

IN THE CENTRAL CRIMINAL COURT
BEFORE THE HONOURABLE MR JUSTICE FRASER

THE OFFICE OF RAIL AND ROAD

v

TRANSPORT FOR LONDON

TRAM OPERATIONS LIMITED

TRANSPORT FOR LONDON
MITIGATION NOTE
Hearing for Sentence 24, 26 and 27 July 2023

INTRODUCTION

1. This Note is prepared pursuant to the Order of the Court dated 21 June 2023.
2. Transport for London (“TfL”) has also served the following statements which the court is invited to read in advance of the Sentencing Hearing:
 - a. Statement of Mark Davis, General Manager of London Trams;
 - b. Statement of Lilli Matson, Chief Safety, Health and Environmental Officer of TfL;
 - c. Statement of Patrick Doig, Interim Chief Finance Officer of TfL. This statement exhibits TfL’s past 3 years’ Annual Report and Statement of Accounts (for 2022/23 in draft). These are very substantial documents running to about 700 pages in total. It is not suggested these need to be read. Mr Doig has summarised the financial position in his statement.

RAIB REPORT

3. TfL refers below to passages from the Rail Accident Investigation Branch (“RAIB”) Report *Overturning of a Tram at Sandilands Junction, Croydon* [Prosecution Ex/pp17-171 and Mitigation Bundle]. The Court is invited to have regard to this material.

4. The RAIB is established by Parliament. It is one of the state’s independent specialist accident investigation branches. The purpose of the RAIB investigation is to improve safety, not to apportion blame or liability. The RAIB’s report is a public document. It provides an objective, impartial account of its specialist inspectors’ extensive and thorough investigation. There is in our submission no restriction on the use of the RAIB report at this stage of proceedings (as distinct from records of the investigation which are protected from disclosure). The value of such reports was considered by the Court of Appeal in *Rogers v Hoyle* [2015] QB 265 (a civil case relating to the admissibility at trial of a report of the Air Accidents Investigation Branch (“AAIB”)). Christopher Clarke LJ held at paragraph 29:

“The potential value of this material to anyone seeking to establish the cause of the accident (and any culpability therefore) is obvious. The inspectors are experienced and expert individuals fulfilling a public duty to investigate air accidents and incidents for the purposes of preventing further accidents or incidents in future. It is no part of their function to attribute blame or responsibility. There is, thus, no realistic possibility of their report being slanted so as to support or refute a claim that any individual or corporation is, or is not, at fault. Their investigation is carried out as soon as possible after the accident or incident. The investigators have the power, and, in practice, the ability to obtain the necessary information from a wide range of sources in order to establish, on the basis of information obtained soon after the relevant events, a composite picture of what happened and why. They need to do that in order to try and avoid it happening again. I agree with the judge when he said that a non-lawyer would be astonished that the report of the AAIB was not something to which a court could even have regard”.

5. Later in the judgment Christopher Clarke LJ returned to this issue. He held at paragraph 82 (in respect of an AAIB report):

“... Parliament has, however, made a distinction between the report and relevant records. It has provided for the report to be made public and has noticeably not legislated, as it could have done, so as to provide that the report shall be inadmissible or that its admissibility must depend on the application of the same or a similar test to that applicable to relevant records ...

Then at paragraph 83 the judge considered the legislation relating to “other bodies which fulfil similar roles to that of the AAIB”. The judge considered the legislation applicable to the RAIB and held:

“Neither the Act nor the Regulations restrict the admissibility of RAIB reports”.

THE OFFENCE AND PLEA

6. TfL is charged with an offence of contravening Section 3(1) of the Health and Safety at Work etc Act 1974 (“the Act”). The particulars of the offence alleged are that between 27 June 2008 and 9 November 2016:

“... being an employer ... failed to discharge the duty imposed on you by section 3(1) of the Act, in that you failed to conduct your undertaking in such a way as to ensure, so far as was reasonably practicable, persons not in your employment who might be affected thereby, including passengers travelling on board tram No 2551 on the morning of 9 November 2016, were not exposed to risks to their health and safety, namely the risk of injury or death attendant upon a high speed derailment on the Croydon Tram Network including on the approach to Sandilands junction ...”

7. TfL entered a plea of guilty at the first opportunity before District Judge Dean on 10 June 2022.
8. TfL will repeat its heart felt apology and remorse for this breach and its consequences during oral submissions.
9. TfL has consistently accepted the shortcomings identified of it by the RAIB, and continues to do so. The RAIB concluded that the underlying factors were (see Report paragraph 468 Ex/p156):

- “a. [London Trams] and [Tram Operations Limited] did not recognise the actual level of risk associated with overspeeding on a curve ... This was for the following reasons:
- i. route hazard assessments did not identify the need for additional mitigation due to the risk associated with overspeeding at Sandilands south curve ...
 - ii. risk profiling for the Croydon network did not fully recognise the level of risk associated with a tram overturning ...
 - iii. route hazard assessments and risk profiling relied on driver performance as the main means of mitigating the risk of overspeeding ...; and
 - iv. route hazard assessments and risk profiling did not take account of evidence from other tram, road and rail systems showing the level of risk associated with trams overturning.
- b. [relates to TOL]
- c. The risk associated with excessive speed around curves was neither fully understood by the safety regulator nor adequately addressed by UK tramway designers, owners and operators”.

10. It follows that TfL agrees with the ORR that:

“The principal failing, which existed from the outset of operations on the Croydon Tram, was the failure to conduct a suitable and sufficient risk assessment addressing the risk of a high speed derailment and overturning. The evidence describes a series of studies, reviews and assessments done over the years, commencing before TfL took over responsibility for the infrastructure, but continuing after it had taken over that responsibility, none of which amounted to a suitable and sufficient risk assessment. Neither in their individual efforts, nor when working together, did TfL and TOL recognise the extent of the risk that existed”. (Opening paragraph 16)

And

“Neither TCL, prior to its acquisition by TfL (with effect from [June] 2008), nor TfL subsequent to that date, nor TOL, throughout the operation of the Croydon Tramlink, performed a risk assessment that addressed the risk of a high speed derailment or an overturning at the Sandilands junction. The consequence was that measures which might have been identified to control the risk of death and injury consequent upon such a derailing or overturning were neither identified nor implemented ...”. (Opening paragraph 63)

TRANSPORT FOR LONDON

11. Parliament has made provisions for transport services to, from and within Greater London. TfL is a statutory corporation created and governed by the Greater London Authority Act 1999 (“GLA Act”). TfL is a functional body of the Greater London

Authority. The Mayor of London is the Chair of the TfL Board. TfL and its subsidiaries operate for the benefit of the public. Transport Trading Limited (“TTL”) is the holding company for all of TfL’s operational delivery companies.

12. TfL runs most of London’s transport services including London Underground, London Buses, Docklands Light Railway, London Overground, Elizabeth Line, London Trams, London Cable Car and London’s red route strategic roads.
13. Tramtrack Croydon Limited (“TCL”) (trading name London Trams (“LT”)) became a wholly owned subsidiary of TTL on 27 June 2008. TfL took over responsibility for TCL because investment by the private sector partner involved in TCL in the tram infrastructure and its relationship with Tram Operations Limited had deteriorated. TfL set about addressing this. Over the following years, substantial sums were invested to improve the infrastructure.
14. LT operates over a 28km route between Croydon and Wimbledon, New Addington, Beckenham Junction and Elmers End and serves 39 tram stops. LT staff are employed by TfL. Hence, TfL and not TCL is the defendant.

APPLICATION OF SENTENCING GUIDELINES

Step 1:

Culpability

15. The ORR submits that this is a case of High Culpability. That requires the ORR to satisfy the Court to the criminal standard that TfL “fell far short of the appropriate standard”. The Guidelines provide that factors indicating high culpability are:
 - a. failing to put in place measures that are recognised standards in the industry;
 - b. ignoring concerns raised by employees or others;
 - c. failing to make appropriate changes following prior incident(s) exposing risks to health and safety;

- d. allowing breaches to subsist over a long period of time;
 - e. Serious and/or systemic failure within the organisation to address risks to health and safety.
16. TfL accepts that the breach subsisted over a long period of time. However, the other features of high culpability are not present. High culpability does not fairly reflect TfL’s shortcomings in this case or ORR’s acceptance that a great deal was done by TfL (and TOL) to ensure the safe operation of the trams.
17. The Guidelines provide that where there are factors present in the case that fall into different categories of culpability, the court should balance these factors to reach a fair assessment of culpability. A fair assessment of TfL’s culpability is Medium.
18. The essence of the prosecution case, which is accepted, is that:
- a. There was a failure to undertake a suitable and sufficient assessment of the risks associated with overspeeding on a curve;
 - b. A suitable and sufficient risk assessment would have addressed the possibility of a driver becoming disoriented and/or approaching at excessive speed and resulted in more effective measures to reduce that risk.
19. Assessing the degree of culpability for those failures requires identification of the “appropriate standard” and an analysis of how far below that standard TfL fell. The appropriate standard is the standard reasonably to have been expected of tram infrastructure managers in the UK in and before 2016. The RAIB report provides context and a reliable and objective assessment of that standard and provides a reliable basis on which to assess the extent to which TfL fell below it.

Regulatory Approval and ORR’s Guidance

20. The safe design and operation of tramways is overseen by a specialist regulator. The Croydon tramway has been continually subject to the approval of and

regulation by (initially) Her Majesty's Railway Inspectorate ("HMRI") and (currently) the ORR.

21. At the time of its design and construction, the tramway was subject to the provisions of Railways and Other Transport Systems (Approval of Works, Plant and Equipment) Regulations 1994 (ROTS). Pursuant to Regulation 4, before the tramway could operate it was subject to assessments, inspections and statutory approval by HMRI. The tramway became operational after this approval in May 2000. The approval of the tramway was given on the basis that it complied with relevant standards, legal requirements and regulatory safety guidance that prevailed at the time [RAIB para 250]. Thereafter, the tramway has been required to operate within and be compliant with a statutory framework. The arrangements at Sandilands were the same then as in 2016.
22. The statutory provisions include line of sight driving as a defining feature of a tramway (see Opening, paragraph 31).
23. In 1997, HMRI published guidance applicable to tramways *Railway Safety Principles and Guidance Part 2 Section G: Guidance on Tramways* ("RSPG-2G"). This guidance was updated by the ORR in 2006 and published as *Guidance on Tramways Railway Safety Publication 2* ("the Guidance") (a copy is exhibited to the statement of Mark Davis). This updated the earlier guidance. It provides:

"Following the guidance is not compulsory and you are free to take other action. But if you do follow the guidance you will normally be doing enough to comply with the law. Health and Safety inspectors seek to secure compliance with the law and may refer to this guidance as illustrating good practice"

And

"This document does not intend to set out mandatory standards. It gives examples of established good practice acceptable to the Inspectorate to provide an acceptable level of safety for the public (passengers and others), employees and contractors".

24. Consistent with the statutory provisions, this Guidance:

- a. Is predicated on line-of-sight operation (see paragraph 22 of the Guidance). While the ORR is right to say that tram operation places a significant responsibility on the driver, that was inherent in all UK tram operations. The Guidance identified good practice on that basis;
- b. Specified the design and size of speed signs (see paragraphs 240 – 243 and Appendix A, read with the Traffic Sign Regulations and General Directions 2002, Schedule 5);
- c. Specified that speed signs should be located at the point at which the change in permitted speed begins (paragraph 243);
- d. Provided that a proliferation of signs should be avoided (paragraph 241);
- e. Provided for illumination of former railway tunnels in the context of passenger evacuation (paragraphs 135 - 137);
- f. Specified required features of tram design and construction, including structural integrity and driving controls and indications (Chapter 8).

25. The RAIB considered the issue of this Guidance in some detail:

Tram line-of sight driving

72 The Croydon tramway, in common with all UK tramways, operates on the line- of-sight driving principle. This is used in combination with ‘route knowledge’: that is, before driving unsupervised, tram drivers must have learnt about speed restrictions, junctions, crossings and other features on the lines they drive over. Signals are only provided where necessary to regulate tram movements at tramway junctions and at some locations where roads cross the tramway ... They are not provided to regulate the spacing between trams.

...

172 [Transport Research Laboratory] assessed the 20 km/h sign that was in place at the time of the accident and concluded that it did not provide tram drivers with a strong visual cue that a brake application was required. It was too small and poorly reflective, so could not be seen until after the driver needed to apply the brakes in order to comply with the speed restriction. ORR stated that the 20 km/h sign met the minimum dimensions and reflectivity requirements in place at the time the tramway was constructed.

173 The 20 km/h tramway sign was not required to meet current visibility standards for other road vehicles on public roads ...

...

“UK tramway guidance

252 The provision of the speed sign, and the absence of other mitigation at the curve, was consistent with the design guidance given in RSPG-2G [the earlier guidance] and RSP2 (paragraph 69). The technical content of RSPG-2G had been developed while the earliest of the second generation of UK tramways were being designed and opened. Both documents reflect the widely held views of both the tram industry and the regulator (HMRI and ORR) with the foreword of both documents acknowledging that HMRI ‘is indebted to the very many people who have contributed to the development of this document’.

253 Although consistent with RSPG-2G and RSP2, the mitigation against overspeeding on the approach to Sandilands was less than would have been provided in comparable situations on European tramways (paragraph 260), UK roads (paragraph 269) and UK railways (paragraph 274). It is likely that direct application of these arrangements would have been inappropriate on the Croydon tramway. However, the lack of any comparable arrangements shows that the risk associated with serious accidents on curves had not been fully appreciated by the UK tram industry or its safety authority.

254 RSPG-2G was applicable when Croydon tramway was opened in May 2000 and stated that:

[RSPG-2G gives] examples of established good practice acceptable to [HMRI] to provide an acceptable level of safety for the public (passengers and others)’ (RSPG-2G paragraph 2);

‘application of this guidance should provide a sufficient level of safety for approval to be given by [HMRI], provided that it has been demonstrated that the use of the guidance is wholly applicable to the works, plant or equipment’ (RSPG-2G paragraph 3); and

‘where arrangements which differ from those set out in this guidance are proposed, those responsible for submitting the works for approval [by HMRI] will be expected to demonstrate that such arrangements provide an equivalent level of safety’ (RSPG-2G paragraph 11).

255 RSPG-2G includes an illustration of a speed sign similar to that at the start of the curve at Sandilands. The accompanying text stated:

‘the [sign] should be large enough to be seen clearly’ (RSPG-2G Appendix A paragraph 3); and

‘Approved lineside signs... should be located wherever...the maximum permitted speed on a section of tramway changes’ (RSPG-2G paragraph 213 (b)).

256 RSPG-2G did not give dimensions for speed signs, other than a size ratio of 3:2 (height : width). The speed sign at Sandilands was of similar size to others on the Croydon tramway and elsewhere on UK tram networks.

257 RSPG-2G makes no mention of signage warning of a speed reduction ahead and no mention of a need for automatic application of brakes on a tram

approaching a hazard at excessive speed. No maximum speed is given for operation of trams except when sharing a road with other vehicles.

258 When using authoritative documents such as RSPG-2G, tramway designers and engineers in many fields would not necessarily expect to provide mitigation in addition to that described in the guidance, unless there is a clear prompt to do so. Prompts can include document text suggesting other factors to be considered, or designers using a document in circumstances for which it is not intended, but for which it may provide helpful advice (for example, a document relating to safety management in another industry). No relevant prompts have been found in respect of using RSPG-2G to design mitigation at Sandilands south curve.

259 A survey of other major UK tram systems found that, before the accident at Sandilands, signage at speed restrictions was generally similar to that at Croydon and comprised only a standard speed sign at the start of the restriction. The exception was six locations on the Manchester system where additional signage was provided at locations considered to be particularly high risk. Additional signage was added on four UK tramways after the RAIB issued an Urgent Safety Advice (Appendix F) based on preliminary findings from the Sandilands investigation.

26. It is reasonable to conclude therefore, that the infrastructure arrangements in place in 2016:

- a. Had been assessed and approved by HMRI;
- b. The signage was consistent with the Guidance;
- c. The absence of other mitigation measures at and on the approach to the curve was consistent with the Guidance;
- d. The infrastructure measures in place reflected recognised standards in the industry.

27. This is a strong indicator that TfL did not fall far below the appropriate standard.

Risk Assessment

28. The RAIB considered the risk assessment process and its shortcomings:

203 A series of risk profiling exercises were commissioned as part of the ongoing management assessment of tram operation on the Croydon tramway. The

first was commissioned by TOL in 2008, related only to TOL operations and only involved TOL staff. In 2011, output from the 2008 work was extended to include management of the trams and infrastructure. LT staff participated in this work. A further update in 2012, involving TfL/LT and TOL extended the earlier work to take account of the forthcoming introduction of the new Stadler trams. The most recent update before the Sandilands accident was in 2015 and commissioned by TfL/LT and TOL. The resulting report describes the intention of the work as including ‘all other aspects of the infrastructure and systems maintenance’.

204 The risk profiling exercises utilised workshops attended by senior managers, most with many years’ experience of managing and operating the Croydon tramway. Some had been involved with the tramway since before it opened. The risk profiling was assisted by a consultant with experience of working with the UK rail industry, overseas rail industries and the bus and coach industries. The consultant’s facilitator at the workshops had rail experience, but only limited bus and coach experience.

205 The risk profiling was based on RSSB’s [Rail Safety and Standards Board] safety risk model which is used to understand the overall risk level and risk profile of the main line railway. The safety risk model lists 131 hazardous events. It does not identify a train overturning as a specific event but RSSB stated that the hazard ‘derailment of a passenger train’ includes the precursor ‘overspeeding’ and that a train overturning is included among the consequences. The consultant facilitating the risk profiling exercise followed the guidance on risk assessment contained in the main line railway guidance note GE/GN8561 ‘Guidance on the preparation of risk assessments within railway safety cases’ (withdrawn on 6 December 2008, after the first Croydon tramway risk profiling workshop) and had adapted the document to make it suitable for use on a tramway.

206 The input to the 2008 workshop included a document listing 42 hazardous events, one of which (designated HE140) was ‘tram overturning’. The consultant stated that, during the workshop, it was decided that ‘tram overturning’ was a sub-set of ‘tram derailed in service’. This was because ‘nobody at the 2008 workshop thought a tram overturning was sufficiently different from a tram derailment to be treated as a separate hazardous event’. None of the participants have provided evidence that tram overturning was subsequently revisited. Although the RAIB cannot discount the possibility that it was mentioned during later workshops, there is no evidence that the hazard of ‘tram overturning’ was ever the subject of risk assessment.

207 The 2015 workshop ranked hazardous events (e.g. derailments, collisions and fires) based on their estimated average frequency and their consequence expressed as fatalities and weighted injuries (FWI). The workshops also identified precursors, which are signposts to potential future harmful events. Typically, precursors are low consequence and seemingly benign events which could have serious outcomes under different circumstances (for example, a track irregularity not causing a derailment has the potential to lead to a derailment).

208 In addition to considering events based on risk ranking, explicit consideration was given to events having multiple fatality or catastrophic risk potential, and these events were agreed and an FWI score assessed for each event. ‘Tram derailment in service’ was one of eight categories identified as having the potential for multiple fatality or catastrophic risk. This led to consideration of previous experience, which suggested that overspeeding could lead to passenger injuries due to excessively high forces on curves, or signals being passed when displaying stop indications. Overspeeding was also seen as a precursor to derailment.

209 Output from the 2015 workshop included an estimate that a tram would derail in passenger service once every 18 months. This was mainly based on the operational experience of the tramway at that time which also indicated that the average consequence of a derailment was one minor injury. The workshop output gave the estimated probability of a fatality from a tram derailing in service as one per 100 derailments, equivalent to one fatality every 150 years.

210 The absence of any detailed consideration of consequences beyond those already experienced by the tramway meant that the adequacy of existing mitigations was not fully considered. Although reference to actual operating experience is important, it is also necessary to assess the risk of high consequence events that occur only rarely. Guidance on risk assessment in the railway sector identifies the need for particular consideration of infrequent multiple fatality events and the need to ensure that the necessary controls are in place. Since such events will often fall outside the experience of any single tramway, it is necessary to imagine the circumstances that could lead to such an event, and to consider experience on other tramways and in other related transport sectors ...

29. The RAIB also concluded:

“249 The risk associated with excessive speed on curves was neither fully understood by the safety regulator nor adequately addressed by UK tramway designers, owners and operators.

...

426 UK tramways did not have a mechanism to promote effective sharing of safety information or the development of common approaches to the management of risk.

427 The response to both the urgent safety advice issued by the RAIB following the accident at Sandilands, and questionnaires sent to UK tramways, indicated that the risk associated with overturning on curves was not generally appreciated. As such, this accident could have occurred on other UK tramways.”

30. Tunnel Lighting. The tunnel lighting was complex and did not work as designed. TfL had taken steps to maintain the lighting but the system was beyond its serviceable life. The context is important. The lighting was provided to illuminate

the walkway in the event it was necessary to walk in the tunnels. That was consistent with the Guidance. It was not provided as an aid to drivers. The poor condition of the lighting had featured in discussions prior to 2016 but was never in the context of a risk to the safe driving of the trams. TfL did not then appreciate that drivers were using the gaps between the tunnels as a cue to braking and that, therefore, the lighting was significant for that purpose. Replacement of the lighting did not, therefore, rank as a high priority when compared, for example, to safety critical work such as maintenance and replacement of track.

31. TfL agrees with the RAIB (Report paragraph 211) and the ORR that had the various risk assessments carried out between 2008 and 2015 recognised the level of risk associated with a tram overturning at high speed, it is likely that:

- a. the need for additional mitigations, such as improved signage, would have been identified and found to be reasonably practicable to implement;
- b. it would have been appreciated that the tunnels did not contain distinctive features which would alert drivers during darkness to normal braking points.

32. Nevertheless, the approach to risk assessment was guided by QSS, who were engaged to bring their objective and specialist knowledge to bear. The failure to undertake a suitable and sufficient risk assessment arose not from a systemic failure within TfL but rather from a failure in the application of what was considered by the industry to be good practice. That is a strong indicator that TfL did not fall far below the appropriate standard.

Audits of TOL by TfL

33. The ORR suggests TfL failed in its “oversight” of TOL in that TfL did not identify the deficiencies in TOL’s risk assessment (Opening paragraph 70 and 71) and that there were “some weaknesses in TOL’s fatigue management regime (Opening,

paragraph 235) which is then linked to the submission that TfL failed to keep abreast of improving technology. That is not accepted

34. First, this submission must be seen in the context of ORR's acceptance that "much has been done by TfL in its oversight of TOL".
35. Second, it is important to be clear about what is meant by "oversight". TfL did not manage TOL. It did not have oversight of its day to day operation. Rather, the Operating Agreement provided for TfL to undertake audits. It did so. The quality of TfL's audits was considered by the RAIB, who also considered audits undertaken by ORR and by TOL. At the inquests, the Chief Inspector expressed the RAIB's conclusions on audits which included:
 - a. It would be "most unlikely" that a competent auditor would have spotted that the risk of tram overturning due to excess speed had not been properly evaluated; and
 - b. it would be "unreasonable" to conclude that the audit processes should have revealed deficiencies in risk profiling.
36. Third, fatigue management was not a relevant factor in the tragedy.
37. Fourth, this is a harsh criticism to be made by ORR, especially in support of submission that culpability is high, when the risks associated with excessive speed on curves was "neither fully understood by the safety regulator nor adequately addressed by UK tramway designers, owners and operators".

Technological Developments

38. By reference to fatigue management (Opening paragraph 235), ORR submits that TfL did not keep abreast of technological developments. This is relied on as a feature supporting a finding of high culpability.

39. The duty under section 3 of the Act is qualified so far as is reasonably practicable. What is reasonably practicable is to be assessed at the point in time prior to the incident complained of.
40. Prior to 2016, no tram operator anywhere in the UK had any kind of technology to detect fatigue. The fact that the ORR suggests in its 2012 guidance that “improving technology makes such aids increasingly feasible” does not mean they were in fact feasible and ought reasonably to have been installed on trams in Croydon (and elsewhere) by 2016.
41. The ORR does not identify or provide evidence of the technological developments it is asserted should have been implemented *before* 2016, other than to refer to the work undertaken *after* 2016 and in particular the development of the Guardian and Physical Prevention of Overspeeding (PPOS) systems for use on trams.
42. Furthermore:
- a. TfL does keep abreast of technological developments;
 - b. The ORR stipulated in the Guidance the safety equipment that trams were required to have, and this did not include anything comparable to Guardian or PPOS;
 - c. The ORR agrees that in respect of PPOS, LT has led the way in the UK tram industry;
 - d. The RAIB concluded:

“401 In common with most trams and trains in the world, there was no device fitted that was capable of reliably detecting drivers’ loss of awareness”.

Summary

43. In summary, therefore, when seen in the context of the industry standards and guidance of the day, the Court is invited to conclude that TfL’s shortcomings fell

short, but not far short of the appropriate standard and that overall this is a case of Medium culpability.

Seriousness of Harm Risked

44. It is accepted that the seriousness of the harm risked by the offence was Level A.

Likelihood of Level A harm

45. The ORR submits that there was a high likelihood of level A harm. It suggests that “this was an accident waiting to happen”, that if it did happen there were likely to be multiple fatalities and that therefore there was a high likelihood of harm. That analysis is flawed.

46. It is accepted that in the event of a high speed tram derailment there are likely to be fatalities, as in fact occurred. But, the question is: what is the likelihood of that event occurring by reason of the breach of duty on a scale of low, medium, high? The fact it has occurred cannot mean there is a high likelihood: if that is correct, likelihood would always be high where Level A harm has in fact occurred and the Sentencing Guidelines would not provide for the scale.

47. It is for the ORR to establish to the criminal standard that there was a high likelihood of Level A harm. The evidence here is overwhelmingly against a finding of high likelihood of harm. The reasons include:

- a. The breach was of long standing. That counts against TfL when assessing culpability, but on the facts of this case is relevant to the likelihood of harm. In *R v Tata Steel UK Limited* [2017] 2 Cr App R (S) 29 Gross LJ held, giving the judgment of the court, at paragraph 44 when allowing an appeal against a judge’s assessment of high likelihood:

“... By itself, the period of operation without incident is a powerfully persuasive pointer against the offence being one of high likelihood”.

In *R v Dimond Box Limited* [2017] EWCA Crim 1904 the court of appeal said *Tata* did not establish a general principle and each case will turn on

its own facts. But there, unlike *Tata* and the present case, injury was sustained without any unusual feature. Here the unusual feature was that the tram was travelling significantly in excess of the speed limit.

- b. There had been no other highspeed derailment of any second generation tram in the UK;
- c. For derailment to occur, the speed of the tram had to significantly exceed the speed limit;
- d. There was no history of speeding and in particular of excessive speeding (RAIB paragraph 383);
- e. Mr Dorris alone had travelled along that part of the network 693 times in 2 years without incident (RAIB paragraph S21);
- f. Since 2012 in the order of 260 million passengers have travelled on the trams without any fatalities, save for this tragedy.

48. A fair assessment is that there was a Low likelihood of Level A harm.

Harm Category

49. This is initially a Harm Category 3 case.

50. It is accepted that the breach exposed a large number of members of the public to the risk of harm and was a significant cause of actual harm. It is, therefore, accepted that the court must consider moving up a harm category or within the range.

Step 2:

Category Range and Starting Point

51. TfL's equivalent of turnover (see below) very greatly exceeds £50m per annum and it is, therefore a very large organisation. It is not, however, necessary to move outside the suggested ranges in order to achieve a proportionate sentence.
52. LT's equivalent of turnover (see below) would place it in the Medium category. Although LT is not the defendant, its financial position is a relevant factor to take into account in order to achieve a proportionate sentence.

Aggravating Features

53. No aggravating features are alleged and there are no aggravating features.

Mitigating Features

54. All of the mitigating feature identified in the Guidelines are present:
- a. No previous convictions;
 - b. Steps taken to voluntarily remedy problem;
 - c. High level of cooperation with the investigation, beyond that which will always be expected;
 - d. Good health and safety record;
 - e. Effective health and safety procedures in place;
 - f. Cooperation and acceptance of responsibility.
55. In addition, TfL has done all that it can to support the victims of the crash by providing immediate financial support, offering facilities for trauma counselling and encouraging and settling civil claims for damages.
56. The detail, which is set out in the witness statements of Mark Davis, General Manager of LT and Lilli Matson, Chief Safety, Health and Environmental Officer of TfL, will be developed orally.

Step 3:

Proportionality of proposed fine to overall means of TfL

57. TfL has provided financial material in the witness statement of Patrick Doig, interim Chief Finance Officer of TfL. The full Annual Report and Statement of Accounts for 2022/23 (in draft), 2021/22 and 2020/21 have been provided.

58. In summary, the headline figures for TfL are:

| | Total Income £m | Operating Costs £m | Group surplus/ (deficit) after tax £m | Group surplus/ (deficit) excluding extraordinary govt grant £m |
|---------|----------------------------|-----------------------------------|--|---|
| 2022/23 | 9,302.3 | (9161.8) | 108.6 | (811.0) |
| 2021/22 | 8,664.5 | (8,106.1) | 504.1 | (1,212.7) |
| 2020/21 | 7,128.1 | (8,046.8) | (911.0) | (3,368.2) |

59. The underlying trading position is a substantial deficit. TfL is dependent upon substantial taxpayer support.

60. In summary, the headline figures for LT are:

| | Total Income £m | Operating Costs £m | Operating Loss £m | Revenue Grant from TfL £m |
|---------|----------------------------|-----------------------------------|------------------------------|--|
| 2022/23 | 18.2 | (34.8) | (16.5) | 19.6 |
| 2021/22 | 15.6 | (41.1) | (25.5) | 31.5 |
| 2020/21 | 11.9 | (43.4) | (31.5) | 37.5 |

61. The underlying trading position is a substantial deficit. LT is dependent upon substantial TfL support.

62. At Step 3 the Court must take into account the financial circumstances of TfL. That should reasonably include LT, which is a discrete part of TfL to which the offence relates.

63. The fine should meet in a fair and proportionate way the objectives of punishment, deterrence and the removal of gain. Here, there is no financial gain and the dreadful event and its consequences act as a deterrent for a public organisation such as TfL. The relevant objective is punishment.
64. Mr Doig's evidence is provided to enable the Court to examine the financial circumstances of TfL in the round. The economic reality is that TfL and LT are loss making. Their financial position is poor. But for very substantial taxpayer support in the order of £6 billion since 2020, TfL would have collapsed. There is some prospect of improvement over the coming year, but the budgeted surplus (which is uncertain and dependent of continuing government funding) is just 0.87% of income.
65. Step 3 requires the Court to have regard to the profitability of an organisation. Where there is a small profit margin relative to turnover "downward adjustment may be needed". It is plain that TfL's income is not a reliable indicator of its overall financial wellbeing. The Court is invited to make a substantial reduction at Step 3.

Step 4:

Other factors that warrant adjustment of the fine

66. Step 4 requires the Court to consider other factors that may warrant adjustment of the proposed fine and in particular:
- "Where the fine will fall on public ... bodies, the fine should normally be substantially reduced if the offending organisation is able to demonstrate the proposed fine would have a significant impact on the provision of its services".
67. This is plainly the case here. As Mr Doig explains, TfL remains dependent on taxpayer support. A significant proportion of TfL's funds are ring fenced or committed. If achieved, the very modest forecast surplus in the coming year is committed. The inevitable effect of the fine will be to deprive TfL of funds otherwise available to be invested for the benefit of the travelling public. Including, in particular, investment to improve public safety.

Step 5:

68. Does not apply.

Step 6:

Guilty Plea

69. TfL pleaded guilty at the first opportunity before District Judge Dean on 10 June 2022. The Court is invited to give a discount of one third.

KEITH MORTON KC
NICHOLAS DOBBS
18 July 2023

Temple Garden Chambers
Temple, EC4