South Western Railway

South Western Railway
South Bank Central
4th Floor
30 Stamford Street
London
SE1 9LQ

For the attention of Assistant Coroner Hill QC
Coroner's Office
Southwark Coroner's Office
1 Tennis Street
London
SE1 1YD

10 September 2019

Dear Coroner

Inquest concerning Annabel Elizabeth Newport

I write for and on behalf of First MTR South Western Trains Limited, which brands its services as South Western Railway and SWR. I refer to your Report to Prevent Future Deaths dated 17 July 2019 in relation to the inquest into the death of Ms Annabel Newport, who died on 23 March 2018 following a cardiac arrest on one of SWR's trains (your "Report"). The purpose of this letter is to respond to the three concerns raised in your Report, to explain how SWR has taken on board those concerns, and to explain what we are doing in light of each.

On behalf of all at SWR, I would like to take this opportunity to again express my sincere and deep condolences to the family of Ms Newport.

BACKGROUND

1 Where a passenger suffers a medical emergency such as a cardiac arrest, SWR has a written procedure which prescribes how the on-board Guard, the Driver, the Control Centre, and (if relevant) Signallers should respond. That procedure is designed to optimise the time taken to determine, in collaboration with the Ambulance Services, the next suitable station, where the Ambulance Services can administer medical aid. With this is mind there are two decision-making pathways in our procedure.

2 The primary pathway will apply in the vast majority of cases. It involves the Guard responding to the incident (for example following the trigger of the passenger alarm system (Pass-Com) by a passenger), determining what is wrong and initiating an ill customer hotline call to the Control Centre. They will in turn set up a three-way call with the Ambulance Services to determine the next suitable location to stop the train based on the Guard's report of the passenger's condition. That decision is relayed to the Driver and Signaller to execute the train movements to bring the train into the station to be met by paramedics.

3 A secondary pathway is available where, for any reason, the Guard is not able to attend the scene. In that scenario, the Driver will relay the information provided to him (for example by a passenger using the Pass-Com), to the Signaller. The Signaller will in turn contact the Control Centre. They will try to contact the Guard (given the advantages of having them attend the scene and be involved in a three-way call) but, if they cannot, will call the Ambulance Service to agree where the train should stop. This information will be relayed to the Signaller, who will inform the Driver.

4 In this tragic case, the Guard was in a compartment where, unbeknownst to him, he could not hear a passenger activation of the Pass-Com and nor was he contactable by the Driver who had been

informed (over the Pass-Com) that Ms Newport had collapsed and was unconscious. In those circumstances, the Guard did not respond to the incident and was not able to reset the Pass-Com.

5 It further meant that the SWR's protocol for dealing with ill passengers and co-ordinating a response progressed via the less usual secondary pathway. The Driver contacted the Network Rail's signal box to say that Ms Newport had collapsed and was unconscious. In turn, the signal box contacted the Control Centre stating that Ms Newport had collapsed. They did not say that she was unconscious. Acting on the information she had collapsed, the Control Centre made the decision to proceed to Waterloo.

6 Ms Newport received CPR from medically trained professionals whilst en route. At Waterloo the awaiting London Ambulance Services' ("LAS") paramedics administered adrenaline and applied a defibrillator. Sadly, Ms Newport died two days later for the reasons stated in your Report.

PROVISION OF DEFIBRILLATORS ON TRAINS AND AT STATIONS

(A) Why provision of AEDs is tailored to the train operating company and surrounding circumstances

7 At the Inquest Hearing, there was evidence and discussion of why different train operating companies take different approaches to making Automated External Defibrillators ("AEDs") available at certain key stations and/or on certain trains. For example, it is understandable that Eurostar chose to install AEDs on-board 42 of its trains. These trains pass through very few intermediate stations en route between its UK terminals and European destinations, the journey times between stops are long (in some cases upward of 1.5 hours), and the trains reach speeds of over 180mph, making interim stopping difficult.

8 Much of SWR's core business is the operation of suburban Metro-style services in and around London. These services run between Waterloo and Clapham Junction where they split into separate routes. These are frequent services with many interim stops, as well as further 'through' stations at which a train could stop in an emergency. For example, the peak-time 08:42 service from Reading to Waterloo is an 82-minute journey stopping at 18 stations, which is an average of one stop every 4½ minutes.

9 SWR also has over 400 trains across 10 different 'classes' of rolling stock which primarily run in 8, 10 or 12-car formations. To *ensure* there was an AED on each train it would require the installation of around 411 on-board AEDs, alternatively having AEDs on certain trains and not others might create confusion and its own difficulties. You heard detailed evidence of practical concerns faced by any operator regarding maintenance, vandalism, ensuring on-board AED locations were known in an emergency (noting that formations within trains change around), and the practicalities of reaching an AED on a busy train.

10 You also heard evidence that of the 819 recorded instances of illness causing delay on SWR services in just over 2 years, there were 14 instances of actual or suspected cardiac arrest. Whilst SWR cannot say how many of those would have responded to defibrillation, the Coroner did consider evidence that in around 79% of cases attended by LAS, the patient had a "*non-shockable rhythm*" (50.1% asystole and 28.7% PEA, per the LAS data cited in the Report). In other words, an AED may not have assisted in the majority of cases.

(B) Addressing your concerns

11 SWR's protocol for dealing with ill passengers is centred around the Guard arriving at the scene, contacting the Control Centre urgently, and then relaying information on a three-way call, to determine the best location to stop the train to be met by the Ambulance Services. Ambulance Services carry 'emergency services' defibrillators (which are different from AEDs that can be used by the public) and adrenaline. LAS's response time target for "life-threatening injuries and illnesses, specifically cardiac arrest" is seven minutes.

12 SWR has commenced a systematic and detailed review of the locations at which AEDs are installed at its managed stations. SWR anticipates this will result in the installation of AEDs at additional locations. It has not yet finalised the list of locations. We have also recently been approached by Network Rail to discuss a wider initiative which Network Rail is spearheading concerning further installations at stations on the national rail network. I am therefore positive there will be an increase in AEDs at our stations in the near future. Since the incident, in addition to the dedicated paramedic

presence at Wimbledon and Clapham Junction stations, paramedics are now also based at London Waterloo in the morning peak, Monday to Friday only.

FIRST AID AWARENESS AMONGST SWR TRAIN GUARDS AND OTHER STAFF

(A) The various aspects of your concern

13 We have understood that your concern is about first aid training and about how SWR employees should respond to information concerning an ill passenger. More specifically, it appears to us that the different aspects of your concern are as set out below:

(a) "A lack of first aid training of the driver and/or the control staff may have led to a failure to recognise that being unconscious is a potentially life-threatening condition" leading to a decision to proceed to Waterloo (paragraphs 5 and 6 of your Report);

(b) Drivers and/or control staff should default to treating a report of certain instances as life-threatening, triggering an appropriate procedural response; as doing so might have resulted in a decision to stop prior to Waterloo (which is implicit in paragraphs 5 & 6 of your Report);

(c) That Guards would benefit from additional first aid training as "it is the guard who is primarily responsible for identifying whether an unwell passenger's condition is life-threatening" (paragraph 4 of your Report).

(B) Regarding 14(i) above, and the Decision-making of the Driver and Control Centre staff

14 It should be noted that the PFD Report contains a factual inaccuracy central to part of the concern expressed. The Report proceeds on the basis that the Driver told the Control Centre that Ms Newport was "*unconscious*" and that there was a failure to recognise "*being unconscious* [as] *a potentially life-threatening condition*". However, the evidence before the Coroner from recorded call transcripts and witnesses was that a passenger attending Ms Newport told the Driver that she had collapsed and was unconscious. This was the information relayed from the Driver to the signal box. The signal box then told the Control Centre that there was "*a collapsed passenger on board*".

15 So, the Driver was not in contact with the Control Centre. The Control Centre was not told that Ms Newport was unconscious. They were told that she had collapsed. They took the decision to proceed to Waterloo on that information. The direct answer to the concern as to why the Control Centre did not treat the report of unconsciousness as life-threatening is therefore that they were told only that she had collapsed. If a customer is reported as being unconscious, the existing protocol advises Control Centre staff to treat it as life threatening, and SWR has recently strengthened that wording as explained below.

16 Having given proper consideration to the concern raised, it is not clear in what circumstances first aid training of Drivers and staff at the Control Centre would make a difference to the treatment of an on-board passenger. We would certainly never dissuade an employee in either role from taking a first aid course. However, in respect of passenger emergency responses, neither is in a position to administer first aid.

17 Regarding the Driver, in the event that the Guard is not available to respond to the incident, the Driver's role is to initiate the communication of the passenger's condition to the Control Centre (via the Signaller). They must do so at the same time as performing the safety critical role of driving the train. The Driver cannot be expected to do more than relay the report of the passenger's condition. Encouraging the Driver to re-interpret what they are told in light of their first aid knowledge would risk the Driver guessing or assuming that they understand the passenger's condition without having any means of confirming if this is correct. It seems preferable that SWR's protocol should remain that the Driver is simply asked to relay information provided.

18 Regarding the Control Centre staff, similarly they are not on the ground to validate the information being given to them. Their role in the protocol does not appear to benefit from them being asked to superimpose a judgment about the best first aid response:

(a) In circumstances were the Guard has responded to the incident and initiated the protocol (via the 'primary pathway' I have described above), the Control Centre will establish a three-way call with the Ambulance Service allowing the Guard to relay the position on the ground.

(b) If the Guard is not available and the report has come into the Control Centre via the Signaller (i.e. the 'secondary pathway' described above), the Control Centre is required to attempt to contact the Guard and make contact with the Ambulance Service to relay the information they have, so the Ambulance Service (who may also have been alerted through another channel such as a passenger 999 call) can agree the best course of action with the Control Centre.

19 SWR has nevertheless considered how it might seek to increase first aid awareness amongst its Drivers, Control Centre staff and Guards, and I have commented on this further below.

(C) Regarding 14(ii) above and the treatment of reports of collapse

20 As noted above, the Control Staff were told that Ms Newport had "collapsed". Evidence was provided to the Inquest as to why it would not be practicable, and in fact could be potentially dangerous, for the Control Centre to assume that a report of a collapse, without more, should be treated as life-threatening. A number of reasons were provided to the Coroner. I have briefly revisited a few of the key reasons below. I have also detailed a change we have made to our protocol for such situations.

21 When a passenger suffers a life-threatening illness, our priority is to get them to the next appropriate location to be met by the Ambulance Services. However, on a very congested rail network any diversion of a train from its scheduled path has a cascade effect in delaying other trains. If there is a genuine passenger emergency, then of course SWR must manage those consequences. However, creating unnecessary disruption to the network not only delays other trains (which is detrimental for passengers and SWR for a variety of reasons) but increases the risk of illness (in particular fainting) on those other services and the serious risk of de-training (where passengers attempt to self-evacuate a train / 'de-train')[1].

22 This incident was highly unusual because the Guard was in a part of the train where he was uncontactable and was not aware of the unfolding situation. Following the incident, a bulletin was issued to Guards to address that situation. No similar situation has been encountered since that briefing was issued. In normal circumstances, the Guard would be in a position to update the Control Centre as the situation developed, for example if what initially appeared to be a 'collapse' was later recognised to be something more serious. Instances where information would be conveyed by any other route will be rare.

23 SWR considers that the Control Centre must be able to act on the information it receives. Realistically, it cannot be required to second-guess whether an incident might in fact be more serious (save perhaps in cases where there is doubt as to the severity of the situation, as explained below). Instances leading people to collapse, in particular to faint, are relatively common in everyday life including on public transport. More than 100 people a year might faint on SWR's services. The number of cardiac arrests is very much smaller (as cited above, it was 14 in just over 2 years). If the Control Centre was required to second-guess all collapses and treat them as though they required urgent medical attention this would have the potential to cause massive disruption to the rail network and harm to passengers on trains caught behind other trains.

(D) Regarding 14(iii) above and First Aid Training for Guards

24 As explained at the inquest hearing, a Guard has a number of important duties to perform including train dispatch duties such as managing the opening and closing of train doors, checking that passengers can board and leave the train safely, ensuring the safety of those on the train and the platform as the train pulls away, ensuring we meet our duties to disabled passengers under the Equality

[1] De-training is a very real possibility, particularly on SWR's metro-style services where disrupted trains may be held at points just approaching, leaving, or at stations, leading to passengers trying to get off the train and onto the platform (for example, by using the emergency passenger door releases). This is a situation which SWR takes active steps to avoid. The Rail Accident Investigation Branch (RAIB) have recently highlighted the dangers associated with de-training after incidents at Lewisham and Peckham Rye. It is widely accepted that de-training may lead to a risk of passengers being electrocuted by the conductor rail or being struck by a passing train. These risks are in addition to the obvious dangers of slips, trips and falls.

Act 2010 and to persons with reduced mobility under EU law, including helping them to get on and off the train and making sure that they are safe on board.

25 When a Guard responds to an ill passenger incident, our protocol requires them to make an initial assessment of what is happening and the passenger's condition. If the passenger's condition appears to require medical attention, the Guard must call the Ill Passenger Emergency number and follow the process outlined above. This process is designed to ensure that the right Ambulance Service is informed as quickly as possible and that a decision on where to stop the train can be made.

26 As was explained at the inquest hearing, the speed of the train, the layout of the railway, and other practicalities such as signalling and the need to change the 'points' on the track to divert the train mean that the process of making this decision and relaying it to the Driver and Signaller is highly time-sensitive. Delay can be the difference between stopping at one station and being forced to continue.

27 If the Guard was required to administer first aid, he would have to do so either before reporting the situation to the Control Centre, delaying the start of that decision-making process and reducing the window of opportunity to stop the train at nearby stations, or whilst he was on the three-way call, which would be likely to reduce the quality and accuracy of information he could relay and the quality of the first aid he would be able to provide.

28 During the work to revise the Ill Passenger Procedure, LAS confirmed that from its perspective the 'critical path' to maximising the prospects of a good outcome is to ensure that as soon as practicable, they are alerted to an incident and a decision is made as to where LAS should meet the train. That is why the Ill Passenger Procedure prioritises (and will continue to prioritise) the Guard contacting the Control Centre and being involved in the three-way call, rather than requiring the Guard to administer first aid.

29 It is also worth noting that our general experience is that passengers will step forward to offer help. On busy services there are frequently medically trained passengers and off-duty emergency service personnel who will make themselves known in response to a call for aid. Publicly available statistics suggest that medically trained personnel (paramedics, doctors, nurses, and others) make up 1-2% percent of the population and that approximately 5% of the population are first-aid trained in dealing with life-threatening conditions. A train such as a 12-carriage Class 450 (on which this incident occurred) has more than 790 seats and additional standing room, and a busy service (during peak hours) is likely to be carrying over 1,000 passengers. It is therefore statistically highly likely that some of them will be medically trained and/or first aid trained and able to respond to the call for aid.

(E) <u>Addressing the above concerns</u>

30 As noted during the Inquest, SWR had been preparing to revise the booklet containing our written protocol for dealing with passenger illness incidents, including cardiac arrest. SWR awaited the outcome of the Inquest so as to incorporate learning from it. We have since published a revised version of that protocol, incorporating a number of changes and improvements, in a booklet called "*Caring for our Customers*".

31 Regarding 14(i) above, we have made more explicit a list of instances which must be treated as "life threatening". The Booklet states that the following conditions are life-threatening: (i) The customer is not breathing or unconscious (customer is unresponsive); (ii) Serious injury or serious blood loss is suspected; (iii) Neck or spinal injury; (iv) Childbirth is imminent or taking place; (v) The customer is having a seizure; (vi) Cardiac arrest. The Booklet has been updated with "Basic Lifesaving / First Aid" guide and an "FAQ" section addressing how to identify each of these conditions.

32 Regarding 14(ii) above, where the Guard is unavailable our booklet now states that the default position:

(a) For a Driver is that "If you were advised of the ill customer via the emergency alarm or the signaller and are in any doubt as to the severity of the situation, treat it as worst case. i.e. as a life-threatening condition, until the condition is confirmed by the Guard, or a medic."

(b) For the Control Centre staff is that "In the event of not being able to contact the Guard to assess the condition of the customer and you have no further information, please treat the situation as worst case i.e. a life-threatening condition, until confirmed otherwise by the Guard/Traincrew".

33 Regarding 14(iii) above, the Booklet has also been updated with a four page "Basic Lifesaving / First Aid" guide. This includes step-by-step guidance, aligned with guides like that of St John's Ambulance, regarding passenger illnesses which may arise. These include sections on: what to do when someone is unresponsive and breathing; unresponsive and not breathing; having a seizure; how to identify a heart attack and what to do; and how to identify a cardiac arrest and what to do.

34 With regards to this Booklet:

(a) Each Guard will be issued with, and will have to sign for, a hard copy of the Booklet for their use;

(b) The Booklet will be available to Guards & Drivers online via the SWR Document Distribution App;

(c) Guards will be briefed on the contents of the Booklet and it will form part of the content of SWR Development Days;

(d) Cue cards will be issued to Guards to carry on their person, prompting them to consider key issues from the Booklet; and

(e) Prompt cards will be produced for Controllers at the Control Centre.

35 SWR is also considering the roll out of a basic first aid awareness briefing within the company's existing training cycle for Guards, which is currently under review given new regulatory requirements for more intensive Equality Act and disability training, the roll-out of which might provide an opportunity for this kind of further training

THE OPERATION OF THE PASS-COM IN AN EMERGENCY

36 We understand your concern is that it is not sufficiently apparent to passengers that once the Pass-Com has been used once, it cannot be used again without being reset by the Guard but that in those circumstances, they can immediately go to the next carriage to use the one there.

37 The Coroner suggested we might put signage next to the Pass-Com. However, our concern is that this might not be read by a passenger under pressure of acting in an unexpected emergency. We think that the best way to address that concern is for Drivers, receiving a Pass-Com communication, to advise the passenger about this limitation. We have therefore updated the Driver's section of the Booklet to reflect this. In particular, the start of the Driver's step-by-step guide to responding to an ill passenger incident begins [emphasis added]:

> *1. You will receive a call from … a customer (via a call for aid or emergency alarm) informing you of an ill customer on board …*
>
> *2. Once you have received all the information from the customer,* ***inform them that if they need to contact you again they will need to use another emergency alarm, situated at any other door, in any carriage****.*
>
> *3. Try and contact the Guard….*

38 We have also issued a bulletin notice to Drivers advising them to give this information in response to a Pass-Com communication.

39 Of course, the circumstances in which this will be important are those in which the Guard is not available to attend the scene. Where he is, then he will be able to communicate with the Driver and reset the Pass-Com. We have also updated the Guard's section of the Booklet to include an explicit reminder about resetting the Pass-Com device.

I hope that this response addresses your concerns.

Yours sincerely,

[redacted]
Managing Director
For and on behalf of SWR