Rail Delivery Group

National Rail

RDG Guidance Note: Investigation of Station Stopping Incidents

RDG-OPS-GN-009
Issue 6 – September 2021

About this document

Explanatory Note

The Rail Delivery Group is not a regulatory body and compliance with Guidance Notes or Approved Codes of Practice is not mandatory; they reflect good practice and are advisory only. Users are recommended to evaluate the guidance against their own arrangements in a structured and systematic way, noting that parts of the guidance may not be appropriate to their operations. It is recommended that this process of evaluation and any subsequent decision to adopt (or not adopt) elements of the guidance should be documented. Compliance with any or all of the contents herein, is entirely at an organisation's own discretion.

Other Guidance Notes or Approved Codes of Practice are available on the Rail Delivery Group (RDG) website.

Executive Summary:

This Guidance Note provides advice on the investigation of station stopping incidents along with a suggested template form for capturing of the relevant information. In doing so, it seeks to encourage consistency across the industry.

Issue Record

Issues 1 to 5 of this document were published as: GN009.

Issue	Date	Comments
1	September 2006	First published version
2	February 2013	Reviewed and amended to include Stop short and release doors and wrongside door release
3	April 2016	Reviewed and updated to include different methods of door operation and control
4	May 2020	Reviewed and amended to clarify Driver Controlled Operation (DCO) and submission of report to industry stakeholders. Updated to RDG format.
5	July 2020	Change to definitions for additional clarity.
6	September 2021	Updated to include: • Section 3: TOCs Good Practice and Mitigations on Station Stopping Incidents • Appendix B: Visual Examples of Good Practice and Mitigations by TOCS

This document is reviewed on a regular 3-year cycle.

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Contents

1 Purpose and Definitions

1.1 Purpose

This Guidance Note is intended to promote the adoption of standard procedures for the reporting and investigation of station stopping incidents across the industry, along with a common definition of what is meant by these terms. In particular, it provides a suggested template for the capture of data needed to support such investigations – see Appendix A.

1.2 Definitions

Term	Definition in the context of this document
Fail/Failure to Call	Failure of a train to make a booked station stop.
Operational Platform	The area of a level platform that is available for passenger use and has been identified as part of the train dispatch area and / or the operation of the train.
Staff Responsible for Door Release	This could be the driver of a Driver Only Operation (DOO) or Driver Controlled Operation (DCO) service or guard, conductor, train manager etc responsible for opening the doors.
Station Overrun Non-Protected	Event in which a train comes to a stand beyond the designated stopping point, where doors, that are intended (/expected) for passenger use and are not on the operational platform, are opened. This may be as a result of the staff responsible for door release, or systems such ASDO, opening these doors.
Station Overrun Protected	Event in which a train comes to a stand beyond the designated stopping point, where doors intended (/expected) for passenger use are not on the operational platform and the doors remain closed. The 'protection' may be as a result of; the staff responsible for door release not opening all, or some of, the doors on the train, or systems such Automatic Selective Door Opening (ASDO), keeping doors off the operational platform closed.
Station Stopping Incident	An overall term that covers Fail to Call, Station overrun, Stop Short and release doors and wrongside door release incidents.
Stop Short Non-Protected	Event in which a train comes to a stand prior to reaching the designated stopping point, where doors, that are intended (/expected) for passenger use and are not on the operational platform, are opened. This may be as a result of the staff responsible for door release, or systems such ASDO, opening these doors.
Stop Short Protected	Event in which a train comes to a stand prior to reaching the designated stopping point, where doors intended (/expected) for passenger use are not on the operational platform and the doors remain closed. The 'protection' may be as a result of; the staff responsible for door release not opening all, or some of, the doors on the train, or systems such ASDO, keeping doors off the operational platform closed.
Wrongside Door Release	Event in which the train doors are released on the side of the train that is not adjacent to the operational platform.

Note: The above definitions of station overruns and stop shorts (protected and non-protected) exclude stations with short platforms where either the designated stopping point is beyond the end of the platform or doors are planned to overhang the rear of the operational platform. As an example, if passengers on an 8 car train have been advised to alight from the rear 5 coaches at a particular station and bringing the train to a stand at the designated stopping point means the front 3 coaches are beyond the platform, this does not constitute a station overrun. However, if the train is brought to a stand beyond the designated stopping point such that any of the doors in these 5 coaches are no longer adjacent to the platform, then that constitutes an overrun. Similarly, if brought to a stand prior to the designated stopping point such that any of the doors in these 5 coaches are no longer adjacent to the platform, then that constitutes a stop short.

2 Investigations

2.1 Fail to call

It is recommended that failures to call be investigated in a similar manner to other station stopping incidents. While many such incidents will result from a failure on the part of the driver which has no direct safety implications (such as misreading of the train's schedule), there may be cases where there is ambiguity as to whether a particular incident was the result of a driver making no to attempt to stop at all, or alternatively failing to manage to do so correctly. The form in Appendix A is accordingly designed to be used for all station stopping incidents.

2.2 Significant operating incident occurring as a result of a station stopping incident

If a station stopping incident results in a significant operating incident, such as a Signal Passed at Danger (SPAD) or a collision, then the investigation procedures for these types of incidents should be applied rather than those referred to in this document. See RIS-3119-TOM, *Rail Industry Standard for Accident and Incident Investigation,* The Railways (Accident Investigation and Reporting) Regulations 2005 and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) for additional information. However, the contents of this document may be used as an aide memoire.

2.3 Action to be taken immediately following a station stopping incident

It is recommended that in the event of any reported station stopping incident the driver concerned should be seen by a responsible Manager at the first available opportunity and an interview carried out to determine:

- the immediate cause (as reported by the driver)
- for station overruns only:
    - the distance overrun,
    - whether the train set back, and if so, whether authority was requested/obtained from the signaller,
    - whether the driver changed ends.
- for stop short (non-protected), and wrongside door release:
    - whether any passengers alighted from a door that was not adjacent to the operational platform.
    - whether the area surrounding the train was checked for passengers that may have fallen / alighted from the train prior to any further movements taking place.

The staff responsible for the incident's 'fitness to continue' duty should also be assessed.

The driver, along with other staff if appropriate, must complete a written report of the circumstances as soon as practicable after the incident and as a minimum prior to booking off duty.

2.4 On Train Data Recorder (OTDR)

OTDR data must be downloaded when a station stopping incident is reported.

2.5 Investigation procedure

A competent person must be appointed to investigate a station stopping incident. All relevant sections of the form provided in Appendix A should be completed.

When completed, it should be submitted for internal sign off according to individual Company procedures and as appropriate to Network Rail and other Industry Stakeholders for acceptance of the conclusion and any recommendations that may apply to them. Incident details and the investigation conclusions and recommendations must be input to Safety Management Intelligence System (SMIS).

2.6 Liaison with Network Rail and other industry stakeholders

The person appointed to conduct the investigation should liaise, as appropriate, with Network Rail and other Industry Stakeholders, to establish and discuss the circumstances. In particular, the results of any Network Rail led investigations into the state of the infrastructure (swab test, eddy current test, etc.) can provide valuable evidence of railhead conditions and an indication as to the operation of on-train sanding equipment.

2.7 Sources of evidence

In conducting the investigation, the investigator should consider the following as additional potential sources of evidence in addition to reports from staff involved:

- OTDR data;
- CCTV images from station and / or train internal CCTV;
- Forward Facing / Rear Facing CCTV;
- Signallers' and witness' reports, including Guards and Train Dispatchers;
- Evidence of causes of distraction (internal / external);
    - Mobile phone records (for examples calls / texts)
    - Authorised / unauthorised cab visitors
- Voice recordings;
- Employee Medical Results;
- Railhead Swab Test results – this may need to be specifically requested from Network Rail;
- Operation of the Rail Head Treatment Train (RHTT) on affected or adjacent lines;
- Driver's schedule card / train list being used;
- Any Not to Stop / Special Stop Orders that may have been issued;
- TOC/FOC/Network Rail Control Centre Log Entry or P2/CCF replays;
- Medical Examination;
- Fatigue Risk Index data;
- Competence Management System (CMS) documentation; and,
- Fleet Engineering
    - A technical report must be obtained to substantiate any allegations of a defect on the train
    - Dependent on the nature and/or seriousness of the incident, consideration should also be given to requesting a download of data held in Train Management and Brake Control Systems (where available)
    - Correct operation and status of sanding equipment

3 TOC Good Practice and Mitigations on Station Stopping Incidents

3.1 Southeastern: 'Driver Skills Enhancing Bulletin' (SE-B)

Southeastern's SE-B is produced for drivers to illustrate ways of improving their driving skills through one-page documents. Some SE-B issues are dedicated to Station Stopping Incidents, using images and skills/actions to give information on the incidents and to consider helping improve safety and reduce these incidents from occurring.

Some SE-B Issues that focus on Station Stopping Incidents are:

a. How to Prevent Stop Short and Door Release Incidents (November 2020)
b. Stop Short and Door Release Incidents: Where does it Start? (October 2020)
c. Multiple Stop Short and Door Release Incidents (February 2020)
d. Increased Risk! Stop Short and Door Release Incidents (May 2020)

See Appendix B, Part A.

3.2 Avanti West Coast: 5/10 Car Slider Modification Fitment

Class 221 fleet have been fitted with 5/10 car reminder sliders as an additional measure to prevent stop short station incidents when in charge of a 10-car formation. When taking charge of the 221's, drivers must ensure that the slider, fitted to the Super Voyager sign on the top right-hand side of the desk, is manually changed and checked to the formation of the train.

Drivers must still be extra vigilant should the formation of the train change mid-journey. To ensure the correct formation is displayed on the slider, drivers must interrogate the TMS to confirm the formation prior to continuing the journey.

See Appendix B, Part B

3.3 South Western Railway: Fail to Call Mitigation

Common causes of fail to call incidents are:

- Changes in signalling sequence upon approach to station;
- Changes in stopping pattern;
- Autopilot and 'fast service' driving; and,
- Failing to check schedule card.

SWR have produced best practice on schedule cards and commissioned highlighter duo pens for all drivers to utilise the best practice guidance and promote the use of personal protection strategies (PPS). Drivers are advised to:

- Check out the best practice guide;
- Utilise PPS that works for them;
- Share incident prevention techniques with their colleagues; and,
- Know their fail-to-call hotspots.

3.4 Platform car stop markings

A universal measure taken to prevent some Station Stopping Incidents such as Stop Shorts from happening is to place car stop markings at the relevant area(s) on the platform.

See Appendix B, Part C

Appendix A

Template Form for Investigation of Station Stopping Incidents

Please note the following form has been designed to be completed electronically as a Word form. Where indicated, guidance text for completion of the form is provided with the instruction that it be deleted from individual completed report.

STATION STOPPING INCIDENT INVESTIGATION

Type of incident
Train details
Location
Date and time
Driver and home depot
SMIS Reference

Produced by:

_____

Name,
Job Title
Location

Authorised by:

_____

Name,
Job Title
Location

Date: _____

Contents

Part 1 - Incident overview

Date of incident:		**Time:**		**SMIS Ref. No.:**	
Location of incident:		**Line:**			
Train: Train ID.:		Time:		From:	To:
Driver's name:		**Depot:**			
If other than booked driver, give details		No. of persons in cab:			
Stock: Leading unit† no.:		Vehicle no.:		Nos. of other units† in train:	
Driven from: Vehicle / cab No.:		How was incident reported?			
Weather Conditions:		**Visibility:**			
Overrun Distance:	*(metres)*	**Gradient:**			
Permissible speed:	*(mph)*	**Approach view (restricted/ open/ view station from braking point.)**			

Consequences: *(tick)*

Train did not return to the platform	☐	Train not permitted to return to the platform	☐
Train returned to the platform with permission	☐	Train returned to the platform without permission	☐
If train returned to the platform, was the correct cab used? (Y/N)	☐	*If No state reason*	

Level crossing involved (see below)	☐	Collision/ Near miss with another train*	☐

Collision with fixed infrastructure	☐	*If so, give details*	
Infrastructure Damage	☐	*If so, give details*	
Passenger/ employee Injuries	☐	*If so, give details*	

Station stop details:

Consider:
History of station stopping incidents – What type of incidents and when.
Have these been highlighted to traincrew
Regular or irregular stopping point
Is this regular work for the traincrew/depot

† Set number(s) (for example BN54) for locomotive worked services.
* As a result of a station overrun at an occupied permissive platform.

Part 2 - Infrastructure details

Level Crossing: *If level crossing involved, state type and any consequences*

N/A	☐		
Whistle Board reacted to	☐		
AHB	☐	CCTV	☐
Manual gates	☐	Manual barriers	☐
Foot crossing	☐	Traincrew operated	☐
Other	☐	*If so, give details :*	
Level crossing closed to traffic	☐	Level crossing open to traffic	☐
Level crossing in process of closing	☐	Collision with road vehicle or crossing gates	☐
Near miss with road vehicle	☐	Injuries / fatality (including pedestrians)	☐

Railhead conditions reported by driver: *(tick)* Dry ☐ Wet ☐ Greasy ☐ Leaf affected ☐ Other contamination ☐

Was incident attributed to railhead conditions? (Y/N)			
If yes Did Network Rail confirm poor railhead? (Y/N)			
Does OTDR indicate poor railhead adhesion? (Y/N)			
Was railhead swab/ eddy current tested (Y/N)		*If Yes state*	
Had railhead treatment been applied? (Y/N)		*If Yes state*	
Has RHTT/Water Jetting taken place on affected or adjacent lines (Y/N)		*If Yes state*	

Date /Time railhead treatment applied prior to incident	Date	Time	
Are Traction Gel Applicators fitted near this location? (Y/N)		Where?	

Reason for poor railhead	
Is location a known poor railhead adhesion location, i.e. listed in Sectional Appendix? (Y/N)	
What time was the last rail movement prior to this incident of the section of line?	
Had there been any reports of LRA in this are in the preceding 24hours (Y/N)	
If yes, what actions were taken	

Station Infrastructure

Are there multiple stopping points? (Y/N)		If yes, give details	
Are the stopping points clearly visible to the driver of an approaching train? (Y/N)		If no, give details	
Is there any special stopping instructions for this location (for example stopping points beyond the platform)? (Y/N)		If so, give details	
Are stopping points boards on the same side as the platform? (Y/N)		If no, give details	
Is DOO equipment on the same side as the platform? (Y/N)		If no, give details	

Are station staff (dispatchers) provided at this location? (Y/N)			
Was station lighting fitted, operable and sufficient? (Y/N)		If no, give details	

Overrun/ Stop Overrun Door Release, Stop Short Release Doors and Wrong Side Door Release Incidents

How many doors were not adjacent to the level platform when the doors were released?			
Did any passengers alight from the train to **other** than the level platform (i.e. alighted onto the platform ramp or ballast)? (Y/N)		If so, give details	
Was the immediate area surrounding the train checked following the incident and prior to any other train movements taking place? (Y/N)		If no, give details	
Is the train operator of the train involved in the incident the Station Facility Operator at the station concerned? (Y/N)		If no, give details	
How long were the train doors incorrectly released for?		(mm.ss)	
Was automatic SDO working correctly?			
Was manual SDO operated?		Give details	

Part 3 - Train details

Type of brake:	Brake control		Type of brake gear	

Sanding Equipment	Sanding equipment fitted?		If Yes, which type?	
	Was sanding equipment functioning?			
	Is WSP fitted and is there evidence of its operation on the OTDR?			
	Date sanding equipment last examined (functional test)			
	Date and location sanding equipment last replenished			

On Train Safety Equipment	Was any on-train safety equipment defective or isolated at the time of the incident? (Y/N)		If so, give details	

Vehicle defects

For each unit/vehicle in the train formation, please enter details of any relevant safety related defects reported during the previous 14 days

Unit/Vehicle Number	Defect Details

Part 4a - Driver details

Date of birth		Date entered service		Date passed as driver	

Has driver been involved in any safety of the line incidents in the previous 2 years, Is the driver PQA or currently on a CDP process and/or, currently participating in a Driver (Competence) Development Plan? (Y/N)	
(Please enter details)	
Was there a known defect on the train, or other issues with route or traction knowledge? (Y/N)	
(If Yes, please state)	
Was the driver adhering to the Company Driving Policy? (Y/N)	
(If No, give reasons)	

Details of hours worked during the previous 14 days

Please enter details of the hours and duties worked by the driver during the previous 14 days. *NOTE: If the Driver has been involved in a Safety of the Line incident during the period shown below, this must be recorded.*

Day	Date (dd/mm/yy)	No. continuous days worked	Time on duty (hh:mm)	Time off duty (hh:mm)	Activity (see below)	Duty No/Comments
Incident						
-1						
-2						
-3						
-4						
-5						
-6						
-7						
-8						
-9						
-10						
-11						
-12						
-13						
-14						

Activities: **A -** Annual leave; **B -** Booked Off; **D** - Worked rest day; **N** - Worked Sunday; **O** - Other; **R** - Rest day off; **S** - Sick; **V** - Worked overtime; **W** - Worked ordinary time; **X** - Special leave

Fatigue Risk Index Assessment details	FRI Index:	Depot Average:	Did driver allege fatigue
Give details if there is technical evidence of fatigue (slow reactions identified on OTDR)			

Part 4b – Guard/ Train Manager/ Conductor details

Date of birth | Date entered service | Date passed as guard

Has Guard been involved in any safety of the line incidents in the previous 2 years, Is the guard PQA or currently on a CDP process and/or, currently participating in a guard (Competence) Development Plan? (Y/N)

(Please enter details)

Was there a known defect on the train, or other issues with route or traction knowledge? (Y/N)

(If Yes, please state)

Was the guard adhering to the Professional Guards Handbook? (Y/N)

(If No, give reasons)

Details of hours worked during the previous 14 days

Please enter details of the hours and duties worked by the guard during the previous 14 days. *NOTE: If the guard has been involved in a Safety of the Line incident during the period shown below, this must be recorded.*

Day	Date (dd/mm/yy)	No. continuous days worked	Time on duty (hh:mm)	Time off duty (hh:mm)	Activity (see below)	Duty No/Comments
Incident						
-1						
-2						
-3						
-4						
-5						
-6						
-7						
-8						
-9						
-10						
-11						
-12						
-13						
-14						

Activities: **A -** Annual leave **B -** Booked Off **D** - Worked rest day **N** - Worked Sunday **O** - Other **R** - Rest day off **S** - Sick **V** - Worked overtime **W** - Worked ordinary time **X** - Special leave **Z** - Worked Emergency call out

Fatigue Risk Index Assessment details	FRI Index:	Depot Average:	Did guard allege fatigue

Part 4c - Dispatcher details

Date of birth		Date entered service		Date passed as dispatcher	

Has dispatcher been involved in any safety of the line incidents in the previous 2 years, Is the dispatcher PQA or currently on a CDP process and/or, currently participating in a dispatcher (Competence) Development Plan? (Y/N)

(Please enter details)

Was there a known defect with station dispatch equipment? (Y/N)

(If Yes, please state)

Was the dispatcher adhering to the Company Dispatch Policy? (Y/N)

(If No, give reasons)

Details of hours worked during the previous 14 days

Please enter details of the hours and duties worked by the dispatcher during the previous 14 days. *NOTE: If the dispatcher has been involved in a Safety of the Line incident during the period shown below, this must be recorded.*

Day	Date (dd/mm/yy)	No. continuous days worked	Time on duty (hh:mm)	Time off duty (hh:mm)	Activity (see below)	Duty No/Comments
Incident						
-1						
-2						
-3						
-4						
-5						
-6						
-7						
-8						
-9						
-10						
-11						
-12						
-13						
-14						

Activities: **A -** Annual leave **B -** Booked Off **D** - Worked rest day **N** - Worked Sunday **O** - Other **R** - Rest day off **S** - Sick **V** - Worked overtime **W** - Worked ordinary time **X** - Special leave **Z** - Worked Emergency call out

Fatigue Risk Index Assessment details	FRI Index:	Depot Average:	Did dispatcher allege fatigue

Part 5 - Additional information (*Fail to Call/Overrun only*)

Driver explanation of reason for failure to call/overrun: *(tick)*	Misread timetable/schedule card ☐ Forgot ☐ Distraction ☐ Other ☐
If Distraction or Other, please give details	
Type of schedule: *(tick)*	WTT ☐ WTT Variation ☐ STP ☐ VSTP ☐ Control Arrangement ☐ Special Stop Order ☐

Part 6 - Summary of events

The information (evidence) presented should follow a sequence of events. The aim is to tell a logical story of what happened. This can be based upon a simple timeline to make sure key facts are included in the correct order. Follow this up with any other factors that have emerged during the course of the investigation that do not naturally fit in the story. The information presented in this section should relate to, and support the conclusions.

Insert text as appropriate.

Part 7 - Factors for consideration

This section is to highlight for the reader how information has been correlated and cross-referenced in order to make sound judgements. It needs to highlight conflicting information and where information is missing.

Insert text as appropriate.

Part 8 - Conclusions and causes

Avoid using single line statements in this section where possible and make sure that the cause is properly described. This should cover two key elements, i.e.

1. *Immediate cause: An unsafe act and/or condition that directly resulted in the occurrence of the event. Concentrate on the people involved and the environment in which they work. There can be more than one such cause. (Make sure there is a 'because' and not just a statement of fact)*
2. *Underlying cause: This relates to the underlying conditions and issues which caused or allowed the unsafe act or condition to occur. Consider: management and supervisory practice, job planning, equipment maintenance and other human factor influences*

When stating and explaining the causes, there should be a focus on what needs to be improved as much as on what went wrong. This method softens the impact to the reader and removes any emotion from the report.

Insert text as appropriate.

Part 9 - Other factors

In this section, record any other issues that were noted in the summary of events, which needs improving, although it did not form part of the identified causes (Part 8).

Insert text as appropriate

Part 10 - Required action to address non-compliances

This section states the actions required to address issues of non-compliance. This is where an existing control measure is already in place and has not been followed (e.g. a rule, regulation or process).
Non-compliances differ significantly from recommendations, as the existing control measures are deemed adequate and robust. All actions stated under this section are mandated.
Make short two or three line statements.
Between this section and that containing the recommendations (Part 11), all the issues identified in Part 8 (causes) and Part 9 (other factors) must be addressed.

Insert text as appropriate.

Part 11 - Recommendations

This section documents suggested changes that focus on improvement to existing controls or the introduction of new controls. Sometimes reasoning for your suggestions may be necessary.
Make short two or three line statements.
Always make sure the recommendation has a champion identified.
Between this section and non-compliances, all the issues identified in Part 8 (causes) and Part 9 (other factors) must be addressed.
Remember, recommendations should be SMART. (Specific, Measurable, Achievable, Realistic and Time-bound)

Insert text as appropriate.

Part 12 – Report compiled by

Report compiled by

Name		Signature	
Job title		Date	

Professional Head of Operations verification

Name		Signature	
Job title		Date	

Network Rail acceptance of report (where applicable)

Name		Signature	
Job title		Date	

Other Stakeholder acceptance of report (where applicable)

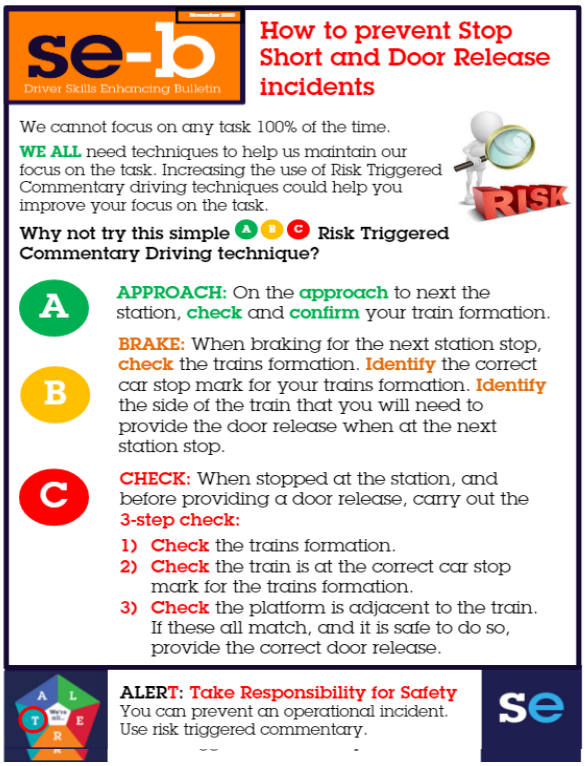
Name		Signature	
Job title and Company		Date	

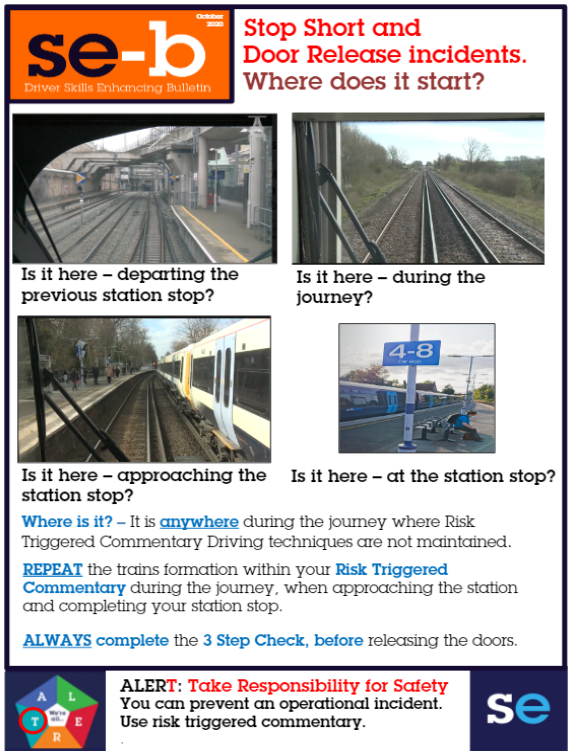
Appendix B

Visual Examples of Good Practice and Mitigations by TOCS

Please note the following items have been shared as Good Practice by TOCs and are only examples of what some TOCs use across their network to highlight the importance of Station Stopping Incidents as well as how to mitigate these incidents.

Part 1 – Southeastern SE-Bs





Credit: **Southeastern**

Part 2 – Avanti West Coast 5/10 Car Slider

AVANTI WEST COAST

Class 221 Operations Notice

5/10 Car Slider modification Fitment

Groups	Drivers, Driver Team Managers	Train Managers, On Board Managers	Station Team, Group Station Managers	On Board Catering Team	Ops Control	Fleet Team	Other Managers	*Relevance ratings* *3 = Critical/must be acted upon* *2 = Need to know* *1 = Information only* *0 = Not relevant*
Relevance ratings	3	0	0	0	1	2	1	

1) Background:

The Class 221 fleet is being fitted with a 5/10 car reminder slider as an additional measure to prevent stop short station incidents when in charge of a 10-car formation.

2) Instructions to be applied

When taking charge of a Class 221, drivers must ensure that the slider, fitted to the Super Voyager sign on the top right-hand side of the desk, is manually changed/checked to match the formation of the train.

This does not relieve the driver of the responsibility to check the formation of the train on the train list and to observe the TMS screensaver detailing the train formation.

Drivers must be extra vigilant should the formation of the train change mid-journey. To ensure the correct formation is displayed on the slider, Drivers must interrogate the TMS to confirm the formation prior to continuing the journey.

Authorised By

Chris Duddy
Operations Standards Manager
Avanti West Coast

Avanti West Coast Safety Reference Number:	**221/OPS/20/140**
Depot Reference Number:	
Notice to be posted:	04/03/20 – 03/05/20
Date Posted:	
Date of Transfer:	
Notice transferred to Notice Case Number:	
Date of withdrawal:	

Credit: **Avanti West Coast**

Part 3 – Platform Car Stop Marking Examples

Credit: **Great Western Railway**

Credit: **Southeastern**

Rail Delivery Group

National Rail

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