

Britain: Damning report on 1999 Paddington rail crash

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Thirty-one people died and 400 were injured in the train crash at Ladbroke Grove, two miles outside London's Paddington Station on October 5, 1999. The report of the public inquiry conducted by Lord Cullen into the worst railway disaster in Britain for over a decade provides damning evidence of how the companies operating Britain's trains since privatisation of British Rail have consistently placed profit before public safety.

The collision involved a Thames Trains' local service to Bedwyn, Wiltshire and a London-bound First Great Western 125 express train, running from Cheltenham. The fatal crash occurred at 8.11am, at the height of the rush hour. The express train was full of commuters. Local people reported hearing a massive explosion as the two trains collided almost head on. One eyewitness described carriages "leaping over" each other. A fireball almost immediately engulfed one of the carriages. Although the emergency services arrived within minutes of the accident and fire fighters sprayed foam over the wreckage, the heat was so intense that it welded two of the carriages together.

Thick acrid smoke enveloped the trains, as shocked and injured passengers struggled to smash carriage windows to escape. As the injured were rushed to hospitals across London, emergency services began the grim task of searching for the dead. They were still cutting bodies out of the wreckage at 5.15 in the afternoon. Many survivors suffered terrible burns requiring years of painful treatment.

Three days later, on October 8, Bill Callaghan, Chairman of the Health and Safety Commission, announced the terms of reference for Lord Cullen's inquiry. The present report covers Part One of the inquiry, investigating the causes of the crash and making recommendations for the future. Part Two, not yet published, will deal with safety issues throughout the rail industry.

Reading through the Cullen report, one gets the sense that the Paddington rail crash was just waiting to happen.

The immediate cause of the accident was that the suburban train driven by Michael Hodder passed a signal showing red. According to Cullen, Hodder thought he had permission to proceed. The positioning of the signal meant he had only a few seconds to see the red stoplight as he emerged from under a bridge. Unusually bright sunlight at a low angle contributed to his difficulty in clearly seeing the red signal.

Hodder's Thames Turbo train hit the oncoming Great Western high-speed express driven by Brian Cooper, killing both instantly. The impact of the crash and the ensuing fire from the spilt diesel fuel killed 29 passengers.

The signal at the centre of the disaster—SN109—was constructed during a track and signal modernisation scheme between Paddington and Ladbroke Grove, approved by the then state-run British Rail in 1989. The scheme was made necessary by the choice of Paddington Station—which had one of Britain's most complicated signalling layouts—as the site for a new Express rail link to Heathrow Airport and as the terminus for the Eurostar Channel Tunnel trains. British Rail wanted high-speed trains to be able to

run almost directly into Paddington.

The new signals and track—consisting of six lines carrying trains running in both directions—were completed in early 1993. But it soon became apparent that SN109 had been built above the maximum recommended height and was obscured by the heavy road-bridge in front of it. As a result, speeds were reduced to 40mph instead of 95mph. The signal was eventually lowered, but by altering the configuration of the lights on SN109, the position of the red warning light became "a rare if not unique feature," according to the report.

Her Majesty's Railway Inspectorate (HMRI) approved the modernisation scheme in 1993, subject to inspection. It was at this time, in the run-up to rail privatisation, that the Conservative government changed the rules to allow continued use of the track before approval, "in order to avoid interruption to the operation of existing transport services". A risk assessment was not carried out, although this was a requirement for all new schemes arising from the Newton collision in 1991, in which four people were killed and more than 20 injured when two suburban trains collided head-on in Scotland.

The first time SN109 was passed at red—known as a SPAD or "signal passed at danger"—was August 2, 1993. Before the Ladbroke Grove crash there would be 67 SPADs in the Paddington area, with eight involving SN109, making it the 15th riskiest signal in Britain. Risk expert Ian Murphy told the Cullen Inquiry there was an 86 percent chance in any one year of a SPAD involving SN109, with a risk of collision once every 14 years. Regulations requiring all high-risk SPADs and altered signal layouts to be visited by a signal sighting committee were ignored.

On April 1, 1994, the Tory government privatised British Rail. Railtrack became responsible for the track and signal infrastructure. The trains became the property of three rolling-stock companies, which then leased them out to 25 separate train-operating companies.

In 1995, HMRI noted that, "There are a number of instances where the signals are considered to be poorly positioned from a driver's sighting point of view". The Paddington modernisation scheme, HMRI concluded, could remain in use but was not fully approved. A proper risk assessment was recommended but Railtrack management refused to carry this out, saying they had not devised the scheme, British Rail had.

To make matters worse, Railtrack installed new overhead power cables as part of the rail electrification programme, further obscuring SN109. A Railtrack official is quoted in the report saying they should "wait and see how many drivers complain" about the sight restrictions caused by the new cabling. The positioning of masts for the cables meant that signalling was "substantially restricted", but another Railtrack official is quoted saying, "moving the masts at a rumoured cost of £200,000 cannot be contemplated".

After a serious accident in 1995 at Royal Oak, about half a mile from Paddington, Signal Standard Engineer Mr C. Bray reported to the subsequent inquiry, "the fact that drivers had to choose one signal from six; the great height of the signals above the line; the signals being on

curved sections of line; and the high speeds in the area” were responsible for the crash. Nothing was done, however.

In 1998, when it was suggested that two of the six lines outside Paddington should only carry trains in a single direction, Railtrack Operational Planning Manager Mr A. Wilson is quoted saying, “I recognise safety is paramount but believe there must be ways of mitigating this risk without crippling the Zone’s [Paddington to Slough track] major revenue generating terminus”. Operations Manager Mr B. Melanophy added, “one would look to find solutions that had the least commercial impact on the travelling public.”

By the time of the fatal crash in 1999, the 1993 Paddington modernisation scheme was still not fully approved; and is still not fully approved today.

The Cullen report criticises the close relationship between HMRI and the railway companies, saying the Inspectorate accepted assurances that work had been completed when it had not. About Railtrack, the report says, “In the years before the crash a number of measures... had been mooted for the improvement of safety. Very little had been achieved. A number of measures foundered as a result of objections on the ground that the change would affect performance.” Senior Railtrack management ignored many recommendations from the two previous serious incidents nearby—at Royal Oak in 1995 and Southall in 1997, when seven were killed and 150 injured.

Gerald Corbett, Railtrack CEO at the time of the Paddington disaster, told the Inquiry that when he took up his post in 1997, he had been struck by the “seemingly endemic culture of complacency and inaction in the Zone”. Corbett said he felt this was “rooted in an industry culture that had been inherited, and that was relatively unresponsive and slow-moving.” He commented that this had its origin in the “hierarchical and rigid culture of the old railway”.

The Inquiry report makes clear that under private ownership little was done to rectify this situation. Cullen comments that remarks by Corbett to a parliamentary subcommittee in 1998 that Paddington was “the best protected major terminal station anywhere in the world” were “not only ill-considered, but it demonstrated either a degree of complacency on the part of senior management or a desire to encourage an undeserved confidence in what Railtrack had actually achieved.”

Cullen highlights the fact that “in all likelihood the accident would have been prevented” had an emergency train warning and protection system been installed on the Thames Turbo.

British Rail had introduced such a warning system in the 1950s. Under this very basic system, if a red signal was passed, an alarm sounds in the driver’s cab and applies the brakes. However, the driver can cancel the alarm and continue. In the late 1980s, British Rail approved plans for a more sophisticated Automatic Train Protection (ATP) system. The use of ATP was also recommended following the Inquiry into the Clapham rail crash in December 1988, when 35 people lost their lives.

A trial system was installed on the tracks running into Paddington, except for the last 12 miles into the station. Then, prior to privatisation of British Rail in 1994, the government decided that the cost—estimated at £3 billion—far exceeded the “normal safety investment criteria as measured by cost per equivalent fatality avoided”. ATP was scrapped and a cheaper Train Warning and Protection System (TWPS) was devised. The government authorised the Paddington pilot scheme to be completed, but it soon fell into disrepair, to the point where it was operable for only 30 percent of the time.

Great Western had inherited trains fitted with ATP from British Rail, although the system had been disconnected in the train involved in the Paddington crash. ATP was never installed in the Thames Turbo—a cost-benefit analysis commissioned by Thames Trains management showed the cost to fit all their trains amounted to £3.5 million. According to Cullen, the brief for the analysis “could be construed as inviting a conclusion

adverse to the fitting of ATP”.

The Inquiry report was also critical of the training given to drivers following privatisation. At the time of the hand over from British Rail to Thames Trains in 1994, drivers were usually recruited from among existing staff, who had some knowledge of the railway industry. They then spent a year travelling with an experienced driver before they could take a train out on their own.

Following privatisation, a significant number of experienced workers, including drivers, signallers, engineers and rail safety experts, were made redundant or left. Railway staff faced constant pressure from management and shareholders to avoid financial penalties imposed on the Train Operating Companies when services are cancelled or run late.

After initially cutting its workforce to boost profitability, Thames Trains found it needed to recruit more drivers to ensure it met its timetable commitments. Eighty of their 259 drivers were recruited in 1999. This batch of new recruits—largely from outside the industry—included Michael Hodder, the driver of the Thames Turbo. He completed his training two weeks before the crash. No one had told him about the history of SPADs in the Paddington area, let alone about SN109, even though special training on SPADs, including the use of videos, was recommended following earlier disasters.

Once Hodder had passed the red light at SN109, the last chance to avert an accident lay with the signallers, who are Railtrack employees. The Slough Integrated Electronic Control Centre controls the Paddington section of the track. Mr D. Allen, who was on duty that week, had been working for more than 72 hours. In a cruel irony, he had been forced to work for so long because inadequate staffing levels meant there were not enough signallers to cover operations when a number of their colleagues attended the Southall crash inquiry on the same day as the Paddington disaster.

Even though there had been 46 SPADs in the Zone between 1993 and 1999, signallers had received no proper training or instructions in the event of such an emergency.

Cullen’s Inquiry presents a terrible picture of the events leading up to the Paddington crash in October 1999. He calls it a “lamentable failure” and makes 89 recommendations, largely directed towards Railtrack and the Train Operating Companies.

The Crown Prosecution Service has confirmed that it will be re-examining the issue of corporate manslaughter charges against Railtrack and Thames Trains in the light of the report.

As the Cullen report was published, it became known that former Railtrack CEO Gerald Corbett received a “golden handshake” of almost £1.4 million when he left the company last year. Figures published in the company’s annual report and accounts reveal Corbett received a lump sum of £912,992 for his pension entitlement, supplemented by £444,000 as compensation for loss of office.



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