead	Report Issue + 7 days	Report Issue + 7 days

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Action	Action Owner	Level 1 Target Date	Level 2 Target Date
Review of effectiveness of Corrective Actions	Investigation lead	Determined by DCP	Determined by DCP

5.6.1 Extension of Investigation Targets

If the investigation is found to be complex and there is a risk of the investigation taking longer, for reasons such as critical witnesses not being available, then the Investigation lead should approach the DCP as soon as it is known an extension may be required, who will consider an extension of time as appropriate. This should be communicated and agreed upon with the relevant client representative as appropriate by the Investigation lead.

Investigation trackers will be managed and reviewed weekly, identifying the events that have exceeded the investigation timescales. The **Rail Investigation Administrator** will provide this information to the DCPs and Business Leads for discussion with Investigation leads.

5.7 Undertaking the Investigation

5.7.1 Appointing an Investigation lead

An Investigation lead will be appointed, who, wherever possible, will be independent of the project involved in the circumstances being investigated and must not have any direct line management responsibility for the staff, contractors or equipment involved in the event to be investigated.

The **DCP** must be satisfied that the person is considered competent to:

- Conduct the investigation or have access to competent technical advice on those aspects outside their technical competence
- Identify safety matters which justify urgent action before the investigation report is completed
- Identify the need for corrective actions / areas for improvement
- Are experienced and competent in accident / incident investigation

5.7.2 Level 2 Investigation Remits

The L2DCP will agree the objectives and timescales of the Level 2 investigation within 48 hours and document this using SAF04F04.

On agreement of the remit, the Investigation lead shall:

- Inform the investigation panel members of the requirement to assist with the investigation process, including the collation of evidence and any other supporting information required. The panel members must be competent in conducting the investigation and what is being investigated
- Arrange a briefing of the investigation objectives to the investigation panel and actions needed

5.7.3 Investigation Team

All investigation teams will consist of the following as a minimum where possible:

- An Investigation lead
- A Health & Safety, Quality or Environmental / Sustainability Advisor / Manager
- A Safety Representative
- A Behavioural Safety Coach
- A subject matter expert (SME) (see SAF04G12 for guidance)

5.7.4 The Investigation lead may seek support from specialist / technical advisors when it is considered that such expertise will assist the investigation. Before any member can participate in the investigation, they must complete the Roles and Conduct of Employees and Investigation Team document. The Investigation lead will control this process and submit the completed document to the **Rail Investigation Administrator**.

5.7.5 Gathering of Information and Evidence

Initial information and evidence to support the investigation will have been gathered by the nominated single point of contact on SAF0406 Appendix D. The Investigation lead will be required to collate further information and evidence which may be available from various sources.

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Examples of evidence / information includes:

- Photographs
- Sketches
- Environmental information
- Description of the work activities
- Machinery / equipment data
- Voice tapes
- CCTV
- Documentation
- Witness statements
- Interviews

5.7.6 Safety Critical Communications

The investigation team shall review the appropriate safety critical communications in compliance with VR's Management of Safety Critical Communications SAF13 procedure, section 5.5.2 (located in the Operational Communications basket on the IMS). The communications review shall be done using Appendix C's Rating of Spoken Communications guidance table.

5.7.7 Witness Statements

Witness statements should be completed immediately after the event using the form SAF04F03.

The nominated Single Point Of Contact will ensure, where possible, that witness statements are completed by all persons involved or who witnessed the event.

5.7.8 Interviews

The Investigation lead / investigation team should develop and use questions in the initial interviews that consider the Capability, Opportunity, and Motivation of all those involved in the event to understand the contribution of human performance. Guidance on this is provided in the Human Factors for Investigations Guidance Document (SAF04G11).

Interviews should be completed as soon as possible within the investigation process. The investigation team will interview the "eye-ear witnesses" (people who have seen or heard the events) and others.

Eyewitnesses may be the best or only source of information for determining the sequence of events. Information gathered should be used to produce a timeline and create a chronological order of events.

The mental state of the witnesses concerning critical accident stress should be considered as they may be in shock or traumatised following the event.

Interviews need to be conducted in a quiet, private, comfortable location free of disruption. The interview evidence should be used to inform the sequence of events. SAF04F03 should be used to capture the information given by the witnesses. Interview notes taken by the investigation team should be used to develop the analysis/sequence of events and kept for the evidence file.

Wherever possible, all interviews should be recorded using an audio device such as a Dictaphone or recorded over Microsoft Team and transcribed and used as evidence for the investigation file. This will support the interview process and ensure a more relaxed and natural environment. All recorded interviews will be protected and not shared outside of the investigation team.

Once the sequence of events has been established, it may be necessary to contact witnesses to ask follow-up questions.

See section 1.4 of SAF04G01 for information on home visits that may be required to gather information and/or witness statements.

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5.7.9 Information Gathering and Investigation File

For all levels of investigation, the investigation team will commence the collection of information / evidence using the agreed folder structure. Personal data collection will require the completion of an Internal Data Request form (SAF04F15).

Microsoft Teams will be used to store information and evidence whilst the investigation is ongoing, and permissions restricted to the investigation team plus those who support the administration of investigations. The filing system is structured so that the investigation team can ensure that all necessary evidence is collected and collated in an organised way using the evidence log.

5.7.10 Order and Analyse Information and Evidence (Ref: ISO 45001, A.10.2, A.10.3, A.9.3, RM3 – MRA3, MRA 5)

Many tools and techniques can be used to order and analyse the information / evidence supporting the causal analysis process and developing effective corrective actions.

Where possible, and following a suitable and sufficient risk assessment, the investigation team should undertake a re-enactment of the event or take an opportunity to observe the same activity to better understand the environment, conditions, and work factors involved. Frodingham Depot and J3 OLE training span can be used to carry out the re-enactment in a safe and controlled environment.

The STEP and Barrier Analysis models are the preferred methods to be used for internal investigations. These methods are mandated for Level 2 Investigations unless otherwise agreed with the DCP. For Level 1 Investigations, the method for determining the root cause(s) as applicable will be agreed with the LIDCP.

The STEP will provide a chronological narrative of the incident, evidence (with number references) to support the individual events leading up to the incident, and the safety factors / areas for improvement. The safety factors / areas for improvement are then assessed using the barrier analysis (SAF04F06 Appendix I).

The barrier analysis is used to determine the effectiveness of each barrier and, in particular, to ascertain if it was active if it failed, and if so, how / why it failed.

The completed barrier analysis is used to develop the corrective actions.

Other recognised methods for causal analysis include.

- Five Whys
- Causal Tree / Cause and Effect Analysis
- Fault Tree Analysis (FTA).

5.7.11 Human Factors

Human performance analysis is completed using the Capability, Opportunity, Motivation (COM- B) method to understand the existing / current behaviours better and identify the changes needed to achieve the target behaviours.

Investigations may be complex, and evidence may not be available. Where it is not possible to fully evidence a finding / area of conflict, the available findings will be reviewed by the investigation team and subject specialists, where necessary. A 'considered view' will be agreed upon by the team, and the team's opinion will be recorded in the report as the considered opinion rather than a factual finding based on the evidence in place.

The Human Factors for Investigations Guidance Document (SAF04G11) provides guidance on applying human factors in investigations.

Upon completion of this analysis, the incident's immediate, underlying and root causes are identified. If human factors are considered a contributory factor, then this must be addressed by a corrective action.

5.8 Lifesaving Rules and Fair Culture

There is a clear system to recognise behaviour around the Lifesaving Rules, whether rewarding positive actions or responding to breaches fairly.

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For all investigations, VR will use the 'Guide to Using the Fair Culture Model' SAF04G07 to assess any breaches of the health and safety policies, procedures or rules, including Lifesaving Rules, to establish a root cause for those breaches and respond fairly.

The Fair Culture Model (FCM) shall be used for all individuals or groups of individuals/teams involved. Where more than one person is involved, working through the FCM for each person will be necessary. However, to determine the outcome of the FCM, the COM-B analysis model must be completed to analyse the human behaviours.

The consequence matrix within SAF04G07 will guide the investigation team in determining appropriate actions based on the investigation findings.

For all Level 2 Investigations, a Fair Culture Panel will be formed to undertake a review of the outcome of the FCM to ensure a consistent approach. The Fair Culture Panel will be determined by the L2DCP and detailed in the Level 2 Investigation Remit (SAF04F04).

As a minimum, this will include the following:

- L2DCP
- Investigation lead
- Training and Competence Manager
- Safety Representative

For all other investigations, the Investigation lead must undertake a review of the outcome of the FCM with the L1DCP and investigation panel members to ensure a consistent approach.

All outcomes will be seen as an opportunity for organisational learning and the promotion of a fair culture.

5.8.1 Consequences for error and violation

Where the FCM analysis has identified human error or violation, the investigation team will discuss the report findings to ensure suitable corrective actions are put forward in line with SAF04G07. The Investigation lead is responsible for ensuring that HR is provided with all the evidence and information required to adequately discharge their duties without HR needing to undertake any further investigation(s). The information provided by the Investigation lead will give HR adequate and unambiguous justification for the action that must be taken.

Wording for the investigation reports corrective action will be as follows:

"As a result of this investigation, and in line with the FCM analysis, this investigation recommends that the individual is subject to [the appropriate Company's HR Procedures/a programme of re-training/re-assessment /etc."

5.8.2 Breaches Of The Sentinel Scheme Rules

Primary Sponsors cannot de-sponsor an individual following an allegation of a breach of the Sentinel Scheme Rules until the investigation has been concluded and, if applicable, a Scheme Outcome has been requested and applied. If there is an alleged breach of the Sentinel Scheme Rules at the outset of an investigation, the **Training & Competence Manager** shall suspend the associated competence(s) on Sentinel. If there is a requirement to suspend any / all competence(s), then Line Managers should refer to SAF07 Safety-Critical Certification Suspension, Withdrawal or Reinstatement.

The initial event review must determine if a Takedown (temporary suspension) is required depending on the severity of the allegation whilst the investigation is taking place. Where a takedown is deemed appropriate, the individual's Line Manager must be consulted with the VR **Training & Competence Manager**, who will then apply the takedown on Sentinel.

If it is identified through the course of the investigation that a Sentinel Scheme Rule breach has occurred, it is the responsibility of the Investigation lead to inform the DCP and **Training & Competence Manager** so that further consideration can be given to competence suspension / takedown.

Upon completion of the investigation, the application of the Fair Culture Analysis Model shall be used for the individual or any other parties found to be involved in a Sentinel Scheme Rules breach.

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The VR **Training & Competence Manager** must be informed where corrective actions have identified a Sentinel Scheme outcome (refer to CMS06 - Sentinel Sponsorship Arrangements).

Where outcome of the Fair culture analysis has determined an outcome of contravention or reckless contravention, the Sentinel Investigation team will then be notified by the **Training & Competence Manger** so that so that they can carry out a Formal Review of the Sponsor's investigation. It must be noted that the Formal Review will look at the investigation as a whole and may identify further Sentinel Scheme Rule breaches. The Sponsor shall be advised in writing of the outcome of the Formal Review within 30 days.

If the individual is an employee of an external organisation (agency, JV or Alliance), the Investigation lead must inform them of the investigation findings. Where the fair culture analysis is deemed to be a contravention or reckless contravention for an individual not sponsored by VR, the Primary Sponsor is responsible for making the request to the Sentinel Investigation Team. The Investigation lead is to provide a copy of the investigation report to the **Training & Competence Manager** who will forward a copy of the report to the Sentinel Investigation Team.

5.8.3 Recognising positive behaviour around the Lifesaving Rules

Where the FCM analysis identifies an individual has carried out a positive intervention or has behaved positively around the Lifesaving Rules with regards to safe working practices, which has reduced the risk of human error or adverse situations, then the investigation report will ensure recognition is given by the individual(s) Line Manager.

Examples of positive recognition could be in the following ways:

Nomination for an AIM Award

- a) Formal praise is given to the individual(s), which is briefed to the company as a positive intervention.
- b) Individual receives positive performance appraisal through their PDR
- c) Individual is given the opportunity to coach others on safe behaviours
- d) Recognise the supervisor/manager if their positive behaviours have contributed to the individual/team's safe actions/interventions

5.9 Corrective Actions (Ref: ISO 45001 – A.10.2, A.10.3) (RM3 – MRA 3, MRA 5)

5.9.1 Identifying and Agreeing

Corrective actions are mandatory and directly relate to the event. They are required to address failings that led to root cause(s) and will be detailed in the investigation report.

Corrective actions should be developed based on the completed barrier analysis, which provides information on why the barrier failed or was not used at the event.

Corrective actions must be written clearly and structured in such a way as to include the following principles:

- a) Detail the issue / investigation finding being addressed (multiple investigation findings can be incorporated into one action where possible)
- b) Be clear on the intent of the corrective action
- c) Be specific but not prescriptive in terms of the corrective action requirements for the action owner to effectively manage a positive outcome

Corrective actions must follow the SMART principle:

- a) **S**pecific targets a specific area for improvement
- b) **M**easurable quantifies or at least suggests an indicator of progress/success
- c) **A**chievable has been agreed, is aligned with specific goals and specifies who will do it
- d) **R**elevant is specific to the investigation findings that need to be addressed
- e) **T**ime-bound specify when the result(s) can be achieved

The investigation team will manage these unintended consequences when developing corrective actions, ensuring a complete analysis of existing risk assessments, company and industry standards and processes. This will ensure the action is SMART and does not have a negative impact.

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The action and its timescale must be discussed and agreed upon with the person to whom it will be assigned to before the report is signed off.

Progress against allocated corrective actions will be monitored by the Investigation lead, who will check the validity of evidence received before closing the action. Evidence should be relevant to the corrective action and confirm that the required improvement has been achieved. The evidence required should be agreed with the action owner when the corrective action is allocated.

Corrective actions will be categorised (aligned to RM3) to enable further analysis at the Learning from Investigations quarterly review steering group meetings. The system for checking the effectiveness of Corrective Actions will be determined during these meetings and incorporated into the Internal Audit Plan.

Following the identification of root causes and application of the 'Fair Culture' model, corrective actions will be agreed and documented within the investigation report.

Investigations can identify areas of concern, an event, or a condition that increases the risk of an accident / incident in the future or highlight areas for improvement. These factors would not necessarily have contributed to the event being analysed. Addressing these through the investigation is still important to the business to ensure continual improvement and learning. These should be recorded in SAF04F06 Appendix H - Other Non-Contributory Issues Identified. Appendix H is not submitted externally with the investigation report but will be used internally within the business, and these will be tracked as a corrective action on EcoOnline.

5.9.2 Effectiveness review

A corrective action selected as requiring an effectiveness review must align with one of the provided categories. This evaluation must entail consultation with the investigation panel, the DCP and the relevant stakeholder overseeing the corrective action.

Effectiveness review categories

- a) A change in a standard, rule, process or procedure
- b) Amendment in operational or maintenance practices
- c) Modifications to infrastructure or equipment
- d) Changes to the specification, procurement, design, testing and/or commissioning of new infrastructure or equipment
- e) A coordination of activities that aims to get individuals to change their behaviour differently from how they would have acted without such action

If it has been determined that an effective review is required, the corrective action within the investigation report will be identified and tracked on EcoOnline. The investigation team should use VR Procedure SAF09 – Validation of Change to Organisation or Integrated Management System should they meet the category requirements; this must be discussed with the DCP. Before an effectiveness review occurs, the specified corrective action must be closed out.

The Investigation lead is responsible for conducting an assurance check on the selected corrective action(s), observing the effectiveness of its implementation and embedment with an understanding of its intent. A quality assurance professional and / or a subject matter expert will support the Investigation lead during this process by advising them on whether the sampling of evidence is sufficient to satisfy the description of the corrective action's intention. All associated evidence of the assurance check will be retained on EcoOnline.

If the corrective action falls short of its required intention or has not been implemented, the corrective action owner must be consulted and a Non-Conformance will be raised on EcoOnline.

The Investigation lead and the accountable person for the corrective action will present their findings at the quarterly investigation review. Depending on the findings of the effectiveness of the corrective action, a further follow up may be required to monitor its complete effectiveness to support the attainment of the corrective action objective. This ensures that the learning process and its principles are fully embedded. The review panel will determine this and will be tracked through EcoOnline from the outputs of the quarterly investigation review meeting minutes.

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Examples of evaluating the embedment of corrective action:

- a) Site observations
- b) Discussions
- c) Desktop sampling of inspections and reporting systems

5.9.3 Recording and Monitoring (Ref: ISO 45001 - A.10.1)

The **Rail Investigation Administrator** is responsible for ensuring all actions arising from any level of investigation are added to the EcoOnline event via the 'add action' section and assigned to the action owner.

The assigned action owner is responsible for ensuring that the actions are completed in line with the agreed target dates and providing relevant evidence for uploading onto EcoOnline. Where actions cannot be completed in the agreed timescales, the assigned action owner should contact the Investigation lead to agree whether the action date can be extended. The Investigation lead shall ensure that the EcoOnline entry is updated accordingly.

The Investigation lead will determine the corrective actions category within the investigation report. They will be categorised in alignment with the RM3 Criteria. This will support further analysis of causes from investigations within the quarterly investigation review meetings and our monitoring, audit, and review process for RM3 assessments.

The Investigation lead will be noted as the 'Verifier' of investigation actions on EcoOnline and will be responsible for reviewing the evidence submitted and 'Verify' (close) the action, where applicable.

The Monthly HSQES Reporting Pack details all ongoing and overdue corrective actions. The EcoOnline system dashboards detailing this information in 'real-time' have also been made available to all General Managers and Business Directors. The status of actions is discussed at the monthly HSQES Leadership group meetings, and the effectiveness of actions will be included in the Learning from Investigations quarterly review meetings.

5.10 Learning (Ref: ISO 45001 – A.10.2, A.10.3, A.9.3) (RM3 – MRA 3, MRA 4, MRA 5)

A shared learning document, SAF04F10, will be produced for investigation reports if determined necessary by the DCP. Determining whether a shared learning document is needed will depend on the significance of the event and its findings.

To monitor the effectiveness of investigations, a quarterly review will be undertaken. The review is a workshop environment where the trained investigators go through their reports and supporting information with the group in a supportive and learning environment. The HSQES Director will lead the review with the assistance of the Investigation lead to ensure constructive feedback with improvement opportunities highlighted for all investigators to learn from and recognise and promote good practices. Additionally, the workshops will review investigation corrective actions, discussing the progress of them being embedded within the organisation and the effectiveness of the actions.

5.11 Acceptance for Issue

Once it has been agreed that the objectives of the investigation have been met, a root cause identified, SMART corrective actions agreed with the action owner(s) and the panel/signatories are in complete agreement with the content, the report should be forwarded to the DCP for review.

The **DCP** will ensure a meeting is conducted for the investigation panel/team to review and finalise the investigation report and agree SMART corrective actions with the action owners. This can be done face to face, through Microsoft TEAMS or conference calls.

The content will be reviewed and either accepted or where the report is rejected, the **DCP** will explain/provide comments and further action needed. The Investigation lead will resubmit to the **DCP** when the comments have been addressed.

5.12 Issue of the Report

The DCP will sign the investigation report for accepting the completion of the report.

The report should only be issued once:

- a) The review of content and acceptance for issue process is complete
- b) Appendix B is received with the investigation report to allow corrective actions to be issued through EcoOnline

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The **Rail Investigation Administrator** is responsible for distributing Level 1 and Level 2 Investigation Reports.

As a minimum, the distribution of Level 2 Investigation reports will be as follows:

- General Manager / Business Lead
- Business Director
- Project Manager
- Safety Representative
- Behavioural Coach
- Corrective Action Owners
- Health & Safety, Quality and/or Environment Advisor / Manager
- Client representative, as advised by the DCP
- Attendees of the DCP call

The Investigation lead will determine the distribution list for Level 1 Investigation reports.

5.13 Records

5.13.1 Accident Book

Under the requirements of The Social Security (Claims and Payments) Regulations, employers must keep an accident book, which must be kept readily available. All records associated with accidents are held and maintained within the EcoOnline system.

5.13.2 Investigation Forms, Evidence, Correspondence

To ensure the investigation files is collated in an organised way, the **Rail Investigation Administrator** will set up an investigation filing area within Microsoft Teams following the DCP call using the template detailed within SAF04G05. Access will be granted to the Investigation lead and investigation team.

The Investigation lead is responsible for maintaining records associated with the investigation whilst it is in progress on the Teams channel. On completion of the investigation, the **Rail Investigation Administrator** will transfer the investigation records and evidence to EcoOnline.

All final records will be held on EcoOnline. Hard copies must be passed to the **IMS Coordinator** once the report has been issued for retention in line with the VR Document Retention Schedule QUA10.

5.14 Reporting to Other Interested Parties and into Systems

5.14.1 Statutory Reporting and Enforcing Authorities

A matrix of events that require reporting to the Enforcing Authorities and their timescales is held by VRCC.

Guidance on whether or not an accident or incident is reportable under the relevant regulations should be obtained from a **H&S or Environmental Advisor or Manager** and/or the **HSQES Director**.

The **H&S Advisor / Manager** is responsible for providing written reports using the Enforcing Authorities approved forms within the timescales required.

The **H&S Manager** will report any Occupational Health related reports, i.e. cases of disease, to the ORR or HSE. All copies of escalation records must be filed with the EcoOnline event log.

5.14.2 RSSB Safety Management Intelligence System

The **Data and Reporting Analyst** is responsible for inputting events into the Safety Management Intelligence System (SMIS) as required by Railway Group Standards.

5.14.3 Network Rail

The **VRCC Duty Controller** is responsible for ensuring that all accidents, incidents, road traffic collisions and operational close calls on Network Rail Infrastructure or Projects are reported to Network Rail SCO/247 within two hours and then subsequently entered into i-tracker within 24 hours.

The **VRCC Duty Controller** must obtain and record all Network Rail reference numbers within the EcoOnline log.

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5.14.4 British Transport Police

The British Transport Police serve the railway environment and its community. This covers the tracks, stations, trains and all related rail infrastructure across England, Scotland and Wales. It also covers the London Underground system, Docklands Light Railway, the Midland Metro tram system, Croydon Tramlink, Sunderland Metro and the Glasgow Subway.

The following circumstances must be reported to VRCC, who will notify the British Transport Police. The **VRCC Duty Controller** must obtain and record a reference number within the EcoOnline log.

- Littering
- Menacing groups
- Suspicious vehicles, packages or items
- Threatening or abusive behaviour (this includes rowdy, noisy or drunken behaviour, offensive or threatening language)
- Vandalism.

The **Environmental Manager / Advisor**, in agreement with the client's representative, Natural England, Countryside Council for Wales or NatureScot, will notify the police wildlife crime unit of any potential wildlife crime.

5.15 Legal Professional Privilege

Legal Professional Privilege ('LPP') is a right which protects communication between a party, their lawyers, and sometimes third parties from disclosure to other parties (such as prosecuting public bodies) as long as certain circumstances are met. There are two types of LPP: litigation privilege and legal advice privilege.

5.15.1 Litigation Privilege

Litigation privilege covers discussions carried out in contemplation of litigation, whether currently ongoing or anticipated and can cover communications between solicitor and client as well as communications with third parties.

Litigation privilege does not apply to documents created in anticipation of an investigation. There needs to be reasonable contemplation of litigation, i.e. prosecution or the filing of a case at court, for litigation privilege to apply to communications between lawyers, clients and third parties.

5.15.2 Legal Advice Privilege

Legal advice privilege is confined specifically to communications between lawyer and client, and those communications must be for the purposes of giving or receiving legal advice.

Legal advice privilege does not apply to records of an internal investigation, as those records will not be for the purposes of giving or receiving legal advice.

Copies of any documents should not be issued to any third party without authorisation from **HSQES Director**.

5.16 Rail Industry 10 Incident Factors

For investigations where an event has involved VR operating as a 'Railway Undertaking' (as defined by ROGs), the Rail Industry 10 Incident Factors, as required by Industry Standards, are required to be inputted to SMIS.

After completing the investigation, the **Professional Head of Train Operations**, with support from the **Performance & Improvement Manager**, will ensure that the Human Performance Factor sections of the SMIS record are updated.

5.17 Inquests

Any requests for attendance as a witness at a coroner's inquest should be forwarded to the **HSQES Director**.

5.18 Training and Assessment

A five-day IOSH accredited Rail Incident investigation training course will be provided for all individuals responsible for undertaking investigations, as determined by the business / project competence profile. The training will be held over five days and will require an end of course assessment and completion of an investigation report to gain the qualification, with a validity of three years.

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An annual technical skills workshop will be provided for all certified Incident Investigators. The workshop content will be based on best practice changes and evidence from completed investigations.

The quarterly review (SAF04G09) is used to assess the quality and consistency of completed incident reports and supports ongoing learning from the 'peer review' process.

A one-day IOSH accredited refresher course will take place every three years. In addition to the five-day course, a one-day IOSH accredited Rail Incident Investigation Awareness Course will be available for all identified as Single Point Of Contact for events and those undertaking Network Rail Level 1 investigations and 'on-call' duties. The course includes a summary of both the incident investigation process, with a focus on the information-gathering stage, and the application of this procedure.

6. ASSOCIATED GUIDANCE & INFORMATION

- SAF04G01 - Reporting Guidance
- SAF04G01a - Accidents and Assaults Reporting Guidance
- SAF04G01b - Operational Close Calls & Incidents Reporting Guidance
- SAF04G01c - Close Call Reporting Guidance
- SAF04G01d - Design Close Call Reporting Guidance
- SAF04G01e - Environmental Reporting Guidance
- SAF04G01f - Road Traffic Collision Reporting Guidance
- SAF04G01g - PC and non-PC Reporting Guidance
- SAF04G02 - Reporting and Investigation Flowchart
- SAF04G04 - Use of the Event Severity Matrix to Determine Level of Investigation
- SAF04G05 - Investigation File Guidance
- SAF04G06 - Role and Conduct of Employees and Investigation Team
- SAF04G07 - Network Rail - A Guide to Using the Fair Culture Model
- SAF04G09 - Terms of Reference - Learning from Investigations - Quarterly Review
- SAF04G10 - Investigation Reporting Guidance
- SAF04G11 - Human Factors for Investigations Guidance
- SAF04G12 - VR Subject Matter Expert Directory

7. DOCUMENTATION (OUTPUTS)

- SAF04F02 - OTM Incident Interim Report Form
- SAF04F03 - Personal Account Statement
- SAF04F04 - Level 2 Investigation Remit
- SAF04F06 - Level 2 Investigation Report
- SAF04F10 - Investigation Summary / Shared Learning
- SAF04F11 - High Potential Event – Initial Event Review - DCP Conference Call
- SAF04F12 - Suitability Assessment for Investigators
- SAF04F14 - Level 1 Investigation Report
- SAF04F15 - Internal Data Request form
- SAF04F17 - Evidence Checklist
- SAF04F18 - Role and Conduct of Employees and Investigation Team Declaration
- SAF04F19 - Mental Wellbeing / Performance Review
- SAF04F20 - Investigation Quality Checklist

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Appendices to SAF04F06 – Investigation Report

- Appendix A – Role and Conduct of Employees and Investigation Team
- Appendix B – List of Sensitive Data
- Appendix D – Evidence List
- Appendix E – Causal Analysis
- Appendix F – Distribution
- Appendix G – Fair Culture Analysis Model Flowchart
- Appendix H – Other Non-Contributory Issues Identified
- Appendix I – Barrier Analysis

8. ISSUE RECORD

Issue	Date	Comments
1	09/11/2012	<p>The procedure has undergone a significant review and has been completely rewritten. A summary of the fundamental changes are below:</p> <ul style="list-style-type: none"> • Replaces SQE/04, SQE/04a, SQE/05 • Level 1, 2 and 3 investigation structures were removed. • Section 6.7 - Introduces an interim report form to effectively document the event's review and further actions without having to investigate. • Introduction of new forms for consistency - service damage information gathering, investigation information gathering, investigation template, OTM Incident Form recognised in procedure and assigned form number • Section 6.11.8 - Introduction of the 'Just Culture' approach
2	23/01/2014	<p>The procedure has undergone an annual review to ensure it remains effective. Various paragraphs have been amended:</p> <ul style="list-style-type: none"> • Section 6.1 Responsibilities, Section 6.2 Reporting General Requirements, Section 6.6 Statutory Reporting, Section 6.7 Industry Reporting / Other Interfaces, Section 6.8 Local Investigation, Section 6.9 Fleet and Road Safety Investigation, Section 6.10 Formal Investigation, Section 6.11 Undertaking the Formal Investigation, <p>The following forms have been amended/added:</p> <ul style="list-style-type: none"> • Form SAF04F01 – renamed Local Investigation Form • Form SAF04F03 - service damage information form details removed and will be captured in EcoOnline. Content replaced by 'Witness Report Form.' • Form SAF04F04 – renamed Formal Investigation Remit • Form SAF04F06 – renamed Formal Investigation Template • Form SAF04F07 – new form - Fleet and Road Safety Investigation Form
3	26/03/2019	Complete re-write of the whole procedure.
4	05/02/2020	<p>Update to various sections of the procedure (5.1.2, 5.1.3, 5.1.6, 5.1.7, 5.1.9, 5.2.1, 5.2.3, 5.3, 5.4.1, 5.4.2, 5.10, 5.10.1)</p> <p>Update to guidance (SAF04G01, SAF04G03, SAF04G04, SAF04G09)</p> <p>Amendment to various sections throughout SAF04F06 and SAF04F11</p> <p>Withdrawal of SAF04F07</p>

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Issue	Date	Comments
5	28/10/2021	Various amendments to the procedure, including Rail Industry 10 Incident Factors, COM-B and corrective action categories aligned with RM3. Introduction of Flash Report. Airswab was renamed as EcoOnline throughout. Withdrawal of forms: SAF04F01, SAF04F13. New forms: SAF04F14, F15, F16 and F17.
6	16/01/2024	<p>Update to various sections of the procedure. Local re-named as Level 1 and Formal renamed as level 2 investigations throughout. Lead Investigator changed to Investigation Lead throughout.</p> <p>New Guidance: SAF04G11 - Human Factors for Investigations Guidance and SAF04G12 – VR Subject Matter Expert Directory.</p> <p>New forms: SAF04F18 - Role and Conduct of Employees and Investigation Team Declaration, SAF04F19 - Mental Wellbeing / Performance Review, SAF04F20 – Investigation Quality Checklist</p> <p>Withdrawn Guidance: SAF04G08 – Use of Conferencing facility.</p> <p>Withdrawn Appendix: SAF04F06 Appendix J – 5 Why’s Causal Analysis Diagram</p> <p>Withdrawn form: SAF04F16 – Network Rail Level 1 Investigation Report</p>

9. WHAT HAS CHANGED IN THIS LATEST ISSUE AND WHY?

- Updates in this revision included amendments to definitions for design close calls definitions and the inclusion of probable and possible within section 4
- Section 4 updates also include Local Investigations being renamed as Level 1’s and Formals as Level 2’s
- Section 5.1.2 outlines line managers expectations when dealing with anyone who has been affected by the SAF07 process and where there is reasonable evidence to indicate that this may impact individual's performance or mental wellbeing
- Section 5.1.5 now includes Head of Health & Safety and Senior Health & Safety Managers who can act as Designated Competent Person for local investigations
- Updates to section 5.1.6 include completion of the Roles and Conduct of Employees and Investigation Team document and completing the Investigation Quality Checklist before publishing the final investigation report. The Rail Investigation Administrator is responsible for checking that the required investigation information is uploaded into Microsoft Teams before publishing the final investigation report
- Sections 5.4.2 and 5.4.3 explains the timescales and mandatory attendees for Initial Event Reviews and the DCP call process. Additional stage gates have been included within the investigation timescales
- The investigation team is to review safety critical communications in compliance with VR’s Management of Safety Critical Communications SAF13 procedure
- Updates to section 5.7.7 discusses the inclusion of Capability, Opportunity, and Motivation to understand the contribution of human performance during the interviewing process
- Section 5.7.10 provides guidance on investigating Human Factors
- Events of a similar character have been included in section 5.8 to analyse underlying and root causes and test the effectiveness of previous corrective actions
- Updates to section 5.9 explains the fair culture panel process and who should be included
- Section 5.9.3 includes Sentinel Scheme Rules and who is responsible for managing the process
- Within section 5.10, any referencing to areas of improvement has been replaced with corrective actions
- Section 5.10.2 includes the criteria of how to determine if a corrective action is warranted an effectiveness review and how the embedment would be measured
- Contained within section 5.11 is the investigation quarterly review workshop, which discusses its purpose and how it should be carried out
- Updates to 5.13 include responsibilities of issuing completed investigation reports
- SAF04F02 OTM Incident Interim Report Form has been amended to remove the assessment of incident

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severity / environmental classification and level of investigation which is covered sufficiently under Section 5.4 Agreeing the Level of Investigation

- SAF04F18 - Role and Conduct of Employees and Investigation Team Declaration has been extracted from SAF04G06 and is a standalone form
- SAF04F19 - Mental Wellbeing / Performance Review form has been added.
- SAF04F20 - Investigation Quality Checklist has been added.
- New Guidance: SAF04G11 - Human Factors for Investigations Guidance.
- New Guidance: SAF04G12 – VR Subject Matter Expert Directory
- Amendment to Guidance SAF04G06 to remove Confidentiality Statement declaration sheet
- Withdrawn Guidance: SAF04G08 - Use of Conferencing facility.
- Withdrawn Appendix: SAF04F06 Appendix J - 5 Why's Causal Analysis Diagram
- Withdrawn form: SAF04F16 – Network Rail Level 1 Investigation Report

10. BRIEFING REQUIREMENTS

All new employees will receive an introduction to the Integrated Management System (IMS) at induction, according to the nature of the role.

All employees with an email address receive the 'Record of Revisions' each month, which details changes to the IMS. All Line Managers are responsible for ensuring their staff are briefed on changes as appropriate.

The following table defines how revised issues of this document are briefed to existing employees according to related specific responsibilities.

This is determined using the 'RACI' principle. Those roles identified as 'Responsible' and 'Accountable' should receive a formal awareness briefing facilitated by the Document Owner.

Discipline	Role	RACI	Type of briefing
All	All Roles	Informed	Awareness
Engineering	Chief Engineer & Professional Heads	Responsible	Detailed
Delivery	Driving Standards Manager	Responsible	Detailed
HSQES	Lead Investigator	Responsible	Detailed
HSQES	Rail Investigator	Responsible	Detailed
HSQES	Rail Investigation Administrator	Responsible	Detailed
HSQES	VRCC Duty Manager / Controller	Responsible	Detailed
HSQES	Head of Environment & Sustainability	Responsible	Detailed
HSQES	Environment & Sustainability / Environment Manager	Responsible	Detailed
HSQES	Environmental Advisor / Trainee / Apprentice	Responsible	Detailed
HSQES	Social Value Advisor	Informed	Awareness
HSQES	Head of H&S	Responsible	Detailed
HSQES	Senior H&S Manager	Responsible	Detailed
HSQES	Trainee / H&S Manager / Advisor	Responsible	Detailed
HSQES	Head of Quality Systems	Responsible	Detailed

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Discipline	Role	RACI	Type of briefing
HSQES	Head of Performance & Strategy	Responsible	Detailed
HSQES	Performance & Improvement Manager	Responsible	Detailed
HSQES	Data & Reporting Analyst	Responsible	Detailed
HSQES	Training & Competence Manager	Responsible	Detailed
HR	HR Business Partner	Informed	Awareness
Project Management	Project Manager- Civils / Senior / Assistant	Responsible	Detailed
Project Management	Project Manager- Power / Senior / Assistant	Responsible	Detailed
Project Management	Project Manager- Signalling / Senior / Assistant	Responsible	Detailed
Project Management	Project Manager- Track / Senior / Assistant	Responsible	Detailed
Project Management	Operations Manager	Accountable	Detailed
Project Management	Operations Manager - East	Accountable	Detailed
Project Management	Operations Manager - North West	Accountable	Detailed
Project Management	Operations Manager - South	Accountable	Detailed
Project Management	Operations Manager (OTM) / Senior	Accountable	Detailed
Project Management	Operations Manager (POM) / Senior	Accountable	Detailed
Project Management	Operations Manager- Track / Senior	Accountable	Detailed
Project Management	Operations Manager- Signalling	Accountable	Detailed
Project Management	OLE Plant Operations Manager	Accountable	Detailed
Project Management	Rail Operations Business Manager	Accountable	Detailed
Senior Management	Business Manager – Light Rail	Accountable	Detailed
Senior Management	Business Manager - OTM	Accountable	Detailed
Senior Management	Business Manager - POM	Accountable	Detailed
Senior Management	Business Manager - SP&W	Accountable	Detailed
Senior Management	Construction Manager / Senior / Assistant	Responsible	Detailed
Senior Management	Construction Manager- Civils / Senior	Responsible	Detailed
Senior Management	Construction Manager- E&P / Senior	Responsible	Detailed
Senior Management	Construction Manager- OLE / Senior	Responsible	Detailed
Senior Management	Construction Manager- Signalling	Responsible	Detailed
Senior Management	Construction Manager- Telecoms	Responsible	Detailed
Senior Management	Construction Manager- Track	Responsible	Detailed
Senior Management	Director of Major Projects	Accountable	Detailed
Senior Management	Director of Specialist Businesses	Accountable	Detailed

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Discipline	Role	RACI	Type of briefing
Senior Management	General Manager	Accountable	Detailed
Senior Management	Managing Director	Accountable	Detailed
Senior Management	Operations Director	Accountable	Detailed
Senior Management	HSQES Director	Responsible	Detailed
Senior Management	Plant Director	Accountable	Detailed
Senior Management	Regional Director LNE	Accountable	Detailed
Senior Management	Regional Director LNW	Accountable	Detailed
Senior Management	Project Director	Accountable	Detailed

Competence	RACI	Type of briefing
DCP (Designated Competent Person)	Responsible	Detailed
Investigators	Responsible	Detailed
Safety Representatives	Responsible	Awareness
On-call staff	Informed	Awareness
First Aiders	Informed	Awareness

11. IMS AUTHORISATION

Document owner approval:

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Approval for IMS:

Paula Roberts, IMS Coordinator, 16/01/2024

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