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| March 2024 |  |  |
| Meeting the needs of passengers when trains become stranded: How well is the industry doing? |  |  |

Transport Focus

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Executive Summary

Introduction

Rail Delivery Group (RDG) and Network Rail have jointly produced Guidance on Meeting the Needs of Passengers Stranded on Trains. Its intent is to put passengers first when they’re stranded on trains: to provide the industry with guidance on how to respond to such incidents in a way that identifies, understands and meets passengers’ needs first and foremost.

This purpose of this research is to understand *how well the industry is doing* to embed and put into practice the intent of this Guidance and to what extent it is meeting the needs of passengers when trains become stranded.

The Guidance has been regularly reviewed and updated by RDG and Network Rail since its initial publication in 2011, and the latest version was published in 2020. This project is the first time direct feedback from stranded passengers has been obtained in order to inform future reviews.

Transport Focus and the Office of Rail & Road (ORR) commissioned Steer to find out directly from people caught on stranded trains about their experience, good and bad, and to identify any factors affecting how their needs were met:

* **Communication:** how well passengers were informed and updated by train staff, and what impact the communication had their experience and expectations
* **Customer service:** how satisfied or not they were with on-board staff and their customer service
* **Additional staff assistance:** if they had special or medical needs and, if so, what the assistance process was, and if or how those needs were met
* **Emotional well-being:** how they felt during and after the incident, and how their emotional wellbeing was affected

This report brings together feedback from passenger interviews with industry representatives’ perspectives on the incident, as well as analysis of operators’ stranded train protocols to assess how well the Guidance has been adopted.

What we’ve done

Steer has engaged with Network Rail, train operators, Trainline, Transport for London, Transport Focus and ORR to identify and research relevant case studies (see Figure 1.1)

The case studies were identified for immediate follow-up, so that we could contact and interview passengers while the experience was fresh in their minds. The case studies were selected to provide a range of different incidents, locations and types of operation and/or operator owning group, and to meet requirements for incidents involving a loss of electricity supply to the train, and at least one train to have come to a halt between stations for two hours or more.

Having identified a relevant stranded incident and agreed with operators to follow-up, Steer worked with the relevant operators, Trainline and Network Rail, to:

* Identify, recruit and interview passengers affected by those operators
* Review the industry protocols and procedures, and discuss with Network Rail and operators how they’ve been implemented
* Review and discuss the case studies and passenger feedback with operators and Network Rail

Figure 1.1 Overview of the researched stranded train incidents

A screenshot of a web page

Description automatically generated

What we’ve found

**The industry has improved passenger focus when trains become stranded, but still has more to do**

From our review of industry stranded trains protocols and passenger feedback across a range of real-life case studies, it is clear that efforts have been made by the industry to embed the intent and principles of the Guidance in procedures and in practice.

Operators have adopted stranded trains policies and procedures that broadly reflect the intent, principles and recommendations of the Guidance.

And we have seen in practice evidence of focus on the safety, wellbeing and comfort of passengers when their train becomes stranded, with passengers appreciating the efforts of on-board staff to provide information and reassurance, and often reporting that communication is quick and frequent.

However, we have also seen evidence that communication, passenger welfare, and the ability to meet passenger needs, is not yet at a consistently high standard. Operators we reviewed incidents with recognised that improvement is needed. Operators find it challenging to deliver onward travel and provide up to date information about this to passengers. We have seen evidence of this both in terms of the quality and extent of information provided while on board, and what passengers subsequently experience. Passengers feel that high-quality customer service sometimes ends once they get off the train. This has proven a particular challenge during rarer but critical major incidents.

**Safety and service go hand in hand:** Our research has shown a strong correspondence between customer service good practice and the factors influencing passenger behaviour that can lead to self-evacuation from stranded trains. Passengers self-evacuated in Case Study 1, with multiple contributing factors including (but not limited to) the lack of information about the duration of the incident and plan for resolution and a lack of welfare facilities.

**The industry Guidance, and individual operators’ protocols could be more passenger-focused**, to further drive the importance of information about, and provision of, onward travel.

**The industry Guidance to 'have a plan within 60 minutes’ isn’t sufficient to meet passengers’ needs** – Despite good intentions to drive decision-making and support communication, it is neither fast enough nor tailored enough. Our research confirms that the experience of passengers is significantly impacted by delayed decision-making and suggests that in the most likely and the most severe scenarios, ‘plan in 60 minutes’ is not fit for passenger circumstances, on-board and external conditions, the nature of the event or passengers’ communications requirements.

**Further passenger-focused good practice guidance is needed:** there is the need and opportunity to develop further supporting guidance on good practice, at a level of focus and detail beyond that which can realistically be included in the Guidance itself.

From our review of industry Guidance, train operator and Network Rail protocols and procedures, the voice of the passenger and engagement with operators across the industry, Steer has identified a high-level framework for good industry practice to be developed further with industry engagement.

**Further action is needed to develop and share good practice** in the following areas:

* Providing customer service in a way that reflects the needs and circumstances of passengers on-board, including passengers with additional needs
* Identifying and responding to the needs of passengers where those needs are less readily identifiable – when staff cannot readily 'survey' the train, and for invisible vulnerabilities as well as observable physical vulnerability
* Further improving communications protocols for stranded trains incidents
* Communicating about end-to-end journeys and providing advice on 'what happens next' after leaving the train
* The ability to provide confidence and reassurance when there isn’t concrete information on incident timescales and resolution.

**Communication and co-ordinated decision-making across industry interfaces remains the biggest barrier** to meeting passengers’ needs. Clearly,the ability to meet passengers’ needs is dependent on having and communicating a plan, and:

* Current stranded trains procedures are predominantly geared for ‘everyday’ disruptive events, not complex, multifaceted incidents with aggravating factors
* It’s imperative that procedures are reviewed and tested, with lessons and actions from significant incidents proactively applied.

What we recommend

**As part of its next review, the RDG/Network Rail Guidance should be strengthened**, to:

* Provide further emphasis on passengers’ end-to-end journey and onward travel
* Update requirements for decision-making and plans to drive faster, passenger-focused decision-making tailored to the circumstances

**Developing and strengthening operators’ stranded trains protocols** **and procedures** in line with good practice and address gaps identified in this report, including:

* Developing and/or reviewing multi-operator incident response plans by line of route, including evacuation points and onward travel plans, in the light of the case studies and other incidents
* Including specific requirements to stress-test procedures and undertake major incident exercises focused on complex stranded trains incidents
* Further focus on training and development, including stranded trains-specific training
* Empowerment of on-train staff and development of skills for empathetic and confidence-building communication amid uncertainty
* Adopting good practice assessment and checklist tools
* Adopting and exploiting available technology for incident management and communications
* Including guidance and protocols related to onward travel
* Review and testing stranded trains policies and procedures as part of seasonal preparedness plans

**Further actions to research, develop and deliver good practice:**

* The industry should be engaged in the development of a Good Practice Guide for meeting stranded passengers’ needs, setting out how best to achieve what is included in the Guidance
* The industry should establish a mechanism to facilitate the sharing of best practice, lessons learned and updates to procedures relating to stranded trains

# Project background

## Broader context and requirements

Train incidents can cause an array of issues, often acute, to passengers and their wellbeing as well as reputational damage to the industry. Stranded trains, those that are neither stopped at a station nor likely to move for an extend period of time, can pose potential health and safety risks, in particular if passengers decide to self-evacuate or if power fails and there is no air conditioning or toilets available. This is to say nothing of the frustration, discomfort and inconvenience caused by passengers being delayed or unable to complete their journeys.

Transport Focus, the consumer watchdog representing the interests of Britain’s rail passengers, and the consumer policy team at the Office of Rail and Road (ORR), have agreed to work together to consider issues of the passengers on stranded trains. In particular, to understand whether the rail industry has been sufficiently focusing on meeting passengers’ needs, and how good practice and lessons can be shared across the industry to improve future rail services and passenger experience.

In 2011, the Rail Delivery Group (RDG) and Network Rail jointly produced the first version of the [Guidance Note](https://www.raildeliverygroup.com/files/Publications/RDG-OPS-GN-049-MeetingtheNeedsofPassengersStrandedonTrains.pdf) (hereafter ‘Guidance’) on **Meeting the Needs of Passengers Stranded on Trains** - the latest issue was updated and published in 2022. Its main purpose is to “provide guidance to enable Network Rail (as the infrastructure manager) and train operating companies to plan for and implement appropriate arrangements for responding to events in which passengers are stranded on trains”.

However, the Guidance is not mandatory and any compliance with it is at an organisation’s discretion. Therefore, Transport Focus and ORR commissioned this research to specifically focus on passenger experience on stranded trains, and established objectives for this study in two areas:

* Establishing the passenger experience, and how well their needs were met, across a number of specific incidents
* Understanding how well the Guidance is embedded and applied within the industry

## Main objectives in detail

### Establishing how well the needs of stranded passengers are met

The main purpose of this project was to find out directly from people involved in stranded train incidents about their experience – good and bad – and to identify any factors affecting meeting those needs in terms of:

* **Communication:** how well they were informed and updated about the incident by the train staff; and what impact the communication had on passengers’ overall experience and if it helped manage their expectations
* **Customer service:** how satisfied or not they were with on-board staff and their customer service
* **Additional staff assistance:** having special or medical needs and if so, what the assistance process was and if or how their needs were met
* **Emotional well-being:** how they felt during and after the incident; how their emotional wellbeing was affected

### Understanding and assessing how the Guidance is applied

It was also crucial to collect the industry view to get a better understanding of how well train operating companies deal with stranded train incidents by:

* Assessing the extent to which the Guidance, specifically section 2.2. relating to Organisations’ responsibilities, has been implemented within the industry
* Establishing whether a “Protocol for Passengers stranded on trains” (recommended by the Guidance) is in place and if not, to establish whether equivalent arrangements exist that meet the intent of the Guidance
* Identifying examples of good practice of adopting the Guidance, in terms of documented policy and/ or delivery in practice, that others in the industry can learn from
* Finding out if there are particular gaps or challenges surrounding implementation of the Guidance or otherwise meeting the needs of passengers in these situations and, if so, how these could be addressed
* Assessing whether the Guidance should be strengthened to make it more passenger-centric, including but not limited to whether *“Agree a plan within 60 minutes”* is sufficiently speedy

In addition, it was essential to gather representative insights that could be turned into practical recommendations and applied across the industry. This required identifying and including:

* A wide range of stranded passengers whose needs are varied and could require extra care or medical assistance
* Passengers with additional needs, for instance, those with physical or mental health issues, people with non-visible cognitive impairment, or non-native English speakers
* Elderly people, pregnant women, or Passengers travelling with children
* Four train incidents to fit the following criteria:
* at least two that involve loss of electricity supply to the train
* one or more trains come to a halt for two hours or more between stations
* each incident is different from one another in terms of type of operation and/or operator owning group as well as geographic coverage of the service or geographic location

Analysis of the wider management, resolution and recovery of stranded trains incidents is outside the scope of this project.

## Overview of the recruitment and research methodology

**The project in numbers**

**17** train operators engaged in the project

**14** operators agreed to facilitate the passenger recruitment process

**11** operators delivered their stranded train protocols and manual

**4** different stranded train case studies

**8** stranded train services met the project criteria

**28** passengers were interviewed, including eight people with additional needs, elderly and passengers travelling with minors

### Engaging with the rail industry

Between September and December 2023, Steer engaged with 17 train operating companies and Network Rail. The conversations were held online and focused on briefing internal teams on the project objectives, including facilitating passenger recruitment, as well as collecting stranded trains protocols, manual or training materials.

As an outcome of the engagement, Network Rail agreed to supply daily National Operation Centre (NOC) reports, which listed all train incidents from the last 24 hours across the country. The file included information such as location and causes of the incidents, number of affected train operating companies or length of the delay. Steer used the reports to identify which train incidents involved stranding and met the project criteria. For the duration of the project, Steer also used the files to assess the frequency and magnitude of stranded train incidents.

Furthermore, 14 operators agreed to facilitate the passenger recruitment process on their services and 11 operators delivered their stranded train protocols and manual for this research review. Steer used the materials to assess the adoption of the Guidance and its extent across the industry as well as to draw further analysis.

### Recruiting passengers to take part in research

Steer utilised a short online survey to recruit stranded passengers. The survey link was shared with the operators so that they could include it in their customer communication channels, such as emails or social media. Passengers who travelled on affected services were identified via ticket purchase or the Delay-Repay scheme and received the email inviting them to take part in the survey. It is worth noting that this approach necessarily excluded people who purchased tickets in person, but after considering all recruitment methods, deploying online channels was the only practical option.

The recruitment questions included screening criteria to confirm if individuals, in particular those recruited from social media, were in fact on stranded trains. The questions also asked a range of demographics to recruit people from different backgrounds. Eligible passengers, upon agreeing to participate, could leave their contact details for Steer to arrange in-depth interviews.

The full content of the screener questionnaire is included in Appendix 1.

There were initially several challenges that constrained the recruitment process such as:

* Insufficient train incidents that met the project criteria
* An insufficient number of eligible passengers identified via ticket purchase or the Delay-Repay scheme to invite to research
* Slow adoption of the recruitment process, due to operator internal procedures, which delayed the process, resulting in low engagement and response levels from eligible passengers

To overcome these obstacles and aid the recruitment, Transport Focus facilitated Steer’s engagement with Transport for London (TfL) and Trainline - a commercial company that sells train tickets and railcards via its website and mobile app. Both, TfL and Trainline, kindly agreed to facilitate and follow the already existing process in the same way as train operating companies.

### Overview of the stranded train incidents

In total, four incidents were researched and included eight stranded train services that met the project criteria. The incidents happened in four different locations across the country, between 7th and 21st December 2023, and were grouped into the following four case studies:

### Case Study 1

* Date and location: 7th December, Ladbroke Grove, Great Western Main Line, London
* Cause of the incident:
  + a damage to the overhead electric cables, resulting in switching off overhead power to all lines between London Paddington and Maidenhead
* Affected train operators:
  + Great Western Railway (GWR) – provides long-distance inter-city services and outer-suburban services in West London
  + Elizabeth line – a high-frequency commuter rail service running in [London](https://en.wikipedia.org/wiki/London) and its suburbs
  + Heathrow Express (HE) - a high-frequency [airport rail link](https://en.wikipedia.org/wiki/Airport_rail_link) operating between [London Heathrow Airport](https://en.wikipedia.org/wiki/London_Heathrow_Airport) and [London Paddington](https://en.wikipedia.org/wiki/London_Paddington_station)

### Case Study 2

* Date and location: 7th December, Beattock Summit, West Coast Main Line, South Lanarkshire
* Cause of the incident:
  + a freight locomotive struggling to travel uphill on Beattock Summit due to heavy rainfall came to a standstill – as a result three train services became stranded
* Affected train operators:
  + TransPennine Express (TPE) - regional and [inter-city](https://en.wikipedia.org/wiki/Inter-city_rail_in_the_United_Kingdom) rail service between the major cities and towns of [Northern England](https://en.wikipedia.org/wiki/Northern_England) and [Scotland](https://en.wikipedia.org/wiki/Scotland)
  + Avanti West Coast (Avanti) - provide long-distance services on the [West Coast Main Line](https://en.wikipedia.org/wiki/West_Coast_Main_Line) between [London](https://en.wikipedia.org/wiki/London), the [West Midlands](https://en.wikipedia.org/wiki/West_Midlands_(county)), [North West England](https://en.wikipedia.org/wiki/North_West_England), [North Wales](https://en.wikipedia.org/wiki/North_Wales) and [Scotland](https://en.wikipedia.org/wiki/Scotland)

### Case Study 3

* Date and location: 9th December, Corby Glen, East Coast Main Line, near Grantham
* Cause of the incident:
  + multiple services became trapped due to issues with electrical sections, often indicating a fault with the overhead equipment line (OLE), between Peterborough and Grantham as well as a track circuit failure in the York South area
  + a further delay was caused to one of the train services due to a fallen tree obstructing the track
* Affected train operators:
  + London North Eastern Railway (LNER) - provides long-distance inter-city services on the East Coast Main Line to and from London
  + Grand Central – provides long-distance rail services connecting Yorkshire and the North East to London with two routes

(An East Midlands Railway (EMR) service was also affected by the incident but was not included in the case study.)

### Case Study 4

* Date and location: 21st December, Bourne End Junction, West Coast Main Line, near Hemel Hempstead
* Cause of the incident:
  + overhead equipment wires came down on the Up Fast line at Bourne End Junction - as a result, all lines were blocked in the area so trains could not pass through, and trains were stopped at stations along the route where possible
* Affected train operator:
* West Midlands Trains (WMT) – provides regional rail services between London and the Midlands

The case studies are described in more detail in the subsequent sections of this report.

### Passenger interview and collecting direct feedback

In total, Steer interviewed 28 stranded passengers, across the four case studies:

* Case Study 1: nine passengers
* Case Study 2: six passengers
* Case Study 3: seven passengers
* Case Study 4: six passengers

This included eight people with additional needs, including passengers who were elderly and passengers who had been travelling with children.

The interviews were conducted between 13th December 2023 and 12th January 2024. They were hosted online, on Zoom or Microsoft (MS) Teams, or as phone calls and lasted between 30 and 45 minutes.

All conversations were conducted in accordance with the Market Research Code of Conduct.

The interviews were semi-structured to allow respondents to share their experiences in their own words, occasionally predefined prompt questions were also asked to collect additional insights.

In general, the main topics discussed were:

* What communications from the staff such as information, advice or reassurance were provided
* Passenger experience with on-board staff in general, and if and how specific needs of passengers were met
* How the evacuation process was executed (if relevant), in particular how any specific needs of passengers were met
* How passengers reached their destination and what support they received

The full list of questions is in the discussion guide included in Appendix 2.

The conversations were transcribed and collected information was anonymised and made non-attributable - no person is identified individually in the analysis or in this research report.

### Interviewing industry representatives to get their perspective

Between January and February 2024, Steer also arranged interviews with senior management representatives and decision-makers from the affected train operating companies, except for Heathrow Express, as well as with Network Rail. Frontline staff members (traincrew) were not interviewed for this project.

The interviews were semi-structured to allow respondents to share their experience and used a set of prompt questions to investigate the subject matter in detail. The conversations were hosted on Microsoft Teams and lasted between 40 and 80 minutes.

The full list of questions is in the discussion guide included in Appendix 3.

All collected information was anonymised (no individual job titles or names are included in this report) to protect respondents’ identities.

### Thank you and acknowledgement

Steer, Transport Focus and ORR would like to thank the train operators and Network Rail, who participated in the project, for their invaluable time and input. Special thanks go to Trainline, in particular the customer relationship team, and Transport for London for their help in facilitating the passenger recruitment.

## Stranded trains incidents

To understand and advise on the industry’s approach to stranded trains incidents, it is important to understand the context, in terms of why and how frequently they occur.

Through the project research period we have been monitoring the nature and frequency of stranded trains incidents across Britain’s rail network through Network Rail’s National Operation Centre (NOC) daily report.

Between 30th October 2023 and 8th January 2024, when on average over 19,500 passenger trains per day were planned to operate, there were 75 incidents, which resulted in 178 trains becoming stranded. This represents on average more than one incident a day, and typically at least two stranded trains per incident.

During this 70-day period, 27 days did not have any trains stranded, including Christmas Day and Boxing Day. This points to a significant level of variability, including the challenges and complexities of managing and responding to multiple incidents on some days.

Table 1.1 shows a breakdown of the stranded trains during the research period by operator and service type.

Of the stranded trains recorded in this period, 44% were commuter services, 36% long-distance services and 22% regional services.

Of the 178 stranded trains 20 were evacuated – a relatively small proportion (11% of the total).

### Causes of stranded trains

It should be noted that the research took place over autumn and winter, during which time the UK experienced multiple severe weather warnings for high winds, increasing the likelihood of stranded train incidents, including six named storms which caused significant travel disruption across all modes of transport. However, each season brings different weather-related challenges that have the potential to cause passenger disruption.

The rail network is susceptible to disruption due to extreme weather events, high winds, extreme heat and cold, and heavy rain which can all cause short- and long-term damage to infrastructure at various times of the year.

Table 1.1: Summary of stranded trains incidents during the research period

| Train operating company | Stranded trains | Long distance service | Regional service | Commuter service | Number of evacuated services |
| --- | --- | --- | --- | --- | --- |
| Arriva Rail London | 4 | 0 | 0 | 4 | 2 |
| Avanti West Coast | 16 | 16 | 0 | 0 | 0 |
| CrossCountry | 9 | 9 | 0 | 0 | 0 |
| MTR Elizabeth line | 9 | 0 | 0 | 9 | 4 |
| East Midlands Railway | 10 | 5 | 5 | 0 | 0 |
| Grand Central Railway | 2 | 2 | 0 | 0 | 0 |
| Greater Anglia | 7 | 0 | 7 | 0 | 2 |
| Govia Thameslink Railway | 14 | 1 | 2 | 11 | 5 |
| Great Western Railway | 13 | 7 | 5 | 1 | 2 |
| Heathrow Express | 2 | 0 | 0 | 2 | 2 |
| Hull Trains | 2 | 0 | 2 | 0 | 0 |
| LNER | 19 | 19 | 0 | 0 | 0 |
| Lumo | 3 | 3 | 0 | 0 | 0 |
| Northern | 8 | 0 | 8 | 0 | 0 |
| ScotRail | 2 | 0 | 2 | 0 | 0 |
| South Eastern | 21 | 0 | 0 | 21 | 0 |
| South Western Railway | 18 | 0 | 0 | 18 | 0 |
| Transport for Wales | 3 | 2 | 1 | 0 | 0 |
| TransPennine Express | 5 | 0 | 4 | 1 | 0 |
| West Midlands Trains | 11 | 0 | 0 | 11 | 3 |
| **Total** | **178** | **64** | **36** | **78** | **20** |

Overall, each of the 75 incidents can be traced back to five categories of root cause:

* Infrastructure failure
* Weather-related disruption
* Train failures
* Trespassers/ vehicles on the line
* Safety-related disruption

Figure 1.1: Identified causes of stranded trains incidents during the research period

As shown in Figure 1.1, infrastructure failure was the most common cause of stranded trains in the research period, with weather-related incidents coming in second. The direct impact of poor weather caused 14 of the incidents resulting in stranded trains.

During our research it was noted that faults with or damage to the overhead line equipment (OLE) that provides power to trains were a significant cause of stranded trains. Of the 75 stranded trains caused by infrastructure failures 43 of these (57%) are attributed to OLE faults (noting it may be possible that weather played a role).

The extent of the impact of electrification failures is often due to the large sections of the route which, for safety reasons, need the electricity supply to be switched off once a fault has been identified.

Major failures affecting electrified railways, including OLE and Third Rail, can cause several trains to become stranded at once and lead to protracted disruption with trains stranded for significant periods of time. This is evident in our case studies one and four, caused by OLE failures. While there were no incidents of stranded trains on third rail-electrified routes logged during our research period, such incidents present different considerations and challenges.

The length of time that trains were stranded for varies significantly. The shortest was 23 minutes, with the longest, 345 minutes, being due to an OLE failure.

The data for this period indicates that most trains are stranded for less than 2 hours:

* 132 were stranded for between 23 minutes and 120 minutes,
* 24 were stranded between 121 minutes and 180 minutes; and
* 13 were stranded for over 180 minutes

Of that final group of 13, the incident cause for 12 was an OLE fault. The remaining one was involved in a fatality.

As noted, 20 of the stranded trains during the review period were evacuated. Of these 20:

* nine were ‘train to train’ evacuation
* five were ‘train to ballast to platform’
* six were self- or uncontrolled evacuations

The six uncontrolled/ self-evacuations were all linked to one incident (case study one).

This incident will be reviewed in depth further in the report but there were a number of contributing factors to the self-evacuations including available welfare facilities, length of time the trains were stranded and staff availability.

The 70-day period we monitored has shown that stranded trains are not unusual events for most train operators, though there were several who did not have an incident during this time.

The majority of stranded trains remain so for less than 120 minutes with less than 25% lasting more than two hours. Infrastructure failures appear to have the highest risk of stranding trains due to the unpredictable nature and need to stop services immediately for safety, this is especially true on networks with OLE. OLE-related incidents, within the research window, had the greatest risk of causing multiple stranded trains over an extended period of time increasing the risk of uncontrolled evacuations.

### Key findings

From our review of incidents over the 70-day research period, the key points to note that inform our understanding of the case studies and subsequent conclusions and recommendations, are:

* While stranded trains are, unfortunately, an everyday occurrence, the most significant incidents and greatest risks to passenger safety and wellbeing are rarer
* There is a significant variation in the duration, impact and complexity of stranded trains incidents that policies and procedures need to manage
* Noting the significance of weather-related causes of stranded trains incidents, we saw no evidence that stranded trains policies and procedures were routinely reviewed, tested or assured as part of seasonal preparedness plans
* Damage to electrification equipment is the most likely single cause of a stranded train; and most likely to lead to more significant, complex and longer incidents. Therefore, this should be the key scenario for the review, testing, refinement, and continuous improvement of stranded trains procedures
* While industry performance improvement plans are beyond the scope of this report, action on managing and mitigating weather-related impacts and preventing failures of electrification equipment would represent the biggest priority for the *prevention* of stranded trains

# Industry adoption of stranded trains protocols

## The Guidance itself and its key principles

The Guidance makes clear that passengers’ needs can’t be understood and met through a single set of standards. National-level guidance needs to be translated into and developed further in local protocols and practices agreed on the basis of what is right for passengers on different routes and trains.

The Guidance sets out a number of key principles that must be considered when managing stranded train incidents to ensure that passenger needs are met. These are:

* the safety of the stranded passengers
* the welfare of the stranded passengers
* providing an excellent service to the stranded passengers
* the safety of rail staff and other responders
* minimising the impact on the performance of the network
* reputational damage to Network Rail, the operators concerned and the wider industry

These principles are expanded on within the Guidance, though it must be noted that they do not result in separate actions or advice, but rather the principles are all considered and together inform the recommendations in the Guidance.

### Safety

The safety of the stranded passengers, train staff and other responders is the core priority during stranded train incidents, and this is clear throughout the Guidance. While the industry top priority is the safety of the whole network, the Guidance reminds that passengers often see their safety as a base requirement and are more concerned with their security and welfare. If these needs are not effectively managed there is an increased risk of uncontrolled evacuations. The Guidance states “Conditions on board the train should generally be the single most important factor influencing the decision on how best to respond.”[[1]](#footnote-2) Therefore, the welfare of passengers must be considered as part of the safety considerations.

The Guidance is clear on what actions should be taken during a stranded train incident to ensure the safety of passengers, staff, and other responders. **Each decision taken must be informed by a risk assessment**. Dynamic risk assessments are very common in rail control environments and decisions to evacuate stranded trains must be co-ordinated between Network Rail and operator control rooms, as well as recorded at the time. Once an incident has occurred and has caused, or may cause, a train to become stranded, **the first action must be to avoid further trains becoming stranded**, or to lessen the impact of the stranding – trains should be stopped in platforms where possible.

The **early initiation of protocols** is recommended to avoid further delay as more information becomes available. The Guidance recognises that it is more effective to roll back the stranded train procedures than it is to start them part way through an incident. By enacting the protocols early, operators mitigate the risk of time slippage and delaying the rescue, recovery and evacuation plan.

The Guidance calls for **informed but swift decision making.** A stranded train champion should be identified to liaise with staff onboard to understand the current situation, including passenger numbers, number of passengers with additional needs, welfare facilities and external conditions. This information should then inform the plan to rescue, recover or evacuate which should be agreed within 60 minutes of the incident beginning. The Guidance recommends that contingency plans should be considered alongside the agreed plan. In the event they need to be changed, most commonly the contingency plan will be to evacuate the service. The information gathered must also be used to prioritise the use of resources - if more than one train is stranded, resource should be sent to the one with the highest needs first.

The risk assessment and onboard conditions must be **reviewed regularly throughout the incident** to ensure that the agreed plan remains the best course of action.

The Guidance focuses on the need for operators and Network Rail to **gather information about the situation quickly** to inform decision making and planning as a priority. This is to form a solid foundation for the rescue, recovery or evacuation plan, and to ensure that both staff and passengers are kept informed about the ongoing situation and plan. The ability to provide information to passengers helps build trust and mitigates the risk of an uncontrolled self-evacuation.

**Welfare**

The information gathered to understand the welfare of passengers on stranded trains is reflected in the information gathered for their safety. It is **vital that onboard conditions (passenger numbers, passenger demographic, group behaviours, onboard temperature, available toilet facilities, number of staff onboard, lighting, refreshments) are understood and monitored** to understand any change as the incident progresses.

**A** **designated person should be responsible for being the voice of the passenger** throughout the incident. The Guidance recommends a senior manager taking the role of the “Stranded Train Champion” to ensure that the passenger needs do not get deprioritised throughout the duration.

Passenger information is recognised as one of the best tools for operators to maintain passenger trust, aid their ability to keep passengers safe and to help meet their needs.

The importance of this is noted for both on the train and once passengers have alighted for their onward travel and about compensation rights. The Guidance focuses on the **accuracy, consistency, and regularity** **of information** across all channels, stating: “where information is incomplete or imprecise it should still be passed on with suitable explanation of its limitations.”

While the Guidance provides a summary of expectations around passenger information, it points operators to the “Good Practice Guide for Customer Information” for more detail.

### Service

The Guidance focuses on providing information to passengers on stranded trains through announcements, social media, TOC websites and customer relations via telephone. Announcements should be made at a 10-minute interval, even if no further information is available. The Guidance highlights **onboard staff soft skills** and making the announcements empathetic and confidence building.

Operators must also be proactive on social media, updating their channels regularly to avoid passengers forming “an incorrect or misleading perception of what is actually occurring”, degrading trust in the operator and increasing the risk of uncontrolled self-evacuation.

Finally, onboard announcements must be made to discourage self-evacuation, explaining the risks, and emphasising that the safest place for passengers is to be on the train.

The focus on safety and welfare are the foundations of providing excellent service to customers but the Guidance identifies other areas that operators should consider.

The **post evacuation experience** should be considered, with the Guidance highlighting:

* Information as to the arrangements for them to continue their journey (or be otherwise accommodated)
* Toilet facilities
* Refreshments
* Medical facilities
* Assistance in contacting concerned friends or relatives
* Information on compensation to which they may be entitled and how this may be claimed

## Reviewed protocols and procedures

During the industry engagement phase, Steer requested access to operators’ stranded train procedures in order to review them alongside the Guidance. Despite the fact not all operators supplied their documents, Steer was still able to provide a good overview across the rail industry, covering multiple regions and service groups (as shown in Table 2.1).

## Key findings

### Protocols are in place

While each operator reviewed owns and maintains a stranded train procedure they are not written in a consistent manner.

They vary from standalone documents which cover all aspects of stranded train management reaching up to 50 pages, to procedures that form part of a larger control manual containing information specific to control measures during stranded train incidents.

Each reviewed operator owns and maintains a stranded train procedure as part of their operational response plans. These are managed and reviewed in line with their internal review processes, with review periods varying from annually to every two years as a minimum. Operators reported that interim reviews are completed, updated changed if actions arise from incident review processes.

Although the reviewed stranded train procedures are designed to work alongside other procedures, such as major incident procedures, they are kept as separate procedures.

### The protocols apply the key principles of the Guidance

As indicated in Table 2.2, the procedures reviewed broadly apply the key principles and timescales within the Guidance.

Each contains considerations for the safety and welfare of staff and passengers, minimising the incident by preventing further trains becoming stranded, providing customer service during the event, and as a result protecting the reputation of the rail industry through the response to the incident.

The protocols broadly apply and reflect the recommendations set within the Guidance, and specifically section 2.2 that describes organisations’ responsibilities.

The gaps shown below, where key elements of the Guidance are not explicitly translated into local protocols documents, does not necessarily reflect an absence of procedure or action. As noted above, relevant information is often included in related procedures. In the reviewed documents related procedures were listed to allow for cross referencing.

Whether further strengthening of protocols could help better meet passengers’ needs, will therefore be informed by understanding passenger’ experience and feedback in practice.

Table 2.1: Stranded train procedure overview

|  |  |  |
| --- | --- | --- |
| Procedures reviewed | Operating regions | Service type |
| Arriva Rail London | London[[2]](#footnote-3) | Commuter |
| Avanti West Coast | Scotland | Long distance |
| North West and Central |
| Wales and Western |
| Chiltern Railways | North West and Central | Regional |
| Wales and Western | Commuter |
| Greater Anglia | Eastern |  |
| Great Western Railway | Wales and Western  Southern | Regional |
| Long distance |
| Commuter |
| North West and Central |
| LNER | Wales and Western | Long distance |
| Eastern |
| Scotland |
| Network Rail |  |  |
| Northern Railway | North West and Central | Regional |
| Commuter |
| South Western Railway | Wales and Western | Regional |
| Southern | Commuter |
| TransPennine Express | Scotland | Regional |
| North West and Central |
| Eastern |
| West Midlands Trains | West Coast South | Commuter |
| North West and Central |

Table 2.2: Overview of the stranded train procedure implementation of the Guidance

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Principles | Arriva Rail London | Avanti West Coast | Chiltern  Railways | Greater Anglia | Great Western Railway | London North Eastern Railway | Network Rail | Northern | South Western Railway | TransPennine Express | West Midlands  Trains |
| **Are the key principles of the Guidance reflected?** |  |  |  |  |  |  |  |  |  |  |  |
| The safety of the stranded passengers | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| The welfare of stranded passengers | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| Providing excellent service to stranded passengers | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |
| Safety of rail staff and other responders | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| Minimise the impact of performance on the network | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |  |  | Checkmark with solid fill |
| Take steps to prevent other trains from becoming stranded | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |  | Checkmark with solid fill | Checkmark with solid fill |
| Take control of the situation | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| **Are the key on-the day organisational responsibilities included?** |  |  |  |  |  |  |  |  |  |  |  |
| Understand the situation on the train(s) and undertake a risk assessment which is updated regularly | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| Agree a plan within 60 minutes be that rescue, recovery or evacuation to be reviewed regularly | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |
| Plans for evacuating trains to be developed concurrently with plans to move the train based on the ongoing situation | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| Clear timescales, including a count-up clock in Control, should be used | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| Where possible the correct resources are deployed to each stranded train | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| Communicate accurate, relevant and meaningful information to Passengers quickly and at regular intervals | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  | Checkmark with solid fill | Checkmark with solid fill |  |
| Ensure that staff are trained, and retain their competence, to deal with Passengers stranded on trains, including evacuation | Checkmark with solid fill |  |  |  | Checkmark with solid fill | Checkmark with solid fill |  |  |  |  |  |
| Trigger the emergency plan arrangements if the event warrants it | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |  |  | Checkmark with solid fill |
| Record the decisions made in managing Passengers stranded on trains |  |  |  |  | Checkmark with solid fill | Checkmark with solid fill |  | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |
| **Are the wider organisational enablers in place?** |  |  |  |  |  |  |  |  |  |  |  |
| Stranded passengers plan as part of Control arrangements | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| Stranded Trains included as part of emergency plans especially for larger incidents/events |  | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |  | Checkmark with solid fill |  |  |  |  |
| A framework for cooperation and sharing between themselves and with other organisations | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |  |  | Checkmark with solid fill |
| Staff trained and refreshed on their responsibilities in respect of Passengers stranded on trains. | Checkmark with solid fill |  |  |  | Checkmark with solid fill | Checkmark with solid fill |  |  |  |  | Checkmark with solid fill |
| Assessment of the need, based on risk, for emergency equipment on trains, stations, in company vehicles and at other locations for dealing with stranded passengers on trains and potential evacuations | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |
| Information protocols and arrangements in line with this document for Passengers stranded on trains | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  | Checkmark with solid fill | Checkmark with solid fill |  |
| Continuous improvement taking into account rail industry good practice |  |  |  |  | Checkmark with solid fill |  |  |  |  |  | Checkmark with solid fill |
| Testing arrangements and staff knowledge using tabletop and/or live exercises | Checkmark with solid fill |  |  |  | Checkmark with solid fill |  |  |  |  |  |  |
| Event, emergency and contingency planning should include managing the risks to Passengers stranded on trains |  | Checkmark with solid fill | Checkmark with solid fill |  | Checkmark with solid fill | Checkmark with solid fill | Checkmark with solid fill |  |  |  |  |

### Good practice management tools exist and can be shared

The procedures, whether standalone or as part of a wider control manual, are extensive documents that are not suitable to be referred to when an incident is in progress.

Many operators have recognised this and created checklists to ensure all key actions are completed for each incident. For instance, South Western Railway (SWR) have a separate checklist, created in collaboration with Network Rail for multiple roles within their control centre, which covers the operational delivery, internal and external communications, gathering and recording information alongside timescale expectations.

Not every reviewed procedure contained a checklist and therefore, relied on the control centre lead to use their best judgement to make necessary preparations and prioritisations to respond to stranded train incidents. Without a clear structure, there is a significant risk of inconsistency in response to such incidents, creating information gaps in the communication with staff and passengers, risking time slippages, delaying the process of making decisions and relying on staff experience to respond quickly and effectively.

Many operators provide templates for the risk assessment alongside their checklists which need to be completed during the incident. They can be initial or completed (when a train is declared stranded) and cover onboard conditions (including passenger welfare), external conditions, staff onboard and designated managers alongside contact details and number of passengers onboard.

The risk assessments completed are used to prioritise the response during each incident, with multiple stranded trains they are used to identify a priority order for rescue or evacuation. Figure 2.1 shows how the GWR initial risk assessments take into consideration the welfare of passengers and the safety considerations

Figure 2.1 Example of initial stranded train risk assessment - onboard conditions

A close-up of a sign

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Where a specific checklist is not provided within the procedures, a summary of the information required is within the procedure itself. While this lays out the same requirements, it may not be easily accessible during a live incident and again relies on the experience and knowledge of the staff working to ensure the correct information is gathered, both in regard to safety and welfare.

Figure 2.2 shows a less detailed requirement for the onboard conditions assessment within a stranded train procedure. The open-ended ‘information available’ could lead to risks not being identified, an increased risk of self-evacuation and poor passenger experience.

Figure 2.2 Example of initial stranded train risk assessment - onboard conditions

A screenshot of a computer

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Figure 2.3 shows the stranded train procedure from LNER and the train evacuation risk assessment provided by Network Rail. The information required is similar to that in the initial risk assessment, highlighting the need to gather the information as early as possible to ensure that decisions can be made swiftly.

All the reviewed procedures highlighted the need for effective internal communications during a stranded train incident. This includes initiating the on-call procedures, identifying a designated person to communicate with the stranded train (sometimes identified as a ‘stranded train champion’), the initiation of conference calls to pass information efficiently, and the use of industry systems such as Tyrell to pass information to frontline teams.

LNER includes an attendee list and agenda in the appendices of their stranded train procedure (as shown in Figure 2.4). This is a good example of ensuring that the correct roles and information is shared on the day, freeing those managing the incident to help them focus on the incident rather than organising internal communications.

Figure 2.3 Example of risk assessment for train evacuation

A close-up of a survey

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Figure 2.4 LNER conference call attendee and agenda

A document with text and numbers

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The use of checklists and templates would be beneficial across all operators to improve efficient and effective decision making and internal communication. This would in turn improve customer communication and understanding of the onboard conditions, leading to better prioritisation during incidents with multiple stranded trains.

The reviewed procedures are clear on the principles to manage stranded trains and they are written to be used where there are single *or* multiple trains stranded.

Throughout the review process, it was stressed by multiple operators that the information gathered from each stranded train must be used to prioritise evacuation or rescue where there are multiple services stranded (as shown in Figure 2.5). However, many train operating companies framed the procedure around a single stranded train rather than additional challenges surrounding incidents with multiple trains.

Figure 2.5 Multiple Train Prioritisation

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There might challenges in fully applying the procedures during incidents of multiple stranded trains across several locations. This is most apparent in the allocation of additional resource during stranded train incidents where there is an emphasis on sending appropriately trained staff to the incident site and providing additional trains either for rescue or train to train evacuation.

### Communication is a clear priority

Most procedures reviewed placed significant importance on providing regular and accurate updates to passengers involved in a stranded train incident. Throughout the review it was noted that most procedures viewed passenger communication as a mitigation tool for uncontrolled evacuation but to also provide passengers with information about the cause, any updates on the incident, availability of toilets/refreshments (where relevant) and for onward travel (see Figure 2.6). The principles for the communication were consistently based on each company’s Passenger Information During Disruption (PIDD) Protocols – a set of documented arrangements to provide clear, consistent, correct, and concise information. However, they go into varying levels of detail. Throughout the review there was a clear emphasis on providing customers with accurate information at regular intervals although the time between intervals is not always defined. Each procedure included the PIDD procedure and Approved Code of Practice – Provision of Customer Information within the related documentation to be implemented concurrently with the stranded train procedure. Where the Stranded Train procedure did not detail passenger communication it should be noted that separate procedures existed and were referenced for this purpose, though these were not reviewed for the purpose of this research project.

Though not consistently, several procedures reference the need for softer skills to be applied during stranded train incidents. Chiltern Railways specify “Announcements are about reassurance and confidence building – even if nothing more is known. The content and style of the announcement are likely to be the biggest factor in managing passenger behaviour and preserving reputation”. The addition of these skills within the procedures shows the operators understanding of the importance of passenger trust and confidence in the operators during stranded trains and how delivery of information not just the content impacts this.

Alongside the need to provide passengers with information the procedures all referenced the management of passenger welfare, although this was to varying degrees. The information gathered at the start of an incident includes the internal and external environmental conditions providing a baseline understanding of passenger welfare. Those with onboard catering or provision of emergency water reference the expectation for this to be provided to customers onboard. Throughout the review it was felt passenger welfare was considered but impacted by the service type, staffing levels and ability to provide refreshments. It should be noted that while there are not specific sections within the procedures for passenger welfare throughout the procedures, the implemented risk assessments, internal communication processes and safety considerations all have passenger welfare running through them.

Figure 2.6 Passenger communication during stranded train incidents example

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### Consideration of onward journeys is insufficient

Throughout most of the procedures reviewed there were references to passenger onward journeys across multiple sections. LNER place organising onward travel within their timed Duty Service Delivery Managers’ checklist within 0-30 minutes stating “Arrangements should also be made to provide rail replacement coaches to provide onward transport, wherever practicable.” Then again between 30-60 minutes that rail replacement and resource to manage this should be mobilised. Great Western Railway place organisation and implementation of onward travel plans within their Customer Action Teams roles and responsibilities. As noted previously the procedures are not consistent in how onward travel is managed, LNER’s use of a timed decision checklist ensures that the onward journey of customers is prioritised within 60 minutes, aligned with the recommendation in the Guidance to have a plan in place within 60 minutes.

Within other procedures, onward travel is referenced but the action owner is not identified, though this may sit within a separate procedure or as part of the role competency, and there are no timing points. This risks the provision of alternative transport being delayed and causing further disruption to passenger journeys. TransPennine Express (TPE) place a particular emphasis on the provision of onward travel, Figure 2.7 shows an excerpt from their procedure, here it highlights that passengers removed from a stranded train may still be stranded and must take priority for onward travel. TPE’s recognition that passengers may remain stranded after evacuation is a clear example that their procedure is not solely focused on the stranded train but on the passengers stranded as a result.

Figure 2.7 TPE Stranded Customer Excerpt

A close up of a document

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There were procedures reviewed that did not reference the provision of onward travel. These examples were all heavily focused on the practicalities of evacuating stranded trains, the technicalities of providing rescue trains to different unit types and passenger needs whilst on the train.

Within these documents there was a focus on the train rather than the passenger during the incident with one quoting “once passengers leave the train, staff at the station will be responsible for managing the situation”, providing no additional advice or guidance on what that management may look like.

### Training and testing could be given more focus

The training and competency around the stranded train procedures are not laid out within them but rather are managed through each company’s Competency Management Systems.

There is little to no consistency in how this is presented within the procedures, those with the most detailed explanations provide the job roles responsible for ensuring the training and competency and any relevant procedures. Great Western Railway were the only operator to reference training exercises within their stranded train procedure, requiring annual testing of the stranded train and controlled evacuation procedure.

### Summary

Overall, the procedures utilise and reflect the Guidance, but application of it is not consistent across the industry. Therefore, some reflect the intent of putting passengers’ needs first better than others.

Indeed, there is a clear split between how the procedures are written. Some heavily focus on the operational technicalities of a stranded train and others took a more holistic view, including the passenger experience, in line with the spirit and intent of the Guidance.

It is clear that each operator uses the Guidance within their procedures, often taking direct text and including it within their documents.

The procedures that include checklists and templates show a clear understanding of the importance of information gathering in stranded train incidents. An LNER detailed checklist, with timing points, should be acknowledged as good practice alongside a stranded train prompt and timeline flow chart from TPE. These examples not only cover operational decision making but also prioritise customer-focused decisions.

Ensuring that operators’ controls have the tools for efficient and informed decision making has a direct impact on the passenger experience, quick decision making, and effective internal communication ensures that passengers can be kept well informed of the situation and are confident in the operator’s ability to control and recover the situation.

The procedures reviewed often do not discuss additional challenges that may impact the response to stranded trains. There is limited recognition of the impact multiple stranded trains may have on the ability to fully implement the procedure and how the response may need to change. In the procedures reviewed there was also little to no consideration for the time of day an incident may occur and the additional challenges that may result for onward travel and staffing levels in particular.

There is considerable inconsistency in approach to onward travel in the procedures reviewed and this is a clear area for improvement that should be highlighted.

Provision of rail replacement services is a significant challenge across the industry and in circumstances such as stranded trains where buses/coaches and taxis are likely to be required, the decision and actions to procure them should take a high priority.

The lack of focus on passengers’ experience once they are off the train, and their onward travel arrangements, suggests there may still be more emphasis on the incident rather than the passenger. The TPE procedure expresses this even better, saying: “please don’t forget them just because they are no longer on the train.”

## Key findings: strengthening stranded trains procedures

While overall it is positive that operators have adopted stranded trains policies and procedures, to embed the intent of the Guidance and continuously improve those procedures, operators should consider:

* Specific requirements to test the procedure, including ‘stress tests’ for more complex scenarios and other factors such as incidents occurring when resources are reduced
* Adopting good practice assessment and checklist tools
* Including guidance and protocols related to onward travel
* Further focus on stranded trains-specific training, including soft skills and empathetic and confidence-building communication amid uncertainty

## Further recommendations on industry adoption

With each operator responsible for their own procedures there is a lack of consistency across the industry, in particular with regard to passenger experience and onward travel.

It may therefore be beneficial for a working group to be established to facilitate the sharing of best practice, lessons learned and updates to procedures. This would help provide, for the passenger, a more consistent experience across the network.

# Case studies

## A screenshot of a map Description automatically generatedIntroduction

Figure 3.1 Overview of the case studies

The train incidents that met the project criteria were grouped into four case studies (as shown in Figure 3.1).

The case studies are described in chronological order and include passenger feedback as well as responses from the rail industry to get a full picture of the stranded train incidents.

The passenger feedback is structured around the following key areas:

* **Onboard condition and facilities**, for instance, lights, heating, air conditioning, toilets
* **Customer service**, including meeting specific needs of passengers
* **Passenger communication** - what information, advice or reassurance was provided by the staff
* **The evacuation process**, in particular ensuring passenger safety and wellbeing
* **Received support from the staff regarding onward travel (after the incident)**

The case studies also include key points discussed in the interviews with industry stakeholders. These were:

* The implementation of stranded train procedure
* Internal stakeholder communication
* Customer communication and welfare
* The evacuation procedure
* Decision-making process

Table 3.1 shows the summary of the passenger feedback for each research area as well as their emotional response.

This feedback was collected from a range of passengers with different demographic backgrounds but highlighted some common experiences:

* When onboard conditions are poor and/ or facilities stop working, in particular during long stranding incidents, passenger discomfort increases sharply, so much so that sometimes it can create a stressful and uneasy atmosphere on the train for all concerned
* Passengers feel more empowered and in control when onboard communication about the onward travel arrangements and reimbursement process is shared. What is more, they feel more understanding and at ease when they frequently receive contextual information about the incident
* In many examples, frontline staff with a professional and calm manner as well as approachable attitude not only improved customer satisfaction but were genuinely appreciated and remembered by passengers
* Evacuations are stressful and pose risks for passengers, so it is paramount that their processes are planned, clearly communicated, thoroughly executed and supported by sufficient staff resources to ensure safety.
* Support and information about onward travel is just as important as getting people to the station. Otherwise, the best efforts at resolving a situation can still leave passengers dissatisfied and inconvenienced

Table 3.1 Summary of the key points from passenger interviews against key research areas across all case studies

|  |  |  |  |
| --- | --- | --- | --- |
| Key areas researched | Summary of the key points from passenger interviews across all case studies | Passenger emotional response |  |
| **Onboard condition and facilities** | * Passengers felt significantly more comfortable when there were working lights, heating, charging sockets, air-conditioning as well as accessible and usable toilets. This was particularly evident for passengers stranded for longer * Stranded passengers were more distressed if the onboard conditions and facilities were poor or not available; in some instances the absence of these caused aggravated behaviour towards fellow passengers and train staff, creating an uneasy atmosphere on the train | **Comfortable Satisfied  Content** **Uncomfortable  Irritated Impatient** | ***“It was actually really hot and (…) because the power went off, obviously there was no sort of air flowing through the train at all.”*** |
| **Passenger communication** | * Passengers were much less anxious and could plan ahead when they received clear and frequent communication, for instance, about the reimbursement process, onward travel arrangements and estimated time of arrival * Passengers felt more understanding and patient when they received explanation about a wider context of the issue * Passengers tend to become annoyed and eventually ignored repetitive updates. They also felt confused when contradictory messages were shared * Passengers with additional needs, for instance those with hearing loss, and elderly felt less informed and less reassured than others. * Very few interviewed passengers mentioned checking social media for updates about the incident | **Empowered Understanding Reassured** **Anxious Confused Frustrated** | ***“It could have been much more uncomfortable and maybe potentially even unnerving (…), but because [the train staff] was so good at keeping you fully informed, it felt like everything was in control.”*** |
| **Customer service** | * Stranded passengers had a very positive experience when the train staff was professional and calm * Passengers noticed and appreciated when the traincrew were proactive, approachable, with a humble attitude * Passengers valued simple gestures from the train staff such as answering their questions, offering that passengers could use their mobiles so that they could inform their relatives about the delay, regularly checking on them or just being present/ visible to them * Passengers noticed that customer service was not always prioritised for passengers with additional needs (who reported feeling distressed in such instances) * Not all passengers stranded on long-distance trains were informed about or received water and/or refreshments. In some instances, there was an insufficient supply of refreshment, or passengers could not access them (water was placed in certain locations or passengers had to queue to get it) | **Appreciative Sympathetic Satisfied Disappointed  Annoyed Unhappy** | ***“[The traincrew] did all they could do; I don’t think there’s anything I’d say that they could do better. (…) It was a bit of personal service as well (…) I couldn’t fault them under the circumstances.”*** |
| **Evacuation process** | * Passengers felt anxious during the evacuation. In severe situations, this was significantly exacerbated by the absence of staff. * Stranded passengers did not feel safe during the evacuation process as often the plan to execute it had not been clearly communicated to them * Passengers perceived that operators did not have contingency plans and sufficient staff resources in place to execute the evacuation process safely and efficiently; some felt disappointed by this | **Safe Grateful Understanding Scared Confused Let down** | ***“I was really disappointed when I realised that the evacuation was actually an organised action until the stations, and then really there was no transportation. I was expecting more from [the operator] (…), I would have expected a representative at the station or at least someone who cared about what would have been our needs.”*** |
| **Received support after the incident** | * Passengers felt reassured by, and highly valued, on-going support and customer service that did not end once they got off the train * People felt satisfied when they received onboard communication about onward travel arrangements and how to get compensated However, they quickly felt frustrated when it turned out that the operator did not deliver on their promises once they left the train * In some instances, passengers felt abandoned when train staff ignored their questions about alternative transport arrangements to get to their destination | **Satisfied Appreciative Reassured Angry Frustrated Dissatisfied** | ***“(…) if someone [a staff member] had been there saying right, come this way, this is the way to go (…) because people were just depending on the phones to plot their 10-minute walk across Glasgow (…)”*** |

## Case Study 1: Ladbroke Grove, Great Western Main Line, London

### Date: 7th December 2023

### Incident overview

Seven trains across three different operators became stranded in the Ladbroke Grove area due to a damage to the overhead electric cables. As a result, overhead power to all lines between London Paddington and Maidenhead was switched off and caused further disruptions to train services in the area. The emergency services attended to the site since the volume of affected passengers was significant and the overall situation was severe. Moreover, the incident occurred on a day when there was an ASLEF overtime ban (a form of industrial action) and reduced staff availability at Great Western Railway (GWR).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Affected operators | Affected trains | Time train was stopped for | Involved evacuation | Had no electricity supply |
| GWR | One | Approximately 4-5 hours | - | - |
| Elizabeth line | Four | Yes | Yes |
| Heathrow Express | Two | Yes | - |

### Interviewed passengers

In total, nine passengers were interviewed - including six men and three women - aged between 25 and “over 70” years old. One of the passengers had a long-term physical illness or health condition that affected their ability to travel by train, and two passengers had a mental health condition.

Passengers noted no signs of disruption before the incident happened but had noticed that fewer journey options were available due to industrial action. As a result, all passengers travelling on westbound services were leaving London Paddington around 18:30. For the passengers travelling with GWR, this was also the penultimate service of the day.

Around 15-20 minutes into their journeys, their trains came to abrupt stops.

### Stranded passenger experience

**Key takeouts from passenger interviews:**

* Stranded passengers on trains with good conditions (such as working lights, air conditioning or heating on) felt much more comfortable than those on services without
* Passengers felt reassured when there were regular announcements, in particular when there was no direct contact with the staff
* Stranded travellers found honest and clear information helpful in planning their onward journey
* In the absence of new updates, passengers found repetition of old information more annoying than helpful
* Passengers felt anxious when no train staff or any industry officials was present during severe situations
* Passengers felt that their safety and wellbeing was impacted by lack of organisation and contingency plans (including quick decision-making processes)
* Stranded passengers felt that customer service was less good when they did not receive assistance or adequate information regarding onward travel

### Situation and conditions on the train

All affected train services were busy with factors affecting passenger comfort varying across the operators.

GWR and Heathrow Express passengers had toilets and charging facilities onboard that, at first, passengers could access during the incident. The Elizabeth line, on the other hand, is not equipped with such facilities – which later appeared to be a contributing factor to the passenger self-evacuation. Additionally, travellers on both GWR and Heathrow Express initially had access to refreshments (mainly bottles of water), whereas those on the Elizabeth line did not.

On the GWR train and initially on the Heathrow Express services, passengers reported feeling comfortable since the lights and heating were available whereas those on the Elizabeth line experienced the opposite. Interviewees remembered that “it was actually really hot and (…) because the power went off, obviously there was no sort of air flowing through the train at all.” Additionally, the power outages resulted in ‘low level lighting’, carriages being ‘reasonably dark’, and no announcements being made to keep passengers informed. Also, people were not able to access charging points for mobile devices and later faced issues with planning onward travel.

Passengers on the GWR and Heathrow Express trains reported that, as the incident progressed, the toilet facilities eventually reached a condition where they were no longer sanitary- “the toilets were pretty bad, there was no way to flush them. Everybody was there trying to flush it and it wasn’t working, for me the toilet was completely inaccessible.” People also couldn’t wash their hands – something a passenger noted as a significant concern in the post-pandemic era.

During the incident, GWR and Heathrow Express passengers were frustrated that their journey was delayed, though the general atmosphere on carriages remained friendly, with interviewees recalling people being in ‘good spirits’. Stranded travellers stayed patient and calmly listened to announcements.

It was the opposite situation on the Elizabeth line, with no access to air conditioning, toilets, or charging facilities (and reduced lighting), some stranded passengers started misbehaving and violently trying to force the doors open. One passenger noted that there were announcements saying, “can people stop trying to open the emergency doors to get out (…), can people stop kicking the doors – I know you’re frustrated but please stop doing that.” This further exacerbated the already stressful and unpleasant atmosphere on the train.

### Customer service

Stranded passengers on the GWR service had very little recollection of staff members, with their main interactions being ‘over the intercoms,’ rather than visibly in person. Travellers who remembered interacting with the train crew, reported feeling that “they [staff members] did not have any more information about what to do than we did.” Nevertheless, all passengers recalled having very positive experiences with train staff who were helpful, reassuring and remained calm throughout the duration of the incident.

In addition, some GWR passengers did not know that refreshments were available onboard and did not get the water– “I think at one point they [train crew] put a case of water at the end of the carriages, but they didn’t announce this at all (…) They just put it there and the people nearby were aware of it.” When the refreshments ran out, some travellers expressed their disappointment and also concern that there was no initiative to prioritise those who were least likely to be able to access the water, in particular passengers with mobility difficulties, were elderly, or people travelling with small children.

Heathrow Express passengers appreciated that staff members did ‘the best they could’. They were regularly going through carriages, offering bottles of water to everyone, and answering questions. Despite this, interviewees noted that the train crew were “left alone from higher levels, so it was up to their initiative and proactiveness to do something.”

Passengers stranded on the Elizabeth line could only see and hear the train driver, no other staff members were present, and thought he was ‘absolutely brilliant’ and ‘communicative’ given the circumstances. There was no open line of communication for passengers after the trains lost electricity supply.

**“There are ways of prioritising and organising mass evacuations and mass transport of people where you have to look at people who've got kids, you've also got to look at the people who are travelling (…) and it can all be done. It's done in the military – [train operators] need to have a plan!”**

Stranded passenger on the GWR service describing their arrival at London Paddington

### Passenger communication

Once the trains came to a stop, passengers across all affected services reported that initial announcements were made fairly quickly. They were informed about the cause of the incident, suggesting it would not be a significant delay, but did not say how long it would last. A Heathrow Express passenger remembered that “the first announcement was very hopeful (…) so there was a sense that the thing would have been sorted quite quickly”, and a GWR passenger said “I think with the initial announcement, I didn’t really realise how late we were going to be”, while an Elizabeth line passenger commented that “[the initial announcement] was totally normal, there was no indication that it would turn into what it did turn into”. The subsequent updates were frequent and provided information about the delay, however the messages were sometimes contradictory.

**“It felt like we were a bit in no man's land because it felt like there was Network Rail, the police and probably other rail organisations. Because Elizabeth line it's not the tube or it's not the train line, it feels like it falls between the cracks sometimes, and it felt a bit likewe were a tube running on a train line (…) and no one really knew whose responsibility we were. Were we [Transport for London]’s [problem], were we Network Rail’s?”**

Stranded passenger on the Elizabeth line waiting for being evacuated

Passengers on the Heathrow Express stated that at first, it seemed that the electrical issue was due to a fault with their train, but later it was confirmed that it was an issue with a train ahead. Whilst those on the GWR train that had struck the damaged overhead electric cables believed the issue was with another service.

As the incident progressed, further conflicting information was provided. Passengers on some trains were informed that they were going to Ealing, only to be informed hours later that they would be taken to London Paddington.

In addition, GWR passengers were initially led to believe that they would be evacuated through the back of the train, they were then informed that this would not be possible due to a high volume of passengers – “there were quite a lot of muddled messages and backtracking on what [train staff] said earlier.”

Passengers felt frustrated with conflicting messages although appreciated that they were clear and shared in a professional and calm manner. Passengers onboard the GWR train noted that the announcements became even more comprehensive when a senior staff member from Network Rail, who was coincidentally travelling onboard as a passenger, helped with the announcements. Others felt the messages became too repetitive and even frustrating, particularly when no new information was shared.

On Heathrow Express, passengers were happy that “there was a member of the staff that was walking up and down because of the questions of some passengers had (…) and he provided slightly more detail”, albeit information about reimbursement was not provided.

Passengers stranded on the Elizabeth line remembered the initial announcements being clear and easy to understand. Once they stopped, there was no other line of communication with any other industry representatives. Passengers reported that “it felt like we were a bit in no man’s land because it felt like there was Network Rail, the police and probably other rail organisations. Because the Elizabeth line it is not the tube or it’s not the train line, it feels like it falls between the ‘cracks’ sometimes and it felt a bit like we were a tube running on a train line (…) and no-one really knew whose responsibility we were. Were we [Transport for London]’s [problem], were we Network Rail’s?”. Interviewed travellers also believed that “there were procedures in place, but no one really knew what they were,” which resulted in passengers feeling the need to take matters into their own hands and get themselves off the train.

The process of getting off the trains was different for passengers travelling with different train operators.

### GWR passengers reaching their destination

Passengers onboard the GWR train were returned to London Paddington at a very slow speed. Onboard, passengers were told there would be a member of staff who would arrange taxis for onward travel. Given that there were over 900 passengers onboard the service, people quickly sensed this arrangement would be unrealistic and felt very anxious. Upon arrival at London Paddington, interviewees described the chaos that transpired at the station as “a mob running to the stand, and that actually was the beginning of the worst part for me, in a way. It was chaos and there was nobody (…)” due to staff shortage to help so many passengers. The process of trying to get a taxi at Paddington resulted in further delay to passenger journeys. Many people had to wait for hours at the station before they managed to organise alternative transport to reach their final destination. Interviewees also reported there seemed to be no prioritisation system for families with children or elderly passengers, or logical grouping of, for instance, passengers who were going in the same direction. To put it simply “there are ways of prioritising and organising mass evacuations and mass transport of people where you have to look at people who've got kids, you've also got to look at the people who are travelling (…) and it can all be done. It's done in the military – [train operators] need to have a plan!”

### Evacuation process experienced by Heathrow Express and Elizabeth line passengers

Passengers on the Elizabeth line and Heathrow Express also had a frustrating and chaotic experience.

A Heathrow Express staff member, while making their way down the train, informed people that they would be evacuated around 20:45, the doors opened at 21:00. But the message prompted passengers to start getting ready as soon as they heard the information about the evacuation, which resulted in making the carriages busier and more difficult for the staff member to move and notify the remaining passengers. The information then had to be spread by word of mouth between travellers. In addition, stranded passengers did not get any information about the evacuation or safety procedures. However, they were assisted by the fire brigade when getting off the train and walking along the track towards Hanwell station.

Prior to that, passengers were reassured via announcements that alternative transport options had been arranged at Hanwell station. They felt disappointed when it turned out they were expected to arrange onward travel on their own. Interviewed passengers reported that they were also under the impression that a Heathrow Express representative would meet them at the station, only to learn there was no such person to welcome them. This made them feel let down and “really disappointed when I realised that the evacuation was actually an organised action until the stations, and then really there was no transportation. I was expecting more from Heathrow Express (…), I would have expected a representative at the station or at least someone who cared about what would have been our needs.”

British Transport Police (BTP) began evacuating stranded passengers on the Elizabeth line around 22:30. However, the interviewees reported being confused as to whether it was an official procedure or led by passengers since, in the absence of announcements, the earlier self-evacuations had already started. Many passengers decided to jump off, riskier than if directed by BTP, and join the crowds for ‘quite a treacherous walk’ to the next station. Additionally, at the beginning of the evacuation, passengers were led in the direction of Paddington for around 5-10 minutes, but were then told to turn back and head the other way, adding further physical and mental exertion. Once passengers reached the station, they were advised to find their own transportation home, difficult for many whose phones had run out of power. The fact that it was dark caused them additional anxiety, especially for female passengers - “I was literally left in a place in London I don’t know, on my own as a woman, and my battery was almost dead. (…) I was panicking about how I was going to get home.” Passengers were not advised on how to claim reimbursement for onward travel - pertinent information given many travelled in taxis.

**“I was really disappointed when I realised that the evacuation was actually an organised action until the stations, and then really there was no transportation. I was expecting more from Heathrow Express (…), I would have expected a representative at the station or at least someone who cared about what would have been our needs.”**

Stranded passenger on the Heathrow Express service describing how they felt about the evacuation process

### Advice to train operators from stranded passengers

During the interviews we asked respondents to share their piece of advice with train operating companies on how to deal with stranded train incidents in future so that passenger experience is improved.

Most respondents advised the operators to take more action in organising onward travel and ask them to clearly and honestly, in particular when there are staff shortages, communicate how they are going to execute their plan. For instance, if taxis for onwards travel would be paid by the operator or by passengers and, if so, how they should claim their expenses back. “As soon as you know that the train will not be travelling anywhere, prioritise the passengers because it can't have been cheap for [Transport for London] to compensate lots of people (…), also you can't really just leave people stranded in the dark at night in an area of London that they have no idea about (…), I think it felt completely avoidable and so my advice would be as soon as you know that it's not going to work, then prioritise the passengers.”

Stranded passengers also urged train operating companies to prioritise and take extra care of people with special needs, elderly or those travelling with small children when stranded train incidents occur. For instance, when serving refreshments, during the evacuation and when organising alternative transport options for reaching the final destination.

### Industry perspective on the incident

### Implementation of the stranded train procedure

During the incident both operators interviewed noted some issues with implementing their stranded train procedures. GWR was hampered due to the impact of industrial action taking place on the day. Competent staff who may have assisted during the incident were unable to as they had been utilised to run a reduced train service throughout the day, working 12 hours shifts. As a result GWR was unable to resource staff to attend the locations of the stranded trains to provide support and a direct line of communication. The industrial action also impacted GWR’s ability to provide a diesel locomotive to move stranded trains that were not trapped, or an additional diesel train to support train to train evacuation. They did not have a driver available and the locomotive, even if they had found a driver, was trapped in the depot by trains not in use due to the limited service running because of the overtime ban.

MTR Elizabeth line (MTREL) noted that their procedure was approximately 50 pages long which had a detrimental effect on its usability. Alongside this was the fact that the incident was the first time MTREL had implemented their Major Incident Procedure. They noted that there was little expectation that they would experience an extended stranded train incident.

### Internal and stakeholder communication

Throughout the interviews both GWR and MTREL noted that communication between the incident site and the operator controls was challenging throughout the incident. Both operators raised that it took a long time to get an estimate for the duration of the incident, although it was noted that this may have been due to those on site being unable to ascertain this. There were also challenges with understanding what the recovery plan and priorities were. GWR identified that this issue would have been mitigated had they been able to resource staff to site.

GWR raised that the Network Rail plan appeared to change a number of times which hampered decision-making within their own control.

MTREL provided their driver reports from the incident and a lack of information to the train was a consistent theme. The driver of one service was advised that it would be evacuated and confirmed this to passengers several times however, a miscommunication meant that the evacuation team went to a different train first.

Internal communications within MTREL and GWR were impacted by the lack of information from site. It was noted by MTREL that their control was unable to pass information to the drivers onboard their stranded trains as they had not received it.

The internal processes for communication were implemented in line with their stranded train procedures. Both operators implemented internal conference calls to share information alongside the use of industry systems, huddles and a control centre incident log (CCIL). MTREL also used MS Teams, with a group set up for the Customer Experience team to share operational updates, social media posts from customers onboard and updates from frontline staff if needed. They also utilised WhatsApp groups for their on-call team.

Both operators had contact with Network Rail Control throughout the incident, GWR Control are collocated with Network Rail and MTREL’s senior members, responsible for service delivery, were in contact by phone.

**Customer communication and welfare**

MTREL is a Transport for London (TfL) concession and within their concession targets they are measured on their provision of Passenger Information During Disruption (PIDD). As a result a detailed report was written on the customer communication for the incident and was shared as part of the case study. Due to MTREL services operating with a driver and no additional onboard staff, all announcements and information would be delivered by one person onboard. Customers also had access to social media and other websites by using their own devices. MTREL’s social media is managed by TfL and messages were passed to ensure that the page was updated regularly.

MTREL trains are electric and have a limited battery once the OLE is not powered, they also have no toilets or catering onboard.

The MTREL interview and report shows that train staff made regular announcements, some supplementing manual announcements with prerecorded ones. However, the challenge highlighted in gaining information regarding the duration and recovery plan meant that there were limitations to what the staff could pass on to passengers. The drivers contacted the signaller to gain permission for several customers to leave the train through the driver’s cab to relieve themselves and made an announcement to the train advising of this. One was allowed by the signaller to open the doors on the train to provide fresh air to those onboard whilst continuing to make safety announcements regarding self-evacuation. The driver of another train was advised that it would be evacuated and advised passengers accordingly. But there was a significant gap between the initial announcement and when the evacuation began due to a miscommunication. Another driver gained permission from the signaller to leave the cab and walk through the train to speak to passengers alongside making PA announcements.

Throughout the incident announcements were made to discourage self-evacuation. The duration of the incident meant that the MTREL trains lost power and the drivers was unable to make further announcements to passengers onboard. Prior to the loss of power an announcement was made advising passengers of this and loud hailers were utilised by the driving team.

GWR trains were staffed by both a driver and customer experience hosts, as long-distance services they also had toilet facilities and catering available. It was noted during the interview that the challenge in getting information regarding the incident resulted in being unable to provide regular updates to passengers onboard. While refreshments were available these were not handed out and the reason for this was not recorded.

GWR also reported that they identified a customer onboard without access to required medication, following this they were able to facilitate the customer’s evacuation with Network Rail as a high priority.

**Evacuation**

Due to the severity of the disruption caused by the damaged OLE, both GWR and MTERL were limited in their ability to evacuate services. MTREL were unable to provide any additional trains due to a complete lack of power, this meant the only options were for the OLE to be repaired and to move the stranded trains when this happened or to complete a train-to-ballast evacuation which would be authorised and led by Network Rail.

GWR were unable to provide a diesel train for rescue or train-to-train evacuation due to the availability of staff. As a result they were limited to the same options as MTREL. During the interview GWR did question the decision by Network Rail to evacuate the customer, who required medical assistance, but not the whole train.

**Decision-making**

Both operators expressed that the nature of the incident and the surrounding circumstances meant they were limited in what they were able to do. The challenge in gaining information from site may have impacted their ability to challenge decisions being made on the ground, GWR expressed that following their review they would likely have challenged the resource allocated to the 1C28 service, that struck the damaged OLE, as it was a diesel hybrid and the only stranded train capable of being moved.

MTREL noted that they felt that the lack of information and clear timescales hampered their ability to make decisions, so while the intent was there the ability was not.

**Onward travel**

GWR advised that there was a delay in ordering rail replacement services, in the form of taxis, due to the delays in the confirmation of where they were required. An initial plan to evacuate the train at Hanwell station was changed and the train was sent back to Paddington. GWR advised that this gave them approximately 15-30 minutes to resource transport. There was also an additional challenge in resourcing the transport due to the amount required and the time of night. The short notice also led to Paddington station being less prepared to receive the customers than they could have been with more advance notice.

## Case Study 2A white figure with a black background Description automatically generated: Beattock Summit, West Coast Main Line, South Lanarkshire

**Date:** 7th December 2023

**Incident overview**

A freight locomotive came to a standstill around 13:38 whilst struggling to travel uphill on Beattock Summit due to heavy rainfall. It was rescued after 90 minutes but resulted in three stranded trains - two Avanti West Coast and one TransPennine Express (TPE).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Affected operators | Affected trains | Time train was stopped for | Involved evacuation | Had no electricity supply |
| Avanti West Coast | Two | Approximately 90 mins | - | - |
| TransPennine Express | One | - | - |

**Interviewed passengers**

We interviewed six stranded passengers, including two men and four women, aged between 25 and 64 years old. One of the respondents had a long-term physical illness or health condition that affected their ability to travel by train. Another interviewee was travelling with small children.

**Prior to the incident**

Passengers acknowledged that there was hint of upcoming disruption when they saw other rail services being delayed and getting stuck behind another train. No interviewee concluded though that services were disrupted due to heavy rainfall as the weather was good at their departure stations.

**Stranded passenger experience**

**Situation and conditions on the train**

Avanti and TPE are both long distance operators which means passengers have access to catering, toilets and charging facilities onboard.

Passengers travelling with both operators told us that conditions onboard were satisfactory during the incident. They had the lights and heating on and felt very comfortable. Fellow passengers remained calm and in reasonably good spirits whilst onboard.

Stranded passengers on the TPE train also reported that at one point, the engine was turned off and it became slightly cooler onboard, but this did not seem to have had a negative impact on their wellbeing.

**Customer service**

Respondents on the Avanti trains reported that the pleasant atmosphere was mainly a result of the efforts made by the train staff. They moved through the carriage reassuring passengers - “if anybody needed to use [staff member’s] phone (…) because [passenger’s] phone had died (…) [staff] said you can use [their] phone to make a call (…) [traincrew] gave loads of information about connecting trains.” The staff member “(…) who was in charge of the situation in terms of informing us, (…) I was very, very happy with it. I feel like it could have been much more uncomfortable and maybe potentially even unnerving, depending on how nervous of a passenger you are, (…) but because [they were] so good at keeping you fully informed, it felt like everything was in control.”

One interviewee from the TPE service noted that when another passenger became distressed, the traincrew was admirable in reassuring the individual - “I’m not sure that I would have had [their] patience”.

As soon as the delay was announced, Avanti passengers rushed to the onboard shop to buy refreshments, in particular hot food. Consequently, the catering quickly sold out, leaving many people without any food – “I think that I would be a lot more prepared if I know they have (…) fresh sandwiches and stuff like that, but if you get stuck on a train for a few hours, I understand that sandwiches can be quite wasteful if people don't eat them (…) but they need to offer more things (…) like a pot noodle or anything like that (…) if you’re completely starving and stranded for a few hours, at least, that sort of food doesn't go off.”

**“It would have been so much more of a painful experience if [the train staff] hadn’t been as good as they were.”**

Stranded passenger on the Avanti West Coast

Passengers onboard the TransPennine Express train experienced a similar discomfort and were also not kept up to date on if refreshments were still available at the onboard shop – “(…) the staff said the shop is open for (…) refreshments for people (…) maybe an hour later, I said to my wife ‘I’ll look down and see if we can get something’, but when I got there, it was empty (…) there was nobody else there so the staff didn’t keep us up to date with that.”

Passengers stranded on the Avanti trains were offered free water, but they had to collect it themselves, which suddenly created an extensive queue. Some interviewees mentioned that it might have been more efficient to have staff members handing out the water to everyone, making it more accessible to all travellers, especially those with reduced mobility.

**“[The train staff] were doing an excellent job (…) I’m not sure I would have had [their] patience.”**

Stranded passenger on the TransPennine Express

A similar situation occurred onboard the TPE service. One interviewee, travelling with small children, joined the queue to collect water for his family, only to be turned down by train staff when showing individual tickets to prove he was travelling with others. He also felt that the policy of providing one bottle of water per passenger was lacking consideration and disadvantaging those who travel with minors – “I mean, if you’ve got your tickets and can prove them (…) we have six tickets (…) providing they’ve got enough water for everybody (…) it’s a little unreasonable to take the whole family and walk through the carriages just to get a bottle of water.”

**Passenger communication**

Stranded passengers on Avanti trains remembered hearing the initial announcement within minutes of stopping. The information was very detailed, providing context to the incident and describing the process of sorting it out. Passengers mentioned that such detailed messages made them feel less frustrated and hopeless – “I don’t feel like it was really more than 15 or 20 minutes between announcements (…) I don’t feel like [the train staff] left anybody waiting or anything for too long at all.” They also shared that knowing how long they would be stranded for - thanks to accurate estimates provided by the traincrew - made them feel less stressed and enabled them to adjust their plans accordingly. “[The staff] was really, really helpful and went through the carriages a number of times as well, so that gave people opportunity to ask [them] more questions.” Further updates were provided every 15 to 20 minutes, or whenever new information was available. The messages were also very clear - “I’m quite deaf and the announcements were perfectly easy to hear.”Overall, Avanti passengers felt very satisfied with customer service - “it would have been so much more of a painful experience if [the train crew members] hadn’t been as good as [they] were”.

It was a different experience for the TPE interviewees. Although the traincrew made the initial announcement in a calm and reassuring tone, within the first 10 minutes of stopping, the cause of incident was not mentioned. Instead it was indicated by the onboard screens which caused confusion amongst the travellers. Further updates did not indicate how long the delay would be, leaving passengers feeling frustrated and out of control – “well, there’s nothing you can do on the train, you’re in someone else’s hands (…) it’s tough, how you feel is kind of irrelevant to the situation (…) I had a restaurant booked for 3 o’clock (…) so I had to cancel the restaurant which was a shame.” Subsequent messages were regular but also contradicted the information shown on the screens. The screens, on the other hand, had not been updating in light of the delay so calculated the journey time incorrectly, leaving passengers even more confused. The screens also advertised a WhatsApp service for accessing further information but, as one interviewee reported, it was ‘redundant’ and ‘offered no further clarity’. Another passenger checked the Network Rail website for information but found it was also conflicting with the information shared onboard. Onboard announcements were “very, very quiet, it was like a whisper so you couldn’t really hear it” and difficult to understand by passengers, in particular the elderly. When the issue with the speakers was noted, the staff moved through the train and provided clear updates, which passengers appreciated – “(…) [the traincrew] was trying [their] best to keep people updated internally.”

**Passengers reaching their destination**

Upon arriving at the station, passengers travelling on the Avanti trains were given advice on how to make connecting services and informed about the reimbursement process -“[the staff member] was really helpful and keeping people up to date with what was happening (…) if people were going on to further destinations, [they]’d had it confirmed that nobody should buy extra tickets to wherever it was that they were finally trying to get to.” Avanti staff members were also present at the station to answer passenger questions– a gesture that was recognised and appreciated by the interviewees.

**Key takeouts from passenger interviews:**

* Passengers not only noticed but also appreciated simple gestures from train staff
* A surplus of onboard refreshments should be a default for long – distance operators
* Passengers felt that less rigid customer service policy should prioritise those with additional needs or travelling with minors
* Passengers were confused when contradictory or outdated information was shared by internal communication channels
* Passengers felt reassured and could plan ahead when explanation of the issue and any time estimates were provided
* Passengers with onward travel needs felt that assistance and inadequate information provided by operators sometimes did not leave a good impression

Passengers travelling on the TPE train did not have such a straightforward experience. Once the train started moving, they were informed the service would be rerouted to Glasgow rather than Edinburgh (the intended destination). And although the train staff explained how to get from Glasgow Central to Glasgow Queen Street station, where passengers could board another train to Edinburgh, interviewees reported relying on Google maps and some were getting lost - “I think everybody just followed one another out of the station (…) we were left to our own devices once you left the train station to get to the other station.” What is more, no interviewed passenger recalled being informed about an option of using a slower train from Glasgow Central to Edinburgh that did not require them to cross town to Queen Street. Also, no information was shared about the free shuttle bus that runs between the Glasgow stations, which would have been beneficial to those travelling with large luggage, young children, and people with mobility issues. Passengers also did not recall receiving any information on how to easily get reimbursed for the delayed travel.

**Advice to train operators from stranded passengers**

Avanti passengers advised the operator to be “more prepared with food and drinks for these incidents (…) maybe supply something that doesn’t really quickly go off,” to better cater for people during long periods of disruptions and having more staff onboard to avoid potential queues.

TPE passengers wished they had been better informed throughout the incident and advised the operator to improve their general communication (shared by staff or via PA speakers), provide more explanation regarding onward journey - “when we arrived in Glasgow (…) maybe if someone [a staff member] had been there saying right, come this way, this is the way to go (…) because people were just depending on the phones to plot their 10-minute walk across Glasgow (…) maybe that's asking a bit too much, but (…) [the staff members] could have done something there”, and simplified the Delay Repay process. Others also suggested making their customer policy less rigid, in particular when distributing free refreshments, and allowing parents to collect multiple water bottles for their children.

**Industry perspective on the incident**

**Implementation of stranded train procedure**

Prior to the trains being declared stranded they had both been impacted by the freight service as it ran at a severely reduced speed in an attempt to get it clear of the running line. Neither operator expressed any issues with implementing their stranded train procedures. TPE advised that they declared their service stranded once the freight train had been declared a failure. Both operators were proactive in ensuring no further trains became stranded.

**Internal and stakeholder communication**

Both TPE and Avanti raised no issues with communication from Network Rail for the duration of this incident, though it was noted that previous experience has left some uncertainty around the accuracy of milestones and timescales provided.

In relation to internal communications both operators use industry systems to relay information, they maintain a control centre incident log and use Tyrell for live updates that can be accessed by all frontline staff.

Avanti advised that they regularly use phones to pass information, and during a stranded train incident this is how they contact the onboard staff. They also use MS Teams within the control and on-call team to answer questions if the phone lines are busy. During disruptive incidents they utilise huddles with Network Rail and internally to pass on key information.

**Customer communication and welfare**

Both operators view keeping passengers onboard as the best option for safety and welfare, Avanti cater all their services and TPE cater 50 per cent with water provision on the remaining 50 per cent. TPE’s catering is outsourced so a tab must be organised for food and drinks to be handed out which they did in this instance.

Prior to becoming stranded both services were impacted by the slow running freight so onboard staff had already been making announcements with updates. It was noted by TPE within the interview that onboard staff are advised not to provide timescales to customers due to the risk of them increasing. They also advise onboard staff to avoid using the term “stranded” to mitigate the risk of passengers becoming panicked and increasing the risk of a self-evacuation. During training, onboard staff are advised to make announcements every three minutes or when there is an update. TPE advised that their traincrew had a passenger with a hearing impairment and when there was an information update, the staff would provide it to the passenger in written form. When the passenger information screens relaying incorrect information was raised, TPE advised that the screens are programmed at the start of the journey and should have been reset during the journey but were not.

During the interview with Avanti, it was noted that passengers had to collect refreshments themselves during the incident rather than staff handing them out. The ability to hand out refreshments depends on the number of staff onboard and Avanti advised they would expect the traincrew to be walking up and down the train in this instance and able to assist anyone who was unable to get to the catering area. Avanti recognised the importance of providing factual and honest information to passengers to maintain trust in the operator’s competence, they advised that their main risks remain mitigating uncontrolled evacuation because the onboard facilities are able to maintain customer welfare.

**Evacuation**

Both operators, in the circumstances of the incident, prioritised keeping passengers safe and comfortable over the option of a planned evacuation. The geographical location and other external factors meant that it was safer for passengers to remain onboard the stranded train. As the root cause of the incident was a broken-down train, once Network Rail had located a rescue locomotive timescales became much clearer, and the broken-down train was moving 90 minutes after being declared a failure.

**Decision making**

Once the decision was taken not to evacuate both operators moved their plans to onward travel. TPE had initially expected to terminate their service at Carstairs rather than Edinburgh to aid service recovery. This was challenged internally due to limited onward travel options and the decision was made to divert to Glasgow, where there would be a 15-minute connection to Edinburgh. This meant that, ultimately, a passenger-focused decision was made when considering the balance of passenger needs and service recovery.

Avanti had no major decisions to make regarding their stranded train, it simply ran to destination late. However, they noted that in other circumstances if an electric train had lost power, they have only 90 minutes before batteries are exhausted so have some hard milestones for decisions around recovery, rescue, or evacuation in some stranded trains incidents.

**Onward travel**

Neither operator had to provide rail replacement for either stranded train, though TPE provided some at Lockerbie due to ongoing disruption. TPE has noted the challenges with procuring rail replacement in Scotland and had a coach on standby from first to last service at Edinburgh, Glasgow and Carlisle as a mitigation. As stated earlier, the operator also made the decision to terminate the stranded service at Glasgow over Carstairs due to the onward travel options.

Both train operating companies noted that had this incident been later in the day, securing onward travel would have been more important but also more challenging. To ensure passengers could continue their journeys ticket acceptance was agreed.

Avanti noted that onward travel, specifically rail replacement services, is an industry weakness and more could be done collaboratively in both the procurement of vehicles and management of stations where they are required.

## Case Study 3: Corby Glen, East Coast Main Line, near Grantham

### A white figure with a black background Description automatically generatedDate: 9th December 2023

**Incident overview**

The LNER staff on the service between London Kings Cross and Skipton reported that the pantograph had dropped from the overhead line (often indicating a fault with the OLE) on the Down Fast line in the Corby Glen area between Peterborough and Grantham. At the same time, track circuits failed in the York South area, resulting in multiple services becoming trapped outside of stations. LNER services travelling north were stranded outside Peterborough and prevented other trains from passing. A Grand Central service that was scheduled to pass through Peterborough on route to Bradford, was diverted via Lincoln because of route knowledge. However, on this route, the service encountered further delay south of Sleaford when a fallen tree obstructed the track. Overall, eight trains became stranded after 19:00 on that day.

|  |  |  |  |
| --- | --- | --- | --- |
| Affected operators | Affected trains | Time train was stopped for | Involved evacuation |
| LNER | Six | Between 2 to 6 hours | - |
| Grand Central | One | Approximately 1 hour | - |
| East Midlands Railway (EMR) | One | Approximately 2 hours | - |

**Interviewed passengers**

For this case study, we interviewed seven passengers from LNER and Grand Central services - five men and two women aged between 25 and “over 70” years. One passenger had a physical mobility condition. Interviewees were travelling on an LNER service from London Kings Cross to Lincoln Central, an LNER service from Edinburgh Waverley to London Kings Cross, and a Grand Central service from London Kings Cross to Bradford Interchange.

Stranded passengers on the EMR service were not interviewed.

**Prior to the incident**

Interviewed passengers on the LNER services did not expect potential delays, particularly those travelling from London where the weather had been better than in the north of the country. Grand Central passengers remembered the platform number (at the Kings Cross station) being announced only two minutes before the departure time – the train left around five minutes late in the end. Later, interviewees had become aware of the disruption around Peterborough, that prevented them from passing through, but did not anticipate that a tree would fall on the tracks until their train approached it.

**Stranded passenger experience**

**Situation and conditions on the train**

Passengers on the Grand Central and LNER services had access to charging and toilet facilities. Passengers on some LNER services reported that toilets remained usable and in a satisfactory condition, whereas toilets on other trains ran out of toilet paper and became overused and inaccessible.

LNER also provided catering – one service opened the shop (closed due to a staff shortage) as soon as the available staff became aware of the delay.

Those on the LNER services had the lighting on and felt comfortable, but some also reported that the heating was too warm until the doors opened when they arrived at Peterborough. Some LNER trains were very busy with standing room only, and one train was very loud as there were many football fans onboard. Nevertheless, the atmosphere remained ‘fairly relaxed’ and only a few passengers became ‘very frustrated and fed up’ with the increasing delay.

**“It what was quite annoying, another train came and overtook us. So, it's almost like we [passengers] were second class citizens being on that train.”**

Stranded passenger on LNER describing lack of information regarding being overtaken by another train

The Grand Central service was not overcrowded and had spare seats available. Passengers reported that “it was comfortable, they [train staff] did actually dim the lights at one point (…) so [passengers] could get some sleep (…) we were well informed, so it was fine.” The atmosphere on the train was calm, “(…) I was reading a book, I slept. I felt like I was in a cocoon”.

**Customer service**

When the shop opened on the LNER train, a long queue formed very quickly and shortly after all refreshments were sold out. However, complimentary water was offered to passengers on all LNER services - on some trains, passengers had to go and collect the water themselves, on other services staff walked through and handed it out to people. Given the length of delay, some passengers felt disappointed with lack of any other refreshments - “for saying we were on there for around five to six hours, it was completely insufficient”.

Grand Central passengers remembered that “[the train staff] came through several times. There was another lad who came through and checked on us all. In fact, “[the traincrew] did all they could do; I don’t think there’s anything I’d say that they could do better. (…) It was a bit of personal service as well (…) I couldn’t fault them under the circumstances.” Throughout the incident the train staff “maintain[ed] that professional presentation (…). I take my hat off to them”.

**Passenger communication**

The initial announcements on the LNER services were made within the first fifteen minutes. Their tone was very apologetic, but the information announced was vague and did not say how long the delay would last. In addition, passengers on one LNER service were not told why a different train service was overtaking them, clearly being able to avoid the incident, which they felt “was quite annoying, (…) so it's almost like we [passengers] were second class citizens being on that [LNER] train”. Further updates were made every 20-30 minutes and rarely included more details, so felt repetitive. In other words, there was a ‘wealth of communication’ but not a ‘wealth of information.’ A couple of passengers also had difficulties with hearing the information. Others remembered that some messages were contradictory, with one saying that their train may find a way around the incident while another suggesting it would be terminated at the next station, Peterborough. There were also conflicting announcements regarding onward travel arrangements.

Despite the inconsistent communication, “I think on the train [the train staff] did as well and as much as they probably could. Obviously, you’re going to have a degree of bias (…) just because you’re still frustrated at the fact (…) you’re stuck at a station, miles from your destination (…) but that’s not their fault.”

Grand Central passengers reported that the initial announcement was made whilst the train was slowing down outside of Peterborough. The message clearly explained the cause of delay and how the train would try to avoid the incident - by going via Lincoln, which would add an hour and a half onto the journey time. Passengers initially felt disappointed by this but quickly realised the decision was sensible – “we didn’t have anybody to kick off, get annoyed at, everybody was quite understanding (…) we were all accepting of [the decision].” They also received some advice on how to arrange their onward travel which eased their frustration. Little information regarding the Delay Repay scheme was shared though.

**“[The traincrew] did all they could do; I don’t think there’s anything I’d say that they could do better. (…) It was a bit of personal service as well (…) I couldn’t fault them under the circumstances.”**

Stranded passenger on Grand Central

When the Grand Central train stopped due to a tree on the line, the initial announcements did not include information about potential delay time, with further updates also sharing no new information. At some point, an automated message shared an incorrect update (that the service would terminate in Doncaster), which caused confusion amongst travellers. However, interviewees remembered that the train staff reacted very quickly by apologising and providing correct information. Their communication was ‘very clear and down to earth’ and the staff were ‘professional in the way they dealt with it’.

**Reaching the final destination**

Upon reaching the final destination, passengers on both LNER and Grand Central services reported feeling frustrated that the operators did not deliver on their promises regarding the onward travel arrangements.

Those travelling on the LNER service from London Kings Cross to Lincoln Central reported that when their train stopped at Peterborough, they were asked to go to the waiting room and received no further information from anyone. Some interviewees shared how ‘frustrated’ they felt when they could not get any clarifications from LNER staff, others felt ‘being ignored at one point’ after staff dismissed them when they tried ask them questions.

At some point, LNER passengers hoped that the staff had managed to coordinate the situation when they arranged a queueing system for taxis outside the station. However, as more services arrived, passengers from these trains began walking straight to the taxis, undermining the existing queues. As a result, LNER passengers had to wait even longer and became angry, in particular at LNER staff who did not rush to provide any explanation or help. Sadly, ‘there was no support or whatsoever’.

Once in taxis, many passengers were under the impression that the transport was prepaid by the operator. Only to find out later that they were required to pay for the journey themselves, which was particularly complicated for those who shared taxis with fellow passengers. Upon arrival at the final destination, interviewed passengers felt that LNER “did not have the staff, skill, logistical ability, or the access to the transport to organise it [onward travel] in any way, shape or form.”

Those onboard the Grand Central service encountered similar issues. Our interviewees spoke about the operator repeatedly promising onboard that transport alternatives, including prepaid taxis, would be organised by Grand Central. However, upon arrival at Doncaster, there was very little organisation and little explanation of which taxis had been actually prepaid by the TOC. This led to confusion and many passengers experienced difficulties when trying to claim money back for taxis – “I think Grand Central could have been clearer and more helpful in terms of reimbursing the taxi fare.”

**Advice to train operators from stranded passengers**

In their final words of the interview, respondents would like LNER and Grand Central to provide clear communication about onward travel arrangements and “be more realistic about what the onward journey is going to look like just as soon as possible. Tell people the honest situation so that they can make better informed decisions.” They wished the information on how to get reimbursement to be better communicated and if there is no staff available to explain it, passengers should receive other forms of communication, for instance, leaflets or a little card clarifying the process.

In addition, respondents wanted to remind the operators that customer service goes beyond the onboard service, but based on their experience, they felt it did not.

**Industry perspective on the incident**

**Implementation of stranded train procedure**

**Key takeouts from passenger interviews:**

* Stranded passengers felt that simple gestures by individual staff members added value to customer service
* Passengers felt dissatisfied and disappointed when no honest communication about onward travel arrangements, in particular who pays for transport, had been shared
* Passengers felt less frustrated when they received an explanation of the issue and its context
* Stranded passengers felt they did not receive enough information how to claim compensation
* Passengers felt that high-quality customer service sometimes ends once they got off the train
* Contradictory information shared by internal communication channels caused passenger confusion, but immediate apologies left a good impression

Neither operator reported any issues with the implementation of their procedures during this incident. During the interview with LNER, the representatives advised that the first action when a train is declared stranded is to declare a stranded train champion - the main point of contact with the onboard staff - responsible for assessing the onboard circumstances. They advised that they prioritise keeping passengers on the train due to the onboard environment and prioritise keeping them informed.

The Grand Central train was still in Kings Cross when the OLE came down, one service was cancelled due to this but the traincrew onboard the second had the route knowledge to divert via Lincoln. This service was then stranded as a result of a tree on the line. It must be noted that the Grand Central control is operated by CrossCountry in Birmingham, so many of the operational decisions are made by them. As a result Grand Central staff are focused on passenger welfare and safety. Grand Central noted that as part of passenger counts and ticket checks onboard staff members make a note of passenger numbers, any passengers with additional needs, and also referenced the group dynamics on each service.

**Internal and stakeholder communication**

Internal communication appears to have been well managed by both train operating companies during the incident.

LNER utilises Aracus, an industry application, to relay information to staff. This can be filtered to show only specific incidents rather than include the business-as-usual operation and is available to all staff. Once the incident was known, the staff responsible for service delivery will diarise calls with the on-call team to pass information on, and the on-call team utilise a MS Teams group to share additional information. As noted, LNER utilises a stranded train champion as the point of contact with the stranded service passing information to the onboard staff and to the control team. The service delivery staff will also send out business updates with a high-level overview of the incident.

LNER’s control team are collocated with Network Rail – this aids communication between the two. They utilise huddles to formalise the key information but due to their closeness information is regularly just passed across the room. Despite this, there were challenges with defined timescales due to the scale of the incident.

Grand Central appear to mostly use phones for internal communication and with their control team at CrossCountry. The on-call staff act as the point of contact between control and onboard members and take a holistic view of the situation. There were no issues raised during this incident.

**Customer communication and welfare**

Due to the service type, LNER trains provide catering, toilet facilities and comfortable seating. As a result, much of the focus remains on providing passengers with information regarding the incident. Onboard staff are provided with as much information as is available with the expectation that this will be passed on to passengers. The Network Rail timescales are shared, and traincrew is not discouraged from sharing this with passengers but it remains their decision. As the scale of the incident became clear, LNER did question whether there was more that could have been done in keeping passengers informed but this became clear in review.

The LNER social media team is located with their control and is directly informed about the situation; LNER encourages Network Rail to share photos of infrastructure issues that have caused disruption so this can be shared on “X” (formerly “Twitter”) to help customers understand the challenges.

Grand Central appears to prioritise customer service. During the interview, the operator advised that their onboard staff do not have a separate area on their trains, so are always visible to passengers. During the disruption, there is an emphasis on being visible throughout the train as well as making PA announcements. To support this, Grand Central has created a training package called “Brilliant Basics”. It focuses on the soft skills associated with customer service and communication. Due to the length of their trains, the operator advised that they want passengers to be able to ask questions to onboard staff as well as hear the PA announcements. The TOC has historically taught on-train staff not to announce specific timescales during incidents due to the risk of the delay extending.

Similar to LNER, Grand Central’s social media team (provided by CrossCountry) are located within their control team and therefore, are directly informed about the situation

Both operators handed out water during the incident, Grand Central also has a catering area and expects that onboard staff will use this as required during prolonged incidents.

**Evacuation**

Due to the nature of the incident and the timescales provided Grand Central did not consider evacuation in this instance. The decision to evacuate would be made by the control team if required, though the on-call staff would have input into that decision.

LNER services were stranded for a longer period than Grand Central, though the decision was still not to evacuate. LNER advised that the location of the trains had a large impact on this alongside the incident circumstances. The OLE had been damaged, so there was no power to the area and trains were stranded in both directions further blocking the infrastructure. The only evacuation option would have been train-to-ballast then to road. In order to mitigate self-evacuation LNER aims to maintain the onboard conditions and keep passengers informed.

LNER reported that, while their priority is to keep passengers on the train, Network Rail would often prefer to evacuate sooner. This can lead to decisions being regularly revisited and challenged during an extended incident, affecting the ability to communicate a clear plan.

**Decision making**

Grand Central’s decision making in the overall disruption was efficient. Following the OLE failure, they made the decision to divert services in order to continue running. When the train became stranded due to the tree, they made the decision to keep passengers onboard due to the timescales provided. The operator focuses heavily on diversionary route knowledge within their onboard team to provide contingency in incidents such as these.

LNER was impacted by the incident on a much wider scale. While their services were stranded, they mitigated the risk of additional trains becoming stranded and began running the service in two halves, with trains stopping north and south of the incident, and then returning in the direction they had come from. During the interview when asked about prioritising the stranded passengers within the wider incident, LNER felt that in this instance the actions to recover the railway were also the actions needed to free the stranded trains, and as such their priorities would remain the same.

**Onward travel**

Grand Central utilises their onboard team to understand the onward travel requirements of passengers on board. This would be passed on to the CrossCountry control to procure if road vehicles are required or to gain ticket acceptance. This was not required during this incident.

During the interview, the operators were asked what the biggest challenges were with managing this incident - one of the key challenges raised was onward travel, including providing rail replacement and requesting ticket acceptance for other rail operators. While LNER has Stagecoach staff within their control, engineering works on the day of the incident meant that there was a shortage of available coaches. The operator was also advised by their taxi provider that they were unable to source taxis. This resulted in LNER making the decision to advise customers to pay for their taxis and apply for a refund. As with the Ladbroke Grove case study, this was an extended incident with unclear timescales which caused a delay to the procurement of road transport.

## Case Study 4: Bourne End Junction, West Coast Main Line, near Hemel Hempstead

### Date: 21st December 2023

**Incident overview**

The staff on a West Midlands Trains (WMT) service reported OLE wires being down at Bourne End Junction. Consequently, all lines were blocked and all services along the route were affected. An examination undertaken by the mobile operations team could not find a fault, so the OLE specialist team deployed a drone that identified the issue further down the line. Power was restored but trains were instructed to carry on at a reduced speed. The incident resulted in four WMT services being stranded:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Affected operators | Affected trains | Time train was stopped for | Involved evacuation | Had no electricity supply |
| WMT | Four | Approximately 2 hours | - | One train |

**Interviewed passengers**

For this case study, we interviewed six passengers travelling from London Euston to Birmingham New Street, including three women and three men aged between 30 and “over 70” years old. One passenger had a physical condition that affected their ability to travel by rail.

**Prior to the incident**

Interviewed passengers noted that on the day of the incident the weather was very poor. However, some respondents had been checking earlier trains from their station and remembered that all services were leaving either on time or within a few minutes of their planned departure. It was not peak time and yet, trains and stations were busy. Nothing else hinted there would be disruption to their journey.

**Key takeouts from passenger interviews:**

* Stranded passengers noticed and appreciated staff with professional and calm manners
* Lack of access to essential facilities (such as toilets) can aggravate passenger behaviour
* Frequent announcements and clear information help passengers make onward travel plans and ease their anxiety
* Passenger felt frustrated when no clear communication about arranging onward travel and the reimbursement process was shared
* Passengers with additional needs would have stayed informed if face-to-face communication (such as train staff moving down the train and updating travellers) was provided

**Stranded passenger experience**

**Situation and conditions on the train**

As a result of no power on one of the WMT services, passengers had no lights and were unable to charge their phones. Toilets were not flushing and eventually became out of order – interviewees reported that this caused confrontational and aggravated behaviour among a few travellers. Air conditioning also went off and, given the already busy service, passengers recalled the train being ‘very stuffy’ at some point and people were feeling ‘claustrophobic’.

**“If I’m honest, it [not hearing announcements] made me slightly anxious. I have mobility issues, so therefore I try to plan train journeys, so I’ve got plenty of time to get from one platform, one train to the next. I don't move terribly fast (…), so the thought that we were stuck outside, and my connecting train was probably going to leave without me (…), it was a bit anxious making.”**

Stranded passenger on the West Midlands Trains

All interviewees reported that there were no catering facilities onboard, and they were not offered any refreshments, which they found disappointing - “it would have been beneficial to at least be offered water” given the length of delay and stuffy environment onboard.

**Customer service**

Some WMT passengers were content with the customer service and credited this mainly to traincrew who remained professional, calm and “(…) tried to stay very positive, which [a passenger] really appreciated.”

**Passenger communication**

The initial announcement was made within 10 minutes and passengers remembered being told that there was a delay further up the line that prevented their trains from passing through but were not informed how long this may take. Further updates were shared every 20 to 30 minutes and mainly notified about the incident investigation. “It [the announcement] wasn't like new information, [the traincrew] just reassured us that if (…) anyone had any issues that they could come and contact [them], but the actual information was basic.”

Due to lack of fresh updates, some travellers became irate and were, what interviewees perceived to be, unfairly confrontational with staff members, ‘causing up a bit of a stir’. Another passenger, with a physical condition that affected their ability to travel, could not hear any announcements and was worried about missing a connecting train (in Birmingham) to reach their final destination (Liverpool Lime Street). “If I’m honest, [not hearing announcements] made me slightly anxious. I have mobility issues, so therefore I try to plan train journeys, so I’ve got plenty of time to get from one platform, one train to the next. I don't move terribly fast (…), so the thought that we were stuck outside, and my connecting train was probably going to leave without me (…), it was a bit anxious making.” An over-70-year-old added that “you had to concentrate because the sound quality of those things [PA speakers] were really not very good” and would have felt less concerned if more staff members had walked through the train so they could ask questions.

Despite the vague communication, passengers were pleased with how the traincrew handled the situation. They also sympathised with the staff as they were aware that the lack of information was not their fault. It “felt like [the train staff] couldn’t do much either. [They] were just looking like [they] don’t know much what’s happening.”

Stranded passengers who were onboard the service with no power did not receive any announcements via the PA speakers. Instead, they were informed by staff members who were passing through the train.

**Reaching the final destination**

Once passengers were off the trains, “there was very little information, in fact none, about what anyone was supposed to do next” and none of the staff at the station could advise on how to arrange onward travel. The passenger with mobility issues, who had to get to Liverpool Lime Street, had their connecting train terminated at Liverpool South Parkway. The platform was very busy, and no staff member assisted the passenger or provided useful information, leaving them feeling ‘bewildered.’

**Advice to train operators from stranded passengers**

Passengers asked the operator that “if this happens again, I think it's very important to let people know what is happening (…) not take long intervals to make announcements”. A 70-year-old interviewee would like WMT to make sure that there is “a greater showing of a railway staff that people could actually talk to” to help passengers make onward travel plans and ease their anxiety. In general, the customer service should be improved as “I think it's that at the moment the ticket prices that people pay for trains don't justify the service that you get.”

**Industry perspective on the incident**

**Implementation of stranded train procedure**

WMT’s stranded train procedure sits within their wider control manual containing all relevant procedures and contingency plans. As a priority information regarding the onboard situation is gathered from any onboard staff and the location of the train is reviewed and access points located. This information then forms the basis for their stranded train checklist which is updated throughout the incident. WMT reported no issues with the implementation of the procedure and went on to advise that within a control team responding to incidents and disruption on the railway this was business-as-usual.

**Internal and Stakeholder Communication**

This was a difficult incident due to the challenge in ascertaining the damage to the OLE. The operator noted that communication with the team on site was good, but the length of time taken to locate and understand the issue with the OLE meant the information was delayed. Due to the challenges with identifying the incident, Network Rail were unable to provide any timescales which impacted decision-making. Even once the power was back on, the duty service staff advised that they were unable to move trains and there was a challenge to get information from Network Rail about the cause.

There are structured internal processes for communication at WMT. The operator also has control teams in two locations – this incident was handled by one collocated with Network Rail. The incident continued during a shift change so an extensive briefing was given to the new shift. One the staff members was a designated point of contact for Network Rail and the onboard team passing relevant information between the two. WMT utilises industry applications, such as Tyrell, to pass information to frontline staff alongside maintaining a control centre incident log. Huddles take place with Network Rail and key WMT representatives to gather and pass on information.

WMT did note that in general during stranded train incidents they see excellent collaboration between Network Rail and other operators with the focus on passenger safety and welfare.

**Customer communication and welfare**

It must be noted that the WMT customer communication team were not present during the interview. Therefore, representatives we spoke to were not able to provide detailed information regarding customer communication.

The operator did advise their customer experience staff to move to the terminating station to meet passengers, and a member of WMT management was onboard of one of the services and able to assist.

The interviewees advised that they passed all information to the onboard team but recognised that sparse information about the nature of the OLE damage reduced how useful the information was to passengers onboard.

As the services were declared stranded, information about the onboard conditions was gathered including passenger numbers, passengers with vulnerabilities, toilet facilities and, in this particular incident, the number of children onboard as a result of the school holidays.

**Evacuation**

The incident was initially reported as the OLE wires coming down, which would result in an extended period of disruption. As a result, information alongside that gathered about the onboard condition and passenger demographics, WMT had made a quick decision to organise a rescue train to facilitate an evacuation. This was to be provided by Avanti. The location and geography had ruled out an evacuation to ballast and then to road due to steep embankments and the road network.

As the incident progressed, it became clear that although there may be some OLE damage it was not as severe as initially thought and the timescale for trains to move was reduced. This resulted in rolling back the evacuation plan in favour of keeping passengers on the train.

A good example of implementing plans early and rolling them back as required rather than waiting and extending the time passengers are stranded.

**Decision making**

WMT advised that there were multiple incidents across the day due to the severe weather which meant that their on-call team had been stepped up since the start of service. While some operational decisions may have been delayed due to the information available, the operator was quick to plan and organise an evacuation.

Following the line reopening one of the services was terminated short of its destination, this was the result of the incident spanning two shifts within the traincrew team, and WMT did not have other staff to take the train forward.

**Onward travel**

No additional transport was required following the incident; however ticket acceptance was requested.

While consideration was made for onward travel, the traincrew on the service that terminated short of its destination had finished their shift and could not take the train to destination and return within their hours.

On a day-to-day basis WMT have Stagecoach representatives in their control to aid in the organisation of rail replacement services when required. There is also a well-formed plan for ticket acceptance within the West Midlands, including on local buses.

# Key findings and recommendations

## Overview

Based on the operator protocols reviewed and feedback from passenger interviews, the industry has made efforts to improve passenger focus when trains become stranded, but there remain some key gaps between what the Guidance suggests and its application. Specifically:

* There is a difference between ‘everyday’ and significant, complex incidents
* There is a lack of priority given to passengers’ onward journeys – both in terms of onboard information and subsequent experience
* There is a gap in alignment between factors in self-evacuation and customer service good practice
* There is mixed evidence that the industry is good at identifying, understanding and responding to the needs of passengers, in particular those with additional needs and/ or whose needs are less visible
* ‘Plan within 60 minutes’ is neither fast nor tailored enough to meet passenger needs
* There is recurring feedback about the reliance on individual skills and experience of onboard staff who directly deliver customer service, and the need for communication supported by soft skills amid uncertainty

Table 4.1 lists other gaps and challenges in delivering good practice when trains become stranded, based on comparisons between passenger experience and industry views on the incident.

## Key findings

We have identified inconsistency in the application of the current Guidance and areas where the Guidance could be strengthened. In our assessment both affect the extent to which passengers’ needs are understood, prioritised, and met when trains are stranded.

### Stranded trains happen regularly, but the most significant incidents with greatest passenger impacts are rarer

Unfortunately, incidents where passengers are stranded on trains are, on average an everyday occurrence on Britain’s rail network.

However, there is significant variation in the duration, impact and complexity of those incidents.

As our four case studies reinforce, there is considerable difference in the passenger impacts and challenges across the range of incidents which stranded trains procedures and protocols need to address.

The most significant incidents with the greatest risks to passenger safety and wellbeing are, thankfully, rarer: a relatively low proportion of incidents during our research period required planned evacuations of passengers; and even fewer led to unplanned or self-evacuation.

The incidents most likely to lead to such significant impacts, and therefore risks, are related to failures of electrification equipment causing loss of power to trains, meaning trains cannot move and onboard systems will eventually fail as batteries become exhausted.

Damage to electrification equipment is therefore the key scenario in which the industry should look to test, refine and continuously improve its stranded trains procedures.

### The industry has improved passenger focus when trains become stranded, but still has more to do

From our review of industry stranded trains protocols and real-life case studies, it is clear that efforts have been made by the industry to embed the Guidance in procedures and in practice.

Operators have adopted stranded trains policies and procedures that broadly reflect the intent, principles and recommendations of the Guidance.

And we have seen in practice clear evidence of focused efforts to support the safety, wellbeing and comfort of passengers when their train becomes stranded.

We have found in our passenger interviews that passengers affected by stranded trains incidents are commendably sympathetic and understanding. This is largely down to on-board staff, who have frequently been praised for their efforts to provide information and reassurance.

However, the quality and execution of customer service is not yet consistently as good as it could be in the circumstances of a stranded train.

And the ability to meet passenger needs during the rarer, but critical, major incidents is demonstrably not where it needs to be.

In particular, a lack of priority is given to passengers’ onward journeys once they leave the train – in terms of both information provided while on-board and what the passengers subsequently experience. This suggests that the industry can still be guilty of focusing on the incident and not the passenger.

**Safety and service go hand in hand**

It is clear from our research and analysis that there is a clear correspondence between customer service good practice and the factors influencing passenger behaviour that can lead to self-evacuation from a stranded train.

### The key themes and gaps we have identified in section 3 are closely aligned with the key factors the Rail Safety and Standards Board (RSSB) analysis has found to influence passenger behaviour in stranded trains incidents[[3]](#footnote-4):

* Onboard conditions
* Traincrew communication
* Other sources of information/ social media
* Other passenger/ group behaviour
* Passenger circumstance
* Nature of the event
* External conditions

With this clear link in mind, we find that the industry’s Guidance itself, as well as its implementation, should be strengthened.

Table 4.1 Summary of Guidance adoption and comparison between passenger experience and industry perspectives

| **Key areas researched** | **What the Guidance says** | **How the Guidance is adopted by operators** | **Passenger experience during incidents** | **Industry perspectives** | **Gaps between the passenger experience and the industry perspective** |
| --- | --- | --- | --- | --- | --- |
| **Onboard condition and facilities** | Onboard conditions, depending on the type of train, are crucial factors influencing the decision on how to best respond during the stranded train incident. To ensure passenger welfare and safety, the operator needs to monitor, for instance:   * Air quality and temperature – to avoid posing significant risks to passenger health * Available and working toilet facilities – passengers should not be without access to usable toilets for more than 60 minutes * Working lights/lighting - minimum levels need to be provided if the stranded train runs out of power to reduce passenger distress | When rescuing, recovering and evacuating stranded trains, the industry prioritises trains with limited (or no) onboard facilities as well as electric trains (due to a limited power supply).  Operators use risk assessments and communicate internally to assess the onboard conditions - information gathered is passed onto passengers and helps ensure their comfort. | Passengers felt significantly more comfortable when there are working lights, heating, charging sockets, air-conditioning as well as accessible and usable toilets. This was particularly evident for passengers stranded for longer.  Stranded passengers were more distressed if the onboard conditions and facilities were poor or not available. In some instances, the absence of these caused aggravated behaviour towards fellow passengers and train staff, creating an uneasy atmosphere on the train for all concerned. | Long distance operators were well-equipped in onboard facilities to keep passengers on the train and avoid their self-evacuation.  Traincrew regularly monitored and communicated onboard conditions and facilities to stranded passengers.  In instances when facilities or conditions were poor, train staff tried and improved passenger comfort by, for example, opening doors or adjusting temperature to improve air quality on the train.  In addition, crowding plays a large part in decreasing the onboard conditions across all service groups. | Monitoring and updating on the onboard condition and facilities becomes challenging when there are staff shortages or issues with internal communication.  When, for instance, toilets, become unusable there is little mentioned, in the reviewed procedures, about improving their conditions.  There are gaps in providing swift (under 60-minute) rescue to stranded passengers on trains with limited or no facilities. |
| **Passenger communication** | Passenger communication needs to be accurate, consistent and regular on all channels to maintain passenger trust and ensure their safety, particularly by discouraging self-evacuation.  Updates should be credible and "where information is incomplete or imprecise it should still be passed.” Information about onward travel arrangements and compensation rights should be explained to passengers.  All communication should be delivered in a caring, empathetic, competent and confident manner. | Operators acknowledge that ensuring effective, regular and accurate passenger communication is a priority and mitigates the risk of uncontrolled evacuation. Some train operating companies utilise checklists to aid gathering quick and reliable information that can be communicated onto stranded passengers.  The update frequency is defined differently by different operators.  There are also differing views between operators regarding providing passengers with expected timescales. | Passengers were much less anxious and could plan ahead when they received clear and frequent communication, for instance, about the reimbursement process, onward travel arrangements and estimated time of arrival.  Passengers felt more understanding and patient when they received explanation about the wider context of the issue.  Passengers tend to become annoyed and eventually ignored repetitive updates. They also felt confused when contradictory messages were shared.  Passengers with specific needs felt less informed and less reassured than others.  Very few interviewed passengers mentioned checking social media for updates about the incident. | All operators utilised passenger communication to mitigate the risks of uncontrolled evacuation.  Not all operators informed passengers about the wider context (as such as more detail about what had gone wrong) of the issue, and some opted out of providing estimated timelines of arrival.  Train staff equipped with diversionary route knowledge and information about contingency plans were able to provide sufficient information and better time estimates.  Many train operating companies are equipped with a range of systems and procedures, but only those with strong collaboration with industry stakeholders received sufficient information and were able to make plans and decisions quicker. They were also able to inform passengers in a timely manner.  Social media is still a commonly used channel for providing updates. | Traincrew need to ensure that passengers with additional needs are also fully informed - this may require a bespoke approach in passenger communication.  Some train operating companies are not communicating about end-to-end journeys and 'what happens' after passengers left the train.  In the absence of concrete information about incident timescales and resolution, operators are not able to reassure passengers and ease their discomfort. Strict rules about frequency of updates can be counterproductive if there is no new information.  Allowing and equipping train staff with contextual information improves customer understanding – not all train operating companies do that.  Social media cannot be the dominant channel for providing updates about the incident or as a substitute for traditional communication methods. |
| **Customer Service** | Providing excellent customer service is the foundation in ensuring passenger safety and welfare.  When trains become stranded, a dedicated staff member (ideally at a senior level) should be appointed to act as a stranded train champion to understand passenger needs and to make sure these are met as well as considered when operators make decisions to recover, rescue or evacuate the train.  Refreshments and/ or water should be offered to all passengers, and passengers with additional needs as well as children should have priority access.  Refreshments and/ or water supplies need to be assessed and provided throughout the incident and evacuation process. | Operators highlight in their protocols that excellent customer service is crucial to ensure passenger safety and welfare.  The reviewed protocols provide different definitions of the customer services and what it entails.  Not every operator appoints a stranded train champion to represent the voice of passengers.  Train operating companies with onboard catering and emergency water provision agree to provide these to stranded passengers throughout the incident.  There are train operating companies that show evidence of incorporating additional staff training on customer service and soft skills. | Stranded passengers had a very positive experience when the train staff was professional and calm.  Passengers noticed and appreciated when the traincrew were proactive, approachable, with a humble attitude.  Passengers valued simple gestures from the train staff such as answering their questions, providing offering personal mobiles so that they could inform their relatives about the delay, regularly checking on them or just being present/ visible to them.  Passengers noticed that customer service was not always prioritised for passengers with additional needs (who reported feeling distressed in such instances).  Not all passengers stranded on long-distance trains were informed about or received water and/or refreshments. In some instances, there was an insufficient supply of refreshment, or passengers could not access them (water was placed in certain locations or passengers had to queue to get it). | Train staff were encouraged to be visible to passengers throughout the incident. During extended incidents, some drivers left their cabs to walk through the train to ensure passengers could see them and to ease their distress.  A stranded train champion was not always appointed, although a designated person was appointed in most instances.  Operators prioritised customer service. Onboard staff was trained on how to deliver excellent service to passengers and remain clam, professional as well as be empathic and caring.  Train staff on services with onboard catering and emergency water supplies passed out refreshments. But operators with staff shortages were not able to do so. | Traincrew are not always able to identify all passengers with additional needs and therefore do not fully consider these needs.  This is particularly challenging when trains are crowded - onboard staff cannot readily 'scan' the train.  The stranded train champion position is not always aligned with what the Guidance suggests, and risks neglecting passengers and focusing on the train rather than their welfare.  Customer service is extremely important in providing passenger comfort and satisfaction but is jeopardised by staff shortages, for example, due to industrial action.  On longer journeys, sufficient refreshments are particularly important, and staff play a key role in ensuring that they are properly distributed. |
| **Evacuation process** | The decision to evacuate, rescue or recover the train should be made swiftly, ideally within 60 minutes. Contingency plans should be considered alongside the agreed plan. If more than one train is stranded, then any available resources should be sent first to the one with the highest needs.  Staff should be present and provide on-going support to passengers during the evacuation, as well as answer any questions they may have to minimise their distress and concern. | In general, operators aim to have a plan to rescue, recover and evacuate passengers agreed within 60 minutes, as well as procedures to execute it.  Not all stranded train procedures detail staff training for evacuation. There are challenges in applying procedures when multiple trains are stranded across several locations, in particular in terms of allocating additional staff resources. | Passengers felt anxious during the evacuation. In severe situations, this was significantly exacerbated by the absence of staff.  Stranded passengers did not feel safe during the evacuation process as often what was planned and how it would be executed had not been clearly communicated to them.  Passengers felt that operators did not have robust contingency plans and sufficient staff resources to execute the evacuation process safely and efficiently. Some felt disappointed by this. | All operators admitted that the decision to evacuate is extremely complex as it depends on a range of factors (such as external environment, staff resource, nature of incident and availability of additional trains). It also requires Network Rail to act quickly in providing support. Industry stakeholders admitted that there are challenges in prioritising stranded trains when multiple incidents happen at once.  Operators were diligent in completing and updating risk assessment throughout the incident, including evacuation. Some showed evidence of concurrent planning and collaborating with other operators to plan train to train evacuations. There is a need for operators to review and maintain evacuation plans and protocols, including access points and onward travel arrangements. | Every incident is different and this is particularly the case with evacuation where circumstances are the most difficult to plan for. Train operating companies therefore face significant challenges in planning and executing evacuations which then have an impact on passenger safety and welfare, in particular those with additional needs.  Collaborative decision making between stakeholders make prioritisation challenging and creates gaps in providing reliable communication to passengers. |
| **Support received after the incident or evacuation** | After the incident or evacuation, passengers should be clearly informed about onward travel arrangements, compensations they are entitled to as well as how to they can get reimbursed.  The operator should also ensure that passengers have access to, for instance, toilet facilities, refreshments, medical assistance upon arrival at the station.  Staff should be present and provide support to passengers while they are waiting for onward transport.  Staff members should assist in answering passenger queries. | There is inconsistency in providing onward travel across the reviewed procedures.  Some operators provide detailed processes of how the onward journey for passengers is prioritised. Others focus more on the train rather than passengers once they leave their train, providing little guidance on what staff assistance should entail, particularly when there are limited staff resources. | Passengers felt reassured, and highly valued the on-going support and customer service which did not end once they got off the train.  People felt satisfied when they received onboard communication about onward travel arrangements and how to get compensated. However, they quickly felt frustrated when it turned out that the operator did not deliver on their promises once they left the train.  In some instances, passengers felt abandoned when train staff ignored their questions about alternative transport arrangements to get to the destination. | All operators admitted that organising onward travel is the biggest challenge.  It requires a strong and efficient collaboration across the industry but also with transport providers outside rail.  It is highly impacted by the availability of staff, time of day and week as well as prompt decision making.  Industry members reviewing case study incidents admitted there is room for improvement and there was evidence of operators looking to act on it. | There are gaps in supporting passengers for onward travel, which results in reduced customer satisfaction.  There is also a wide range of factors that impact the incident management and resolution - some of them are beyond the scope of this project |

### Industry Guidance could be more passenger-focused

The RDG and Network Rail-produced Guidance could be strengthened to promote consistent focus on two key areas for passengers.

First, focus on passengers’ whole journey. The Guidance includes considerations of post-evacuation experience but given the importance to both safety and service, it could further emphasise the importance of information about and provision of onward travel.

Second, despite good intentions to drive decision-making and support communication, the recommendation to have a ‘plan within 60 minutes’ is in practice neither fast nor focused enough to meet passengers’ needs.

Our research confirms that information on and provision of onward travel, and the whole-journey experience of passengers, is significantly impacted by delayed decision making, as well as the timing of the incident.

This is clear across our case studies and in different ways for different types of incidents and passenger circumstances.

Where people are stranded on commuter trains with facilities and on-board environments designed for a high volume of passengers making short and often time-critical journeys in urban areas, then taking up to an hour to reach a plan, and then communicate and execute it, is likely to exacerbate those factors that lead to uncontrolled evacuation. In these circumstances, an early decision to support passengers’ quick, safe exit from the train should be the focus of industry policy.

For passengers on long-distance, high-speed services (in the incidents logged during our research, alongside commuters the most likely to be stranded), the conditions, circumstances and passenger needs are different:

* Where possible, the best thing for passengers and first preference in the hierarchy of options will be to keep them safe and comfortable on the train
* The trains, their facilities and staffing are designed for passengers spending longer on board
* When stranded they are more likely to be further from a station or safe place to exit the train; however
* Average passenger journeys even on long distance trains are 95-99 miles[[4]](#footnote-5), so the average time the passenger has planned to be on the train is under the 60 minutes threshold
* For longer-distance journeys onward travel can be less flexible and more sensitive to time of day
* In many cases, the nature of the incident and action required to resolve the incident is relatively clear

Therefore, there is both a need and opportunity to devise and communicate a plan well within 60 minutes.

As such, in both the most likely *and* the most severe scenarios, ‘plan in 60 minutes’ is not fit for passenger circumstances, on-board and external conditions, the nature of the event or passengers’ communications requirements.

Addressing these factors in the Guidance should not be difficult and should not delay further action in other areas.

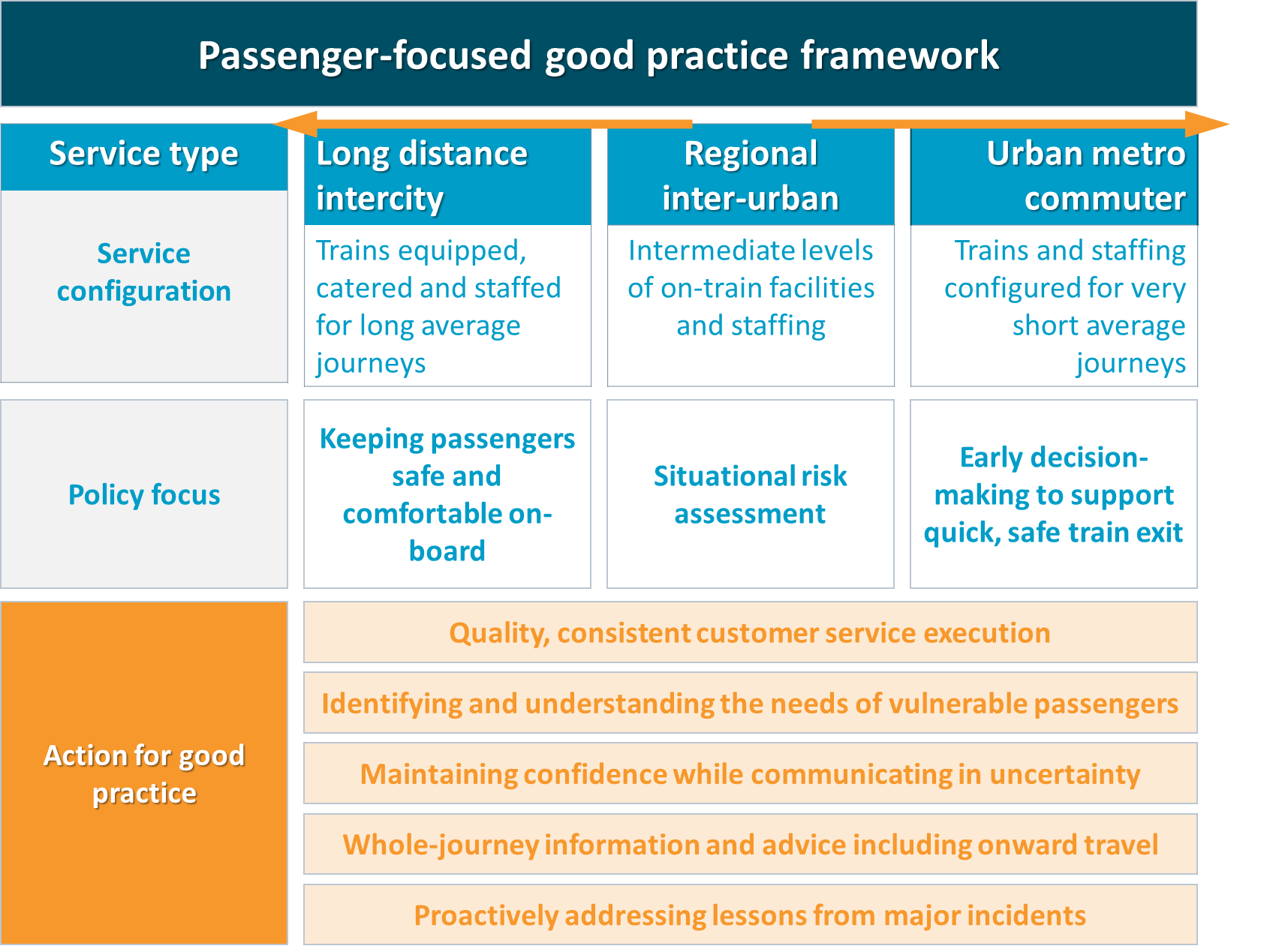
### Further guidance on passenger-focused good practice is needed to promote consistent, high quality customer service

Indeed, we find that there is the need and opportunity to develop further supporting good practice guidance at a level of focus and detail beyond that which can realistically be included in the Guidance itself.

The diagram below sets out at a high level a potential framework for developing further good industry practice in meeting the needs of stranded passengers.

This is based on our review of existing guidance, protocols and procedures, the voice of the passenger and engagement with operators across the industry and sets out where good practice could be developed in more detail to build on the Guidance.

Figure 4.1 Overview of the passenger focused good practice framework



The gaps we have identified point towards the need for further action to develop and share good practice in the following areas:

* Providing customer service, including for example processes for providing food and drink, in a way that reflects the needs and circumstances of passengers on-board stranded trains, including passengers with additional needs
* Identifying and responding to the specific needs of passengers, in particular if those whose needs are less readily identifiable
  + Awareness of vulnerabilities that aren't as obvious or visible, including language and wellbeing needs
  + When staff cannot readily 'survey' the train, including if crowded or staff have limited coverage of the train
* The further development of communications protocols, which could be informed by MTR Elizabeth line concession requirements on communications during disruption
* Communicating about end-to-end journeys and providing advice on 'what happens next' after leaving the train
* The ability to provide confidence and reassurance in the absence of concrete information about incident timescales and resolution, where there is commonly a reliance on the personal skills and experience of individual on-train staff

### Communication and co-ordinated decision-making across industry interfaces remains the biggest barrier to meeting passengers’ needs

As we have seen, the ability to meet passengers’ needs is dependent on having and communicating a plan.

It is beyond the scope of this research to analyse and make recommendations on the wider question of industry processes for responding to, managing and recovering from major disruption to train services.

However, we have found that stranded trains procedures are predominantly geared for ‘everyday’ disruptive events, not complex, multifaceted incidents with aggravating factors.

It is therefore imperative that these procedures are reviewed and tested, with lessons and actions in response to significant incidents proactively identified, transferred and applied. This may include the development of line of route-focused multi-operator incident response plan, including evacuation points and onward travel plans, as has been developed for the Thames Valley area following the 7th of December incident described in case study 1.

We have also seen that there is variation in the tools and technology used by operators to support incident management and communications, so there is a further opportunity to share and exploit best practice in this area.

## Recommendations for action

Transport Focus and ORR have requested that our recommendations in this report should identify broad areas for action, in order to inform their own development of specific follow-up actions.

As such, reflecting the themes and findings from our research and analysis, we recommend the following areas of focus:

**Reviewing and strengthening the industry Guidance**, as part of its continuous improvement and response to significant incidents, to:

* Strengthen ‘whole journey’ focus and emphasis on onward travel, in addition to the existing guidance on on-board conditions and post-evacuation considerations
* Update guidance on requirements for decision-making and plans within 60 minutes, to drive faster, passenger-focused decision-making tailored to circumstances

**Improving and strengthening operators’ stranded trains protocols** in line with good practice, including the following areas of action:

* Joint incident response plans across operators who share a line of route, including evacuation points and onward travel plans, learning from the follow-up to the 7th December and other case studies
* Including specific requirements to test procedures and undertake major incident exercises to ‘stress test’ for aggravating factors including day of week, time of day and reduced on-the-day resource levels
* Including guidance and protocols related to onward travel
* Further focus on training and development, including
  + stranded trains-specific training
  + empowerment of on-train staff and development of ‘soft skills’ for empathetic and confidence-building communication amid uncertainty
* Adopting good practice assessment and checklist tools
* Adopting and exploiting available technology for incident management and communications
* Reviewing and testing stranded trains policies and procedures as part of seasonal preparedness plans

## Further recommendations for research and development

In addition to these practical areas of focus, we recommend that:

* Those specifying passenger contracts and concessions consider how adoption and delivery of best practice in managing stranded trains incidents can be incentivised among train operators
* The industry should be engaged in the development of a Good Practice Guide for meeting stranded passengers’ needs, setting out how best to achieve what is included in the Guidance
* Given our findings of the clear link between safety and service, and alignment with RSSB’s previous analysis, the development of this Good Practice Guide could be taken forward in partnership with RSSB
* The industry should establish a mechanism to facilitate the sharing of best practice, lessons learned and updates to procedures relating to stranded trains

# Appendices

## Appendix 1: Passenger recruitment screening questionnaire

**ASK ALL, SINGLE CHOICE**

**In the last month or so have you been involved in any of these incidents?**

1. A **[TOC]** train going from **[ORIGIN]** to **[DESTINATION]** that was stranded between stations due to **[INCIDENT NAME]** on **[DD/MM/YYYY]**
2. A **[TOC]** train going from **[ORIGIN]** to **[DESTINATION]** that was stranded between stations due to **[INCIDENT NAME]** on **[DD/MM/YYYY]**
3. I did not take any of these journeys – **THANK AND CLOSE**

**ASK ALL, SINGLE CHOICE**

**We would like to invite you to take part in our research.  
  
If selected, this would involve an interview with a member of our research team lasting approximately 30-45 minutes.**

**The interview would take place either on the telephone or online (e.g., via Zoom or Teams).**

**As a ‘thank you’ for taking part, you would receive a high street shopping voucher worth £XX.**

**As a reminder, you have the right to withdraw your consent at any time and here is the link to** [our data privacy policy](http://visuals.sdgworld.net/Files/TransportFocusRecruitmentSurveyPrivacyNotice.pdf)**.**

**Do you consent to taking part in an interview if selected?**

1. Yes
2. No

**ASK IF “OPTED TO RECEIVE A PHONE CALL”, OPEN END**

1. **Please tell us how you would like to be contacted to arrange your interview:**

**Your contact details will only be used to arrange the interview.**

**Once the interview has taken place and your voucher has been sent, these will be deleted from our records.**

1. Receive an email – please type your email address here:
2. Receive a phone call – please type your phone number here:

**ASK IF “OPTED TO RECEIVE A PHONE CALL”, OPEN END, MUTLI**

1. **If you’d like to receive a phone call, please let us know which days or times it’s most convenient for us to call you to arrange the interview.**

**If you have no time preferences, please leave the below text boxes blank.**

1. Please enter weekdays and/or weekends:
2. Please enter times of the day (e.g., 10-11am, 4-5pm, etc.):

**ASK IF “OPTED TO RECEIVE A PHONE CALL”, OPEN END**

1. **Please let us know if we need to make any adjustments to accommodate your participation in the research interview e.g., if there is somebody else who would need to be present to help during the interview.**

**If you don’t need anu adjustments, please leave the text box blank**

**Now we would like to ask you a few questions so that we can learn more about you. This is only to ensure we are hearing from and speaking to a range of various passengers. As mentioned earlier, the survey is completely anonymous and non-attributable. This means that your name will not be included, and no person will be able to be identified individually in the analysis or in any research report.**

**We have provided the option of ‘prefer not to say’ where we feel questions may be particularly sensitive.**

**ASK ALL, SINGLE CHOICE**

1. **What gender do you identify as?**
2. Female
3. Male
4. Non-binary
5. In another way - open
6. Prefer not to say

**ASK ALL, SINGLE CHOICE**

**Which of the following age bands are you in?**

1. Under 18 – **THANK AND CLOSE**
2. 18-24
3. 25-29
4. 30-34
5. 35-39
6. 40-44
7. 45-49
8. 50-54
9. 55-59
10. 60-64
11. 65-69
12. 70+

**ASK ALL, SINGLE CHOICE**

**What is your ethnic group?**

1. Asian or Asian British
2. Black, Black British, Caribbean or African
3. White
4. Multiple ethnic groups/ dual heritage
5. Other ethnic group
6. Prefer not to say

**ASK ALL, MULTI CHOICE**

**Do you have any of the following long-term health conditions, impairments or disabilities? By long-term we mean lasting 12 months or more.**

1. Hearing / Vision (e.g., deaf, partially deaf or hard of hearing; blind or partial sight)
2. Physical / Mobility (e.g., wheelchair user, arthritis, multiple sclerosis etc.)
3. Mental health condition (lasting more than a year e.g., major depression, schizophrenia etc.)
4. Learning disability (e.g., dyslexia, dyspraxia etc.)
5. Long-term physical illness or health condition that affects your ability to travel (e.g., Cancer, HIV, Diabetes, Chronic Heart disease, Rheumatoid Arthritis, Chronic Asthma, Long Covid, etc.)
6. No – none of these **EXCLUSIVE**
7. Prefer not to say – **EXCLUSIVE**

**ASK ALL, MULTI CHOICE**

**Do you have, or are you expecting, any children? Please select all that apply**

1. I am expecting a child(ren)
2. I have a child(ren) aged 0-5
3. I have a child(ren) aged 6-10
4. I have a child(ren) aged 11-17
5. I have a chid(ren) aged 18 or older (grown-up children)
6. I don’t have children– **EXCLUSIVE**
7. Prefer not to say – **EXCLUSIVE**

**Thank you for your answers so far! We have just a few final questions about your train journey that was disrupted by the incident.**

**ASK ALL, MULTI CHOICE**

**Who did you travel with on that day?**

1. Alone – **EXLUSIVE**
2. Partner/ spouse
3. Friend(s)/ adult relative(s)
4. Children aged 0-5
5. Children aged 6-10
6. Children aged 11-15
7. Children aged 15+
8. Colleague(s)/ business partner(s)
9. Other – please specify

**ASK ALL EXCEPT THOSE WHO TRAVEL ALONE, MULTI CHOICE**

1. **Does the person(s) who you travelled with have any of the following long-term health conditions, impairments or disabilities? By long-term we mean lasting 12 months or more.**
2. Hearing / Vision (e.g., deaf, partially deaf or hard of hearing; blind or partial sight)
3. Physical / Mobility (e.g., wheelchair user, arthritis, multiple sclerosis etc.)
4. Mental health condition (lasting more than a year e.g., major depression, anxiety, schizophrenia etc.)
5. Learning disability (e.g., dyslexia, dyspraxia etc.)
6. Long-term physical illness or health condition that affects their ability to travel (e.g., Cancer, HIV, Diabetes, Chronic Heart disease, Rheumatoid Arthritis, Chronic Asthma, Long Covid, etc.)
7. No – none of these **EXCLUSIVE**
8. Prefer not to say – **EXCLUSIVE**

**ASK ALL, SINGLE CHOICE**

1. **What was the main reason for taking the train journey?**
2. Commute to/ from work
3. Commute for education
4. Business (e.g., trips that are not part of your commute and which are paid by your employer)
5. Personal business (e.g., job interview, dentist, hospital, bank, lawyer appointment, etc.)
6. Leisure (e.g., visiting friends/ family, travelling for holidays, shopping trip, going to a museum, sporting events, festivals, etc.)
7. Other - please specify

**ASK ALL, RANDOMISE, SINGLE CHOICE**

**Thinking about the time when the train was stranded, how would you rate your overall experience in terms of:**

**ROWS:**

1. Being informed and updated about the incident by the train staff
2. Being reassured about resolving the issue by the train staff
3. Being offered refreshments e.g., snacks, bottles of water, etc.
4. Being able to access refreshments e.g., snacks, bottles of water, etc.
5. Being able to use toilets
6. Being informed about alternative options of completing the journey, e.g., with a different train operator and/ or by other modes of transport (e.g., coach, taxi, local buses, etc.)
7. Being informed about how to claim compensation (e.g., the Delay Repay scheme) by the train staff
8. Being informed and updated about the delay and estimated arrival time at the following stations by train staff

**COLUMNS:**

1. Very good
2. Good
3. Ok
4. Poor
5. Very poor
6. Don’t know/ not sure
7. Not applicable – it was not relevant to my train journey

## 

## Appendix 2: Passenger discussion guide

**Warm-up and setting the scene**

**Can you tell me a little bit about yourself?** Probe if needed:

* Your name/ where you live/ what you do/ what your hobbies are, etc.

**Can you tell me more about the train journey that you took when the incident happened?** Probe if needed:

* Where were you travelling from/ to?
* What was the train operating company?
* What was the reason of your journey?Probe if needed:
  + Was it for commute/ leisure/ business/ personal business?
* Who did you travel with? Probe if needed
  + How many companions?
  + If with children or elderly, probe for their age
* Did you travel in first or standard class?
* When was it? What time of the day/ evening was it?

**Before the journey started, was there anything that could hint that there might be potential disruptions?** Probe if needed

* What was the weather like?
* Any announcements or news from elsewhere?

**What was it like on the train before the incident?** Probe if needed:

* How busy/ crowded was the train?
* Were all seats taken? Were people standing?
* Were you sitting or standing? Where were you in a carriage?

[Ask if not mentioned earlier] **What were you doing when the incident happened? Where were you on the train?** Spontaneous answer

**Communication from the train staff - Information, reassurance and advice**

**Now let’s chat about the time when the train stopped…**

1. **How did you first find out what had happened?** Probe if needed:

* Was it announced by the train staff/ manager?
* Was it from the train staff passing through the carriage?
* Was it mentioned online? Probe if needed:
  + If so, where did you read/ hear about it?
  + What/ whose device did you use? Was there a phone signal/ WIFI?
  + How often did you go online to find out more about the incident? Or asked someone to check if there were any updates online?
* Was it mentioned by other passengers? Probe if needed:
  + How did they find out about the incident?

1. [Ask if not mentioned earlier] **How long did it take for the train staff to make the initial announcement and inform passengers about what had happened?** Probe if needed:

* How long roughly (in minutes)?
* Was it quick/ delayed information?

1. [Ask if not mentioned earlier] **What information did the announcement include?** Probe if needed:

* Reasons why the train stopped?
* How the issue might be resolved?
* Advice on what to do or not?

[Ask if not mentioned earlier] **How easy or difficult was it to understand the announcement? How relevant/useful was the information? Why?**

* Probe only if necessary: Was it easy or difficult to understand it because of a technical system (e.g., speakers/ microphones), train staff’s accent/ diction (use of words), etc.?

[Ask if relevant and not mentioned earlier] **How did the initial announcement make you feel? Why? What exactly made you feel that way?** Spontaneous response

Cross-reference to the previous section if needed

* [If no initial announcement] If there was no initial announcement from the train staff, how did this make you feel? Why?

**How often did the train staff share further announcements/ updates?** Probe if needed:

* Were they frequent/ infrequent?
* What was the time gap between the updates? Roughly in minutes?

**What information was shared/ updated in the further announcements?** Probe if needed:

* Information about **the nature of the incident**? How serious was it?
* Information about what was **being done to resolve the incident?**
* How long would it take to resolve it?
* **Advice** on what you can and cannot do?
* [Ask if relevant/ the incident was serious] **Safety instructions** and/ or information about **potential danger**?
* Information about **the delay and** **estimated arrival time at the following station**?
* Information about the **alternative transport options to complete the journey**?
* Information about how to **claim compensation** (e.g., Delay-Repay scheme)?

[Ask if not mentioned earlier] **How easy or difficult was it to understand announcements? How relevant/useful were they? Why?** Cross-reference to the previous section if needed

[Ask if not mentioned earlier] **What was the tone of these messages? How did the train staff/ manager communicate the updates? What was their tone of voice or delivery style?** Probe if needed:

* Reassuring/calm/confident/reliable?
* Polite/ apologetic/ humorous?
* Vague/ unclear/ confusing/ inconsistent/ rude?

[Ask if not mentioned earlier**] How did the announcements/ updates make you feel? Why? What exactly made you feel that way?** Cross-reference to the previous section if needed

[Ask if not mentioned earlier] **What was it like on the train during this time?** Probe if needed:

* Was there any electricity/ lighting/ heating? Did electricity/ lighting/ heating turn off at any point?
* [If yes] **Please describe it for me…**
  + How long did it last?
  + What was the impact on you?

**Their experience with on-board staff**

**Now let’s talk about the train staff and customer service during the incident….**

Cross-reference to the previous section if needed

**Did it seem like there were enough members of the train staff or not enough**? Probe if needed

* What were they doing? How many of them were there?

[Ask if not mentioned earlier] **How would you describe your experience with the train staff? Why?** Semi-spontaneous. Probe if needed

* How did you feel towards the train staff? How would you describe your feelings? Why?
* Were you satisfied/ happy/ frustrated/ disappointed with their customer service? Why?
* What went well?
* What did not go well? Probe for suggestions of what could be/ should have been done to improve it

**Their specific needs**

[Ask if not mentioned earlier] **How was the situation with accessing any refreshments?** **Was the staff offering any refreshments? What? When?** Probe if needed

* Water/ hot drinks/ sandwiches/ snacks?
* When? On the train or upon arriving at the following station?
* Was it prompted by the conditions on the train (e.g., too crowded/ too hot)?

[Ask if not mentioned earlier] **How about accessing/ using the toilets?**

**Did you require any special assistance or medical attention?** [If yes] **Could you please tell me more about it?**

* Was this affected by the train becoming stranded?

[Ask if relevant] **How did the train staff respond? What was their behaviour?**

[If multiple needs were mentioned, moderator to ensure a clear discussion around each, as well as overall]

* How quickly did you receive any help? How quickly did they respond?
* If you’ve booked assistance in advance, were they aware of your specific needs/ requirements?
* Were there any adjustments made to accommodate your needs?
* Was the staff helpful/attentive/ impatient/ rude?
* How often did they check on you?
* How did they make you feel? Why?

[Ask if relevant and refer to the earlier conversation] **Did those who you travelled with require any special assistance or medical attention?** [If yes] **Could you please tell me more about it?**

[Ask if not mentioned earlier] **How did the train staff respond? What was their behaviour?**

[If multiple needs were mentioned, moderator to ensure a clear discussion around each, as well as overall]

* How quickly did you receive any help? How quickly did they respond?
* Were they aware of your specific needs/ requirements in advance (if booked assistance in advance)?
* Were there any adjustments made to accommodate your needs?
* Was helpful/attentive/ impatient/ rude?
* How often did they check on you?
* How did they make you feel? Why?

**Evacuation process**

Only ask if it’s the train incident included evacuation – this is to be notified prior to the interview

Note: It’s expected that respondents will mention an evacuation earlier in the interview. If they do not, here are potential questions to ask:

**Let’s talk about the train evacuation now….**

**How did you find out that the train had to be evacuated?**

**When was it announced (since the train stopped)?** Probe if needed

* How long roughly (in minutes)?
* An hour or longer?

**What information did the announcement include?** Probe if needed

* Information about the evacuation plan?
* Any advice or safety instructions?

**How clear was the information? How easy or difficult was it to understand the announcement?** Probe if needed

* What was communicated well?
* What was not shared but should have been?

[Ask if not mentioned earlier] **How were you updated on what was going on?**

* Announcements from the train staff?
* Information shared by the train staff walking thorough the train

**What happened next? What was the evacuation process?** Probe if needed

* How were you evacuated? Where?
* What went well? What did not go well?

[Ask if not mentioned earlier] **How did the train staff behave?** **What were they doing?**

* How well did they look after the passengers (including yourself)?

[Ask if have special needs] **Did you require any help from the staff because of your needs?** [Yes] **Please tell me more about it**

[Ask if not mentioned earlier] **Could you please tell me how you felt during the evacuation process? Why? What was going through your mind?** Spontaneous response

**Emotional experience**

**Now I would like you to chat about your emotional wellbeing when you were stranded on the train …**

**Can you please tell me more about how you felt during the incident? What was going through your mind? Why?** Spontaneous response – if not already mentioned

[Add if necessary] If you’d like to pause at any point or skip the question, that’s absolutely fine.

[Ask if relevant and refer to the earlier conversation] **What about those who travelled with you, how did they feel? Why?** Spontaneous response – if not already mentioned

**Reaching the destination**

**How did your train journey end? How did you get to your final station/ destination?**  Semi-spontaneous response

Ask if relevant and refer to the earlier conversation

* Was there any staff when you arrived at the station?
  + How did they behave? How did they treat you/ other passengers?
  + Did they offer any refreshments (e.g., snacks, water)?
* Did you get any help or advice on how to continue your travel?
  + What was offered/ arranged (e.g., taxis, hotels, bus transfers)?

**Summary - overall experience**

**Thinking about everything what we have just discussed, in no more than three words, how would you summarise your overall experience? Why?** Spontaneous response

Cross-reference with what was discussed earlier

**Future advice**

**If there was one bit of advice you would want to give to the train company about how to handle incidents like this, based on your experience, what would it be? Why?** Spontaneous response

**Concluding reflections**

**Is there anything else that we have not discussed that you would like to mention?**

Moderator to consider inviting the respondent to give ‘key takeaways for the train company/ staff’ about any aspects relevant to the train incident.

## 

## Appendix 3: Industry representative interviews – discussion guide

**Warm-up and setting the scene**

**Can you tell me a little bit about yourself and your role in the rail industry?** Probe if needed:

* Your name/ length of time in role/what your responsibilities are during stranded train incidents etc
* What does your day-to-day role look like
* What is your role during disruption (if relevant)
* What is your role in planning for disruption (if relevant)

**Moving onto disruption specifically caused by stranded trains**

**Can you talk through the training you have had in managing stranded train incidents**?

* Within the training how much would you say you are taught to consider the experience of passengers on stranded trains vs wider route recovery

**What is your role in the management of stranded train incidents?**

* What part of the decision-making process are you involved in
  + If you are not, can you talk us through how you are notified about what decisions are being made and if you are able to feed into them
* When a stranded train occurs can you talk us through the process that happens from notification of a disruptive incident to declaration of a stranded train to recovery and return to normal working.
  + Within this process can you run through the key timings and points that you would be considering the needs of passengers onboard the stranded train – passenger numbers, passengers with additional needs, temperature, hydration, accessibility needs, onwards travel etc

**Communication**

* What is the process for passing information internally
* What is the process for providing passengers initial information about the disruption
  + How often are announcements on the train expected to be made
  + What considerations are given, if any, regarding what information to provide passengers with or how information is phrased?
  + How do you ensure passengers who may be hard of hearing/visually impaired are fully informed?

**Training and Competency**

* **What training is provided to roles likely to be involved in stranded train incidents**?
  + How is this kept UpToDate
  + Is the training updated key findings from previous incidents?
  + Are there any resources used to aid training
    - Do you use RSSB or RDG research/guidance to feed into these?
* **What information or guidance is provided to help manage stranded train incidents?**

**Can you tell me more about the incident?** Probe if needed:

* What was the planned train journey?
* What was the cause of the disruption?
* How long did it take for the train(s) to be declared as stranded?
  + (On train staff) When and how were you made aware that the train would be declared as stranded?
* **What information was gathered about the onboard situation was gathered?**
  + What staff were onboard?
  + What was the demographic? Families, commuters, long distance etc
  + Were any passengers with additional needs identified? If so what additional considerations were given?
  + How many passengers were onboard?
  + Was food or drink available?
  + Toilet Facilities etc
* Were additional staff requested by stations, social media, customer relations, control to help manage the incident?
* How long did the incident last?

**What was it like on the train before the incident?** Probe if needed:

* How busy/ crowded was the train?

**Note to the interviewer:** Record passenger’s emotional response and any non-verbal cues during the interview

**Internal Communication**

**If we can move on to how information is passed on….**

**How did you first find out what had happened?** Probe if needed:

* Network Rail Control, Train Driver, signaller – if control staff
* TOC control, Signaller Call, other onboard staff – if onboard
* TOC Control, On Call Staff – if frontline stations or customer services

**Focusing on those of you who work within the Rail Control…**

**Where was your primary source of updates coming from in relation to this incident?**

**Roughly how often were updates provided regarding the recovery of the incident**

* Was this at the frequency you would expect?
  + If not was there an impact on keeping key contacts informed?

**Who were your key points of contact to update?** Probe if needed:

* On Call Staff, Station Staff, On Train Staff, Customer Relations

**Moving onto those of you who were in charge of keeping passengers informed, both on train and via social media…**

**How often did you receive updates on the situation?**

* Was this at the frequency you would expect?
  + If not was there an impact on keeping customers informed?

**What information were you given to pass on to passengers?**

* Is there any information that wasn’t passed on that you feel would have benefited the passengers either in this specific incident or during stranded train incidents overall?

**If you were required to pass information on who was that to and what information was required?**

**Passenger Communication**

**How did you initially relay information regarding the disruptive incident**

* Was there disruption prior to the train being declared stranded?
* What information did you announce?
  + Reasons why the train stopped?
  + Information on how the issue may be resolved
  + Advice on what to do or not?

**How often were announcements made on the train to passengers?**

* Relating to this how often are you trained to make announcements?
* Were you able to/did you give any indication of the time frame
  + Could you explain why you made this decision?
* What additional information were you able to provide in subsequent announcements?
  + Further Updates on incident resolution
  + Advice or safety instructions
  + Information regarding compensation

**Were you able to provide any refreshments such as water or food?**

* How did you advise customers of this?

**What were your main challenges with providing customer service in this situation?**

**Did you make any announcements regarding onward travel?**

* Where was this information received
  + Did you have to actively seek this information or was it provided without asking?

**To what extent was social media used to inform passengers onboard the stranded train?**

* What mitigations are in place to avoid differing messages to onboard announcements being passed on?

**Do you have any suggestions to improve the passenger experience while on a stranded train**

**Decision Making**

**If we could discuss the decision-making processes during the incident**

**What service recovery plans were out in place?**

* How did these consider the passengers on the stranded train
* Did they follow any specific guidance you have in place
* Is there a set “checklist” to follow when planning the recovery?

**What were the timescales for decisions made – did they meet those laid out in the procedure/were they similar to other incidents of this nature?**

* Once a plan had been made was it reviewed?
* How long did it take to create the rescue/recovery plan
  + Were there any factors that delayed planning or expediated it in this instance?

**Internally was the Gold command structure put in place to aid decision making**

* Could you explain why it was/wasn’t?
* If so, how did it interact with external command structures?

**What were your concerns about the stranded train and passengers onboard?**

* Was a risk assessment performed if so, how?

**At what point did you consider a controlled evacuation**

* What considerations went into the final decision?
  + Location, number of passengers onboard, onboard passengers with additional needs, demographic, weather, onboard conditions (aircon/heating, toilet availability, refreshments)
* What information did you require to make the decision?

**What decisions were made to mitigate the risk of an uncontrolled evacuation?**

* What is considered in this process?

**At what point was onward or alternative travel considered?**

* What challenges were identified?

**What were your main challenges with providing customer service in this situation?**

**Do you have any suggestions to improve the passenger experience while on a stranded train**

**Review**

**Has a review into the incident taken place?**

* Who would be invited to attend this?
* Is there a set structure?
* What is reviewed
  + Service recovery, performance, onward travel, passenger experience?
  + Do you review passenger feedback in these?
* Does this happen to all stranded train incidents or only ones that have a high impact on overall service delivery?
* What actions were taken and how are these implemented?

**Concluding reflections**

**Is there anything else that we have not discussed that you would like to mention?**

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1. [Meeting the Needs of Passengers Stranded on Trains (raildeliverygroup.com)](https://www.raildeliverygroup.com/files/Publications/RDG-OPS-GN-049-MeetingtheNeedsofPassengersStrandedonTrains.pdf) [↑](#footnote-ref-2)
2. Arriva Rail London operates on TFL infrastructure and across multiple Network Rail Regions [↑](#footnote-ref-3)
3. [Understanding and Preventing Passenger Self-Evacuation from Trains (S341) - rssb.co.uk](https://www.rssb.co.uk/en/research-catalogue/CatalogueItem/S341) [↑](#footnote-ref-4)
4. ORR passenger usage data, tables 1221 and 1231 [↑](#footnote-ref-5)