

the bereaved. It would also help identify how each party could assist the other, within the bounds of our respective legislation, so that our respective investigations can each proceed effectively and in parallel, and without interference or hindrance.

The RAIB investigation may involve interviewing witnesses, gathering and analysing both documentary and physical evidence, and conducting detailed examination, testing and analysis. In some situations it may also need the involvement of the Coroner or the Procurator Fiscal in facilitating the release of the pathology and toxicology reports. Where relevant, modelling reconstructions will be undertaken to gain the fullest possible understanding of what actually happened.

During the course of a RAIB investigation, technical evidence, which can be attributed to either specific injuries on the body or the circumstances that led to death, may be identified that might properly be shared with the Coroner or the Procurator Fiscal in advance of any RAIB report being produced. In such instances the RAIB will communicate such information by means of a formal letter.

Family liaison matters

The RAIB has a policy of establishing early contact with the bereaved and, should they wish, maintaining dialogue with them during the course of the investigation. Where applicable, the RAIB maintains a close relationship with police Family Liaison Officers to ensure the needs of the bereaved are effectively co-ordinated.

The consultation report

At the conclusion of its investigation processes, the Regulations require the RAIB to circulate a copy of the draft report to certain categories of person, including the bereaved, and invite their representations on the contents. These copies are provided 'in confidence' and the contents cannot be disclosed without RAIB's permission (to do so is a criminal offence). The Regulations also prohibit the RAIB from sharing a copy of the draft report with the Coroner or the Procurator Fiscal.

The Final Investigation Report

The Regulations require the RAIB to publish a final report in the shortest time possible and normally not later than 12 months after the date of occurrence. However, while complex investigations can take longer, many are produced earlier.

The RAIB considers that its investigation is complete upon publication of the final report and any information provided before then is likely to be provisional.

The final report, which is made public through the RAIB's website, will include a description of: the accident; the investigation process and evidence; the analysis; the immediate cause and other causal factors; and recommendations to prevent or mitigate similar accidents or circumstances happening again.

Functions of a RAIB Inspector at inquests / fatal accident inquiries

The RAIB considers that the outcome of its investigation and publication of the report could form an important part of the evidence at an inquest as the RAIB will, in many cases, have been the lead investigator. In this respect, the RAIB believe that it would be beneficial to all concerned if there could be early liaison to take into account the anticipated date of publication of the RAIB investigation report before the date of the inquest or fatal accident inquiry is set.

At a coroner's inquest or fatal accident inquiry the RAIB's inspectors can substantiate the factual findings of the RAIB's investigation report and can explain technical aspects about the material in the report. However, RAIB's inspectors are prohibited by the Act from attributing blame or liability, and do not act as expert witnesses or give opinions as this may draw them into speculation which could give the impression that they were apportioning blame or liability.



For further information about the RAIB or for information concerning specific accidents, please contact the RAIB at the address below.



Fatal Railway Accidents Information for Coroners and Procurators Fiscal Leaflet 04

This leaflet explains how the Rail Accident Investigation Branch (RAIB) is involved in investigating the cause of fatal railway accidents in the United Kingdom. It is intended as a reference for those responsible for conducting judicial inquiries into the circumstances leading to death.

It also provides information that supports the Memorandum of Understanding (MoU) between the Chief Coroner of England and Wales (dated October 2017) and the three Accident Investigation Branches that cover air, rail and marine transport.

The MoU can be found under the library section at www.gov.uk/raib.

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The Rail Accident Investigation Branch

The Rail Accident Investigation Branch (RAIB) is the independent railway accident investigation organisation for the UK. Its purpose is to identify the cause of accidents and incidents, and make recommendations to improve safety of the railways and prevent further accidents from occurring. The authority for the RAIB to undertake its investigations originates from:

- the Railways and Transport Safety Act 2003 (the Act);
- the Railways (Accident Investigation and Reporting) Regulations 2005 (the Regulations); and
- the European Railway Safety Directive 2004/49/EC.

The RAIB is part of the Department for Transport but is functionally independent of the department. The RAIB's investigations are also entirely independent from the industry, the police, the Office of Rail and Road (ORR), and other government departments. The Chief Inspector reports on matters concerning accident investigation directly to the Secretary of State.

The RAIB investigates most types of serious accidents affecting the UK's railways, particularly where loss of life is involved, with the exception of situations where it reasonably believes that the death was the result of natural causes, assault, suicide or trespass. These are excluded from the scope of the RAIR regulations. The Regulations cover accidents and incidents on:

- the national railway networks in Great Britain and Northern Ireland;
- the Channel Tunnel (in co-operation with its equivalent operation in France);
- metro systems such as London Underground, Strathclyde Subway and Docklands Light Railway;
- light rail and tramways;
- heritage railways (including narrow-gauge systems over 350 mm gauge); and
- cable-hauled railways of 1 km or longer.

RAIB investigations are focused on safety improvement (it does not apportion blame or liability, or act as an enforcing authority). Any such enforcement is a matter for the relevant safety authorities: ORR; the Department for Regional Development (Northern Ireland); or in the case of the Channel Tunnel, the Intergovernmental Commission.

Where there is no clear indication that the railway accident has been caused by serious criminality¹, the RAIB will assume lead responsibility for determining the causes of the accident, the factors affecting the severity of the consequence, and the efficacy of the response of the industry and emergency services to the accident.

The RAIB will co-operate with the police service and safety authority investigations and will share evidence. It is however prohibited by the Regulations from disclosing witness statements, medical records and other detailed witness information that it unilaterally obtains, unless compelled to disclose such material by the High Court (or equivalent). In such circumstances, the court must judge whether the interests of the public in making such evidence available are sufficient to outweigh the adverse implications for future RAIB investigations. The RAIB also has discretion on disclosing other types of information, if it believes that to do so would damage the RAIB investigation.

When an accident occurs

The Regulations require defined types of accidents and incidents to be notified to the RAIB by the railway industry. Following notification, the Chief Inspector will decide whether or not to investigate, taking into account the potential for improvement of safety through an in-depth investigation.

When investigating, the RAIB will deploy Inspectors to the accident site, who are trained and experienced in both the rail industry and in the investigation of rail accidents.

¹ "Serious criminality" includes the crimes of murder and culpable homicide, and any criminal act which results in a terrorist incident, deaths, multiple casualties, serious injury and/or other serious consequences, e.g. derailment of a train, or a train collision. This does not include criminal offences which properly fall to be investigated by the Office of Rail and Road.

The investigation

Preliminary examination

On deploying to an accident, the RAIB usually carries out a preliminary examination to identify the causes and circumstances of an accident. The purpose is to gather sufficient information for the RAIB to decide whether the potential safety benefits for the industry warrant a full investigation and publication of an investigation report.

The RAIB's involvement will cease if it is decided, as a result of the preliminary examination, that the safety benefits do not justify a full investigation. This decision will normally be made within two weeks of the accident and all involved parties will be informed.

Where the RAIB will not be carrying out a full investigation, it will inform the relevant Coroner or Procurator Fiscal by letter and offer, upon request, to provide information on any facts identified by the RAIB during the preliminary investigation.

Full investigation

Where the RAIB has decided to carry out a full investigation it will make this fact public by placing a summary of the accident and areas of investigation on its website.

The aim of a RAIB investigation will be to seek answers to the following questions:

- what happened?
- how did it happen?
- why did it happen?
- what can be done to prevent it happening again?
- what can be done to reduce the consequences should such an accident recur?
- what lessons can be learnt from the response to the accident?

It will also inform the relevant Coroner or Procurator Fiscal by letter that the RAIB is conducting a full investigation and propose an early discussion. The purpose of such a meeting would be for both parties to understand the investigation timescales, the evidence held, and the arrangements for briefing