



9<sup>th</sup> October 2025

Dear Sir,

We write in response to your Regulation 28 Report to Prevent Future Deaths dated 5 August 2025 addressed to Network Rail Infrastructure Limited ("**Network Rail**"), which was issued following the inquest touching the death of Simon Anthony Moore.

We are grateful for the opportunity to respond, and the extension to the timeframe for response by two weeks.

As Network Rail was not designated Interested Person status at the inquest, nor in attendance at the hearing, it was not able to address HM Coroner on or provide clarification or context on matters relevant to your concern at the time of the hearing. We therefore take the opportunity to provide what we consider to be important contextual information – both in respect of Network Rail generally and in relation to a point of clarification relevant to your concern - before summarising relevant actions, some of which industry-wide, taken to date. I also take the opportunity to extend my condolences to the family and friends of Mr Moore.

As it is hoped is made clear through the content of this response, Network Rail has systems in place for, and is committed to, effective communication channels in the aftermath of an incident, and the prevention of future deaths on the railway, and it is hoped the content helps ameliorate the coroner's concern outlined in the Regulation 28 report. As reiterated later in this response, should you require any further information, Network Rail will be happy to assist further.

#### **Introductory comments**

Network Rail owns and manages Great Britain's rail infrastructure including the track, signals, tunnels, viaducts and level crossings, which includes 10,000 miles of route track, 20,000 miles of boundary, 30,000 bridges and viaducts and over 6,000 level crossings. In addition, there are 2,565 stations on the mainline rail network, nearly all of which are owned by Network Rail, and Network Rail is responsible for structural safety refurbishment, renewal and upgrading of all the stations it owns. Network Rail manages around 30 mainline and London stations, with the remaining stations operated and managed by train operating companies (TOCs) which lease the stations from Network Rail.

TOCs are responsible for passenger safety on trains and at stations that they manage including the day-to-day management of the stations such as risk assessment, and generally providing a safe, reliable service to passengers in order to keep those passengers and other station visitors safe.

The rail companies and organisations that make up the railway industry work together and collaborate to operate safely and to apply safety standards set by the Rail Safety Standards Board (RSSB) which is the safety standard setting body for the rail network in Great Britain.

Network Rail has an established health and safety management system that describes the principles, roles, responsibilities, systems and processes that are in place by which Network Rail manages the health, safety, welfare and security of its employees and others affected by its activities, and the health and safety management system is underpinned by rules, standards, specifications and procedures, which form an intrinsic part of the overall system. Network Rail is structured with 14 main Routes across the network. The Routes are responsible for operations, maintenance and minor renewal, including day-to-day delivery of train performance and the relationship with the local train operating companies. The 14 Routes are supported by five Network Rail regions. I am the Managing Director for the Southern Region which carries over 1 million passengers a day.

### **Concern in respect of communication between Signaller and TOC**

We take the opportunity to provide further information and context in respect of the following finding in the Regulation 28 report:

*The Network Rail Signaller has no means through which to relay the details of any discussions with drivers (in this instance Mr Moore) to the train company Control who could then pass this information on to the attending Driver Manager.*

The Network Rail Signaller does have a means through which to relay the details of any discussions with drivers (in this instance Mr Moore) to the train company Control who could then pass this information on to the attending Driver Manager. The below explains what that system is, and how it was utilised in respect of Mr Moore. Network Rail's understanding is that the system in place was utilised by the Network Rail Signaller, but that joint Control did not pass the information to the attending Driver Manager.

By way of background, Network Rail operates Incident Control Centres, which are dedicated hubs for managing and coordinating the response to incidents on the railway. They bring together key operational staff including signallers and Control managers, monitoring the network in real time and ensuring the safe and efficient management of train movements. Relevant to coordinating information, liaison with TOCs and response to incidents nationwide, there are detailed standards, processes and procedures for incident management, which are not explored in full for the purposes of this response.

Incident Control utilise tools such as the Control Centre Incident Log (CCIL). CCIL is Network Rail's incident management and logging tool used to collaboratively manage any incident impacting upon the operational railway. It allows Control from different organisations to work together to effectively manage incidents and enables Control centres to record and share information with other organisations involved in the incident, providing common and real time incident information across the rail industry.

Signallers play a vital, safety-critical, role in ensuring the safe and efficient movement of trains across the railway, including in incident management by communicating with drivers and implementing emergency procedures. As part of their role, having undergone extensive training, they relay critical information to Incident Control Centres (or Route Control) for wider management and investigation. As part of this, signallers are expected to promptly and accurately record tactical operational detail of an incident, such as the location, time and specific

irregularities. Though signallers are not a welfare-related specific role, this would include the communication of any concern or distress presented by a train driver.

In this instance, the Signaller in question included in the information provided to Control in respect of the SPAD incident the presentation of the driver having been in distress. The Investigating Officer, namely the On-call Local Operations Manager, subsequently reviewed those communications and confirmed that the driver sounded shaken during the call. Such reports were recorded on the CCIL, which is enclosed with this response, with relevant extracts highlighted for ease of reference, and names redacted. Whilst SWR Control has access to the CCIL and opportunity to relay information to its On-Call Driver Managers, or other personnel as needed, it appears on this occasion that these entries were not communicated as effectively as they could be.

### **Actions**

Whilst it is hoped that the above information provides helpful context and clarification in respect of your concern, Network Rail remains committed to the prevention of future deaths and set out below is information on the various workstreams following the Incident which fall relevant to the Regulation 28 report.

### **Investigation, recommendation and consideration of next steps**

As part of Network Rail's commitment to preventing incidents on the railway, it has in place a range of tools and processes to learn from incidents, manage outcomes and recommendations of investigations and drive continuous improvement. It collaborates closely with industry partners, regulators and trade unions to ensure a joined-up approach to learning.

Examples are set out below of relevant investigations/reviews in the aftermath of this incident. All of these occurred before the inquest into Mr Moore's death and before the Prevention of Future Deaths Report was issued:

- **The incident was considered at Southern OPSRAM.**

OPSRAM is an industry wide meeting to work jointly with colleagues and operating companies to identify and reduce risks, put measures in place to prevent incidents, and share good practice to support the safe and effective management of operations.

- **Network Rail's Operations Risk Control Coordinator collaborated with and formed part of SWR's investigation.**

As you are aware, SWR's incident investigation found that, notwithstanding the existing processes in place as described above, opportunities existed to strengthen escalation and communication protocols between signallers, Incident Controllers, TOC Control and Driver Managers. The investigation included a recommendation that Guidance will be created for signallers to support them when communicating with a driver post incident. This Guidance will be developed by the Industry Working Group on Welfare Communications, described further below.

- **The SWR investigation report, including the above recommendation, was considered at the NR SPAD Recommendations and Review Panel.**

The SPAD Recommendations and Review Panel is set up to review investigations into SPADS, check that the causes and contributing factors have been fully understood, ensure that recommendations are clear and practical, and agree how actions will be tracked to closure so that lessons are learned, and similar events can be prevented in the future.

Industry working group

Upon receipt of HM Coroner's Regulation 28 report, and in considering your findings, Network Rail set up an Industry Working Group on Welfare Communication, which includes representatives from Network Rail, Train Operating Companies, and trade unions.

The working group's remit is to review the end-to-end process for incident communication, with a view to ensuring that welfare concerns are communicated effectively at all stages of the process.

A workshop for the working group is scheduled for early October.

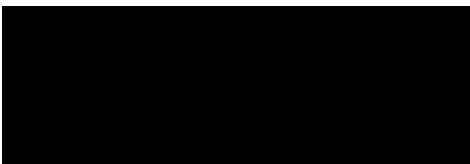
Should you be assisted by receiving a further updates on the output of this group, we would be happy to keep you informed.

**Concluding comments**

We thank HM Coroner for the time taken to consider this response, and it is hoped that the clarification and further information ameliorate your concerns.

Network Rail remains committed to ensuring that welfare concerns are communicated effectively, and to the prevention of future deaths on the railway. Should Network Rail be able to assist further in anyway, it would be happy to do so.

Yours sincerely



Managing Director, Southern Region