Consultation comments and responses

Document number: **RIS-8070-TOM issue 2, draft 1i**

Title: **Drugs and alcohol testing**

Consultation closing date: **11 October 2021**

1. Responders to consultation

No	Name	Company
1	KM	Matrix Diagnostics Ltd (MD)
2	SB	ORR
3	CH	Scotrail (Sct)
4	JW	West Midland Trains (WMT)
5	SD	Independent (Ind)
6	ST	Great Western Railway (GWR)
7	Dr SP	Transport for London (TfL)
8	IC	LNER
9	SH	Avanti West Coast (AWC)
10	CO, KM	North West and Central Region, Network Rail (NR)
11	JS	Merseyrail (Mer)
12	KA (comments are from a professional perspective)	Greater Anglia (GA)
13	Occupational Health Advisory Group	OHAG
14	Express Medicals	ExM
15	Dr JC	GTR
16	SG	Transport for Wales (TfW)

2. Summary of comments

Comment Code (CC)	Description	Total
-	Consulted	203
CE	Critical errors	1
ED	Editorial errors	1
TY	Typographical errors	0
OB	Observations	68
-	Total comments returned	70

Classification codes for a way forward:

- DC – Document change
- NC – No change

3. Collated consultation comments and responses

No	Page	Clause	Comment	Suggestion	By	CC	Way forward	Clause	Response
1	All		Drugs and Alcohol testing should not be limited to Safety Critical colleagues. It should also include non-safety critical staff working in a hazardous environment e.g. railway yards, sidings, on train cleaning and also those that undertake work and duties to ensure a safe working environment for themselves and their colleagues		GWR	OB	NC	NA	The Railways and Other Guided Transport Systems (Safety) Regulations 2006 (as amended) include all sidings as part of the transport system and controllers of safety-critical work for vehicles that are being used on the transport system. Transport operators can decide to extend their drugs and alcohol policy to other employees such as those that carry out on-train cleaning. However, the scope of RIS-8070-TOM is limited to staff who performs safety-critical tasks. That's because the purpose of the standard is to help transport operators meet their legal obligations under the Transport and Works Act 1992 and the Operations and Traffic Management National Technical Specification Notice (OPE NTSN). Both pieces of legislation require transport operators to exercise all due diligence, so staff who perform safety-critical tasks are not unfit to carry out work if under the influence of drugs or alcohol. Where a company's drug and alcohol policy includes testing for non-safety critical workers, management of the testing programme should be kept separate from safety-critical workers (SCWs). That means having one pool of employees for the non-SCWs random testing programme and another pool for SCWs. Thus, ensuring the quota of SCWs tested across the year is met.
2	All		Testing should include the effects organic drugs readily available in nature e.g. magic mushrooms etc would have on individuals including non-illegal drugs		GWR	OB	NC	NA	This is already covered by clauses G 3.2.1 c) as transport operators determine which drugs to test for based on the ability of a drug to impair work performance. It is also covered in G 3.2.2 which defines the term 'drugs', which includes 'illicit' drugs and other substances including medicines. Cause G 3.2.3 gives advice on which drugs to include by asking accredited laboratories. Additionally, Appendix A gives guidance on situations where someone has eaten poppy see products or consumed cannabidiol oil more medicinal purposes.
3	N/A	Briefing note	Briefing note RIS-8070-TOM issue 2, draft 1i.pdf (192 KB) This is noted as for 'Occupational Health Managers' but should also be specifically for HR personnel.	Drug and Alcohol testing is part of terms and conditions rather than OH direction, recognising that the outputs / undertaking of testing policy and procedure may result in OH interventions.	GA	OB	DC	NA	Noted. The briefing note now includes HR personnel.

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4	7	G2.1.3	This guidance does not refer to employee responsibility	Include a comment that companies shall suitably inform safety critical colleagues to be able to tell prescribing or dispensing practitioners that they are safety critical workers in order to consider alternatives where appropriate.	GA	OB	DC	G 2.1.3 g)	Employee responsibility is covered under clause 4.2.1 a) and G 4.2.3 c) as part of the support to staff. To make this clearer, we have also redrafted G 2.1.3 g) to mention employee responsibilities.
5	7	G2.1.3 (l)	Good practice suggestions: Remotely managed employees		TfL	OB	DC	G 2.1.3 l)	For clarity, we have changed the working to say "staff working remotely".
6	7	G2.1.3 (n)	Employees who refuse a test – see my comments 3.3.2 (Failure to take the test is treated as a positive- Do we say this in our policies – in practice employees find reasons not to take the test rather than outright refusal – could this be extended to specifically include situations where it is reasonable to conclude that employees are avoiding being tested?)		TfL	OB	DC	G 2.1.3 n) G 3.3.8 G 3.8.8	Additional wording added to G 2.1.3 n) as suggested. To help with candidates that might not be available for at test we've created a new clause (G 3.3.8) and complemented G 3.8.8 with additional guidance. This is all supported by clause 4.3.3, which states that "Transport operators shall prevent staff from avoiding tests without a valid reason."
7	7	G2.1.3 (n)	Guidance on staff who refuse to be tested.	Also add guidance for staff who are willing but unable to due to religious fasting.	NR	OB	NC	NA	See response to comment number 6. There are no circumstances where fasting should interfere with the ability to undertake a test at random. However, dates selected for random testing could have an impact on whether the sampling is random as it could be reasonable to assume that particular groups may be more likely to be on leave at some time more than others. It is best to have tests performed when the available pool of employees to select for testing is less likely to be affected by such events. See clause G3.8.8.
8	9	2.4.1	Adjust panel of testing if required on a yearly basis.	Monitor drug use and test panels regularly to reflect local issues and good practice.	OHAG	OB	DC	G 2.3.5	Additional wording added.
9	10	3.1	this section is confusing in its definitions, a pre-appointment test refers to both pre-employment and periodic medical assessments and then there is a further "periodic test" that relates to pre-appointment and "random".	Simplify the section to make it clear which test is being carried out and for which purpose.	LNER	CE	DC	G 3.1.1	Agreed. Clause G 3.1.1 now refers to 'Medical examinations' which is the term used in the OPE NTSN. We've also removed the definition for 'Periodic' tests as it was adding confusion.
10	10	G 3.1.1	This section implies that drugs and alcohol testing is required at every periodic medical examination.	Align with the OPE NTSN.	TfW	OB	DC	G 3.1.1	Based on other comments section 3.1 has been simplified as it was confusing. G 3.1.1 now aligns with the OPE NTSN and it is now clearer that periodic medical assessment only include drugs and alcohol testing if indicated by a medical advisor.

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11	10	G 3.1.1	Guidance states: 'Pre-appointment' tests are required by the OPE NTSN as part of the medical assessment of staff appointed to posts involving safety-critical tasks. Such tests occur: a) Before staff first undertake safety-critical tasks; and b) As part of a periodic age-related medical assessment. 1. A periodic age related medical assessment is not a pre-appointment test. This is confusing. 2. Also OPE NTSN says the periodic medical examination must include screening for abuse of drugs where clinically indicated.	1. Don't refer to periodic age related medical testing as pre appointment testing. 2. I would suggest that RSSB either state that this testing is done at each periodic medical or provides guidance on what the clinical indications would be.	TfL	OB	DC	G 3.1.1	Based on other comments section 3.1 has been simplified as it was confusing. See responses to comment numbers 9 and 10.
12	10	G3.1.1	It states Transport operators are required to ensure staff performing safety-critical tasks are tested for drug or alcohol use prior to recruitment and during periodic medical examinations. We do not test for drug and alcohol during periodic medical examinations.	is this new or an existing requirement for testing at periodic medical examinations?	AWC	OB	DC	G 3.1.1	Based on other comments section 3.1 has been simplified as it was confusing. See responses to comment numbers 9 and 10.
13	10	3.1.2	What is a reasonable time between a random test selection and the maximum time notice given – is it hours, days or up to 1 month?	-	OHAG	OB	DC	G 3.8.5	Clause 3.8.1 mentions that transport operators shall have safeguards in place, so the testing activity does not compromise operational safety. Therefore, a maximum notice period depends on local operations, which the transport operator must determine. However, to explain why the notice period should be as short as possible, we've complemented clause G 3.8.5 with additional guidance.
14	10	G 3.1.2	This clause references random tests being carried out without prior notice or where not possible it is minimised.	Would it be better to give a "maximum time" as good practice to prevent any misunderstanding of the reasoning behind this action.	LNER	OB	DC	G 3.8.5	See response to comment number 13.
15	10	G 3.1.2	Minimising the period of notice where 'pure' random testing cannot be done.	Does this give an acceptance that those affected by current terms and conditions allowing notice (i.e. 48 hours) will continue or does industry seek to consult for change on this at any time?	GA	OB	DC	G 3.5.8	48 hours does not allow for a random test, that's because individuals get the opportunity to take steps to reduce the change of a positive result. For example, someone who had alcohol in their blood at the time of selection for testing could abstain from alcohol. It puts people at an advantage compared with someone who reports for testing immediately. This is now explained in G 3.5.8, which is guidance on the 'Testing procedure'. Also see response to comment number 13.
16	10	G 3.1.3	The definition of Periodic Testing here includes unannounced and pre appointment - this seems unnecessary and conflicts with 'Periodic Testing' described in 3.1.1. which refers to the testing taking place at routine medicals.	Periodic Testing definition should be restricted to referring to 'testing conducted as part of a periodic age-related medical assessment'.	Ind	OB	DC	NA	Based on other comments section 3.1 has been simplified as it was confusing, as a result, 'Periodic testing' has been removed. Please, see response to comment 9.
17	10	G3.1.3	'Periodic' tests include pre-appointment tests, and unannounced random testing. Again this is confusing as I don't think most people would refer to pre appointment or random testing as periodic.	Pre appointment = pre appointment Random = random Periodic = periodic	TfL	OB	DC	G 3.1.1	Based on other comments section 3.1 has been simplified as it was confusing. See response to comment 9.

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18		G 3.1.4	Regarding Guidance on 'for cause' tests G 3.1.4 'For cause' testing is a requirement of the OPE NTSN. It occurs when there are reasonable grounds to suspect that a person: a) May have contributed to an accident or incident; b) Is under the influence of drugs and alcohol; or c) Is putting the safety of the operational railway at risk.	It may be advisable to insert the word "believe" into b and c as the wording as it stands suggests you would require proof that the person is under the influence or putting the safety of the railway at risk b) Is believed to be under the influence of drugs and alcohol; or c) Is believed to be putting the safety of the operational railway at risk.	ORR	OB	NC	NA	The wording of G 3.1.4 already says that 'for-cause' occurs when there 'are reasonable grounds to suspect'. Therefore, there is no need to include 'believe' into b) and c). G 3.1.4 also explains that it is good practice to document how the decision to test was reached, which means that the responsible person documents their evidence. This is also included in in the 'for cause' flowchart in Appendix B.
19	10	G. 3.1.4	'for cause' screening is becoming so prevalent on the railway and the emphasis should be on regular supervision and monitoring of staff reporting for duty as a deterrent.	Whilst screening must be carried out following an incident, we must not lose sight of promoting preventative measures.	ORR	OB	NC	NA	We agree with that, preventative measures are included in G 2.2.5. This is also why the industry does random testing, and this preventative measure is explained it its rationale (clause G 3.8.2).
20	10	G3.1.4	'For cause' testing is a requirement of the OPE NTSN. It occurs when there are reasonable grounds to suspect that a person: a) May have contributed to an accident or incident; b) Is under the influence of drugs and alcohol; or c) Is putting the safety of the operational railway at risk.	Can you clarify therefore whether for cause covers post incident and that this term should no longer be used?	TfL	OB	NC	G 3.1.3	'For cause' covers 'post-incident'. Although the term 'for cause' is not used in the OPE NTSN, it is a common industry term, it was used already in RIS-8070-TOM issue 1. This term is a common term used by occupational health professionals and is described and defined in the UK's two most authoritative occupational health academic publications 'Fitness for Work: the Medical Aspects, 6th edition' and the 'Oxford handbook of Occupational Health, 2nd Edition'. 'Post-incident' is included as G 3.1.3 as it says "When there are reasonable grounds to suspect that a person may have contributed to an accident or incident".
21	10	G3.1.4	How can someone anticipate whether an incident will be subject to public inquiry.	The document appears to have inconsistencies around this definition, and it isn't clear in the standard when a 'public inquiry' threshold would be met.	OHAG	OB	DC	G 2.1.5	We have changed the wording as 'public inquiry' was not the right one for an investigation. The applicable regulations are The Railways (Accident Investigation and Reporting) Regulations 2005. Schedule 1 provides details on accidents and accidents which transport operators have a duty to report. This change of wording now reflected throughout the document – which now refers to 'an investigation from RAIB' – and a new clause (G 2.1.5) mentions this legislation.

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22	10	3.2	I think that it is important for each operator to determine the test battery (as there may be local variations in usage of specific drugs).	Consideration to be given to adding a minimum (basic) test battery to the guidance?	LNER	OB	NC	NA	RSSB and the Occupational Health Advisory Group do not recommend presenting a minimum panel of drugs as there are changing patterns in the types of drugs and how they are use in the UK. Therefore, the standard recommends transport operators to determine which drugs to test for and to monitor and analyse the result of tests to improve the testing protocol. The standard points to reputable information sources to help inform companies of drugs of greatest prevalence or risk. See G 3.2.3, G 3.2.4, G 3.2.5. The standard also points to research on common drug sampling (see clause G 3.7.3). Although the research was carried out in 2004, still offers valid information.
23	10	3.2	The business case states: RIS-8070-TOM issue two provides clarity on which drugs to test for. I don't think it does really. And also states: The standard excludes from its scope providing a minimum panel of drugs to test for. The reason is that patterns of drug use change all the time, as soon as the document is issued it will begin to fail to reflect changing patterns of drug use in the UK. However it includes guidance to transport operators on how to determine the drugs to test for. I can understand why RSSB doesn't want to give a list of drugs which may become outdated but I think it could set out a minimum panel and update this every 2-3 years. It seems illogical that different companies are testing for different drugs with no set guidance and although guidance is given on how to determine the drugs to test for there are no links or references eg to the ONS etc.	Set out a minimum panel which all companies should adhere to.	TfL	OB	NC	See above	The standards give a methodology of selecting a panel of drugs, see response to comment number 22.
24	11	3.3.2	Failure to take the test is treated as a positive	Do we say this in our policies – in practice employees find reasons not to take the test rather than outright refusal – could this be extended to specifically include situations where it is reasonable to conclude that employees are avoiding being tested?	TfL	OB	DC	G 2.1.3 n) G 3.3.8 G 3.8.8	See response to comment number 6.
25	11	3.3.3	Could be more clarity about what constitutes therapeutic levels of prescribed medication versus levels suggestive of abuse.		OHAG	OB	DC	G 3.3.10	The OHAG has agreed that this is covered by clause 3.3.1 as it is the role of the Medical Review Officer (MRO) to confirm a positive result. Therefore, the MRO will determine what constitutes therapeutic levels of prescribed medication. To provide clarity clause 3.3.3 (from the standard draft version 1i) has been moved to guidance (now clause G 3.3.10) and refers to the MRO and the responsibility to determine whether there is a legitimate explanation of the substance that may have been detected.

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26	11	3.3.3	In my view it would be useful to have a statement on medically prescribed cannabis, which could lead to a positive test. If this is declared before the test, and the individual has a legitimate prescription and reason/explanation, according to this section transport operators shall not regard this as a 'positive result'. However, if the test result is above the cut off, it could still impair performance and safe execution of duty. (for example with prescription of medical cannabis		GTR	OB	DC	As above.	Please see response to comment 25.
27	11	3.3.3a	The medicine should be reported to the occupational health to be checked to see if they are ok to work when first prescribed.	Add a c) The medicine was authorised by the medical authority to be taken whilst carrying out safety critical duties. All must apply.	WMT	OB	DC	2.1.3 g) G 3.3.10 c)	We have strengthened the wording in 2.1.3 g) so it is clear that it is the staff responsibility to report the use of medicines before commencing safety critical tasks and the importance of declaring medicines before a test. In addition, to support this, we have added a new bullet point to the guidance in clause G 3.3.10. However, it is not the role of an employer's Occupational Health (OH) department to authorise medication. This is the responsibility of the prescribing doctor. OH would advise about fitness for work for those who may be impaired by the prescribed medication.
28	11	3.3.3b	b) There is a legitimate explanation for the use and quantity of the drug that has been detected	Should this say 'medicine' rather than 'drug'? Should there be a 3rd point that notes that medicines declared should be within the parameters of legally prescribed prescription or approved over the counter medicines (and declaration of foods and dietary supplements)	GA	ED	DC	3.3.10 b)	Thanks, we've changed the word to "medicine". This clause is now guidance (G 3.3.10 b)). It is up to the MRO to satisfy themselves that levels of medicine detected are consistent with the prescription, this is part of requirement 3.3.1. See also response to comment 25.
29	11	3.3.9	MRO – advice on what training is required refer to ARIOPS.	RSSB should lay out the training requirements for the MRO not refer to ARIOPS which is a collection of railway OH professionals but not in itself qualified to give guidance on this area.	TfL	OB	DC	NA	This piece of guidance has been removed because it is not within the scope of the standard to determine the competence requirements of an MRO and it does not relate to the requirements of 3.3.
30	12	G 3.3.11	How can the industry manage applicants who may have failed a pre-placement or in-service drugs or alcohol test in a company but apply for a job in another? The information about prior failure is not portable and therefore this could introduce a risk.		OHAG	OB	DC	G 4.4.3	Currently, there is no mechanism to record failed tests for pre-placement testing that could be shared across the industry for cross-reference by different employers. GDPR offers protections to individuals and their data, and it's a barrier for sharing this information. When a train driver fails a drugs or alcohol test, operators inform the ORR, so their driver licence is withdrawn. Employers should be diligent in their employment checks by checking their full employment history and references. Clause G 3.3.11 has removed, see response to comment 31.

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31	12	G 3.3.11	This clause states a person who returns a "positive result" can be considered for employment later if they can satisfy it was not an indication of habitual or continuing abuse	In practice this is difficult for an operator to define, should a type of test or further guidance be provided to allow consideration on how to ensure this is the case	LNER	OB	DC	NA	Thank for your comment, we received several comments with a similar point of view. Therefore, we do not think there is any justification to have that clause in the standard and it's been removed.
32	12	G 3.3.11	This is a significant 'relaxation' of existing standards which I think is unnecessary and will import additional risk to the railway. New starters should be aware at the interview stage that drug testing will be required so by the time they have their 1st screen they should have had abstained and pass the test. Those that fail a pre-employment drug screen are very unlikely to be the result of a 'one off' and more likely indicate drug use exists in their social circle.	Stay with the existing standard requirement that individuals who test positive for drugs at pre-employment are excluded from industry for 5 years.	Ind	OB	NC	NA	See the response to comment 31.
33	12	G3.3.11	This clause does not support zero tolerance. This reads that the individual would be able to self-certify reason for positive return and potentially incur employee relation issues post-employment.	This would be a risky strategy for an employer to inherit as assurances would require additional testing and monitoring post appointment which could have operational impact and delay training and productivity.	GA	OB	DC	NA	See the response to comment31.
34	12	G 3.3.11	this statement is concerning to me. I would be very wary of allowing someone to retake the test after a positive result , unless they can demonstrate an intervention such as treatment by a suitably qualified D&A adviser.		GTR	OB	DC	NA	See the response to comment 31.
35	12 and 13	G.3.3.11 and G3.5.3	A person who returns a 'positive result' at pre-appointment testing may be permitted to retake the test later if they can satisfy the result was not an indication of habitual and continuing abuse of drugs or alcohol. Habitual and continuing abuse of drugs can only be detected using hair samples. I find this advice rather odd. A positive test is a fail. It may not have indicated habitual abuse but it indicates that the person is at least an occasional user and therefore poses a safety threat. Individuals who declare medicines after a 'positive test' may find it very difficult to prove that its use was legitimate, which would be necessary to avoid a 'positive result' reported to the employer. So an occasional cocaine user is ok to employ but an employee who forgot to declare their occasional legitimate codeine use is not?	I don't think that RSSB should tell companies how to manage their employment practices.	TfL	OB	DC	NA	See the response to comment 31.

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36	12	3.5.1	Testing procedure	As above – consideration given to those who may be unable to provide a sample due to religious fasting (most policies state that the person to be tested should be given water at intervals for a set period of time, but this would cause someone to break their fast)	NR	OB	As comment 7	As comment 7	See response to comment 7.
37	13	G 3.5.6	States donor signature should be used for identification purposes in addition to photo identification however I am not convinced this adds any value as signatures are easy to forge and a legitimate photo ID should suffice.	Use photo ID as the means of identification and do not include signature.	Ind	OB	DC	G 3.5.6	Noted, the signature is not necessary to confirm their identity. So, we have removed that from the clause. However, we took the opportunity to improve de clarity of the clause by re-structuring the information and adding a bullet point to mention that is good practice to obtain a signature to confirm the sample has not been tampered with.
38	13	G 3.5.8	This clause good practice for time scales for call outs, it states 2 hours then 4 hours for remote locations	Has consideration been given to how operators define remote locations, is it geographically remote areas or in relation to employees availability (management on call arrangements)	LNER	OB	DC	G 3.5.8	Note. This clause is now redrafted to add clarity and to explain why is important to complete the test promptly.
39	14	G3.7.2	G 3.7.2 states urine sample can be done in some cases. Our testing provider does not carry our alcohol testing through urine sample, we were advised that urine samples ferment and are not as accurate as breath samples so all testing providers have stopped doing them as no labs will process them anymore.	I would therefore like to challenge this content/ suggestion as I don't believe a) it is possible, and b) based on what I have been advised that it should be recommended as it is not accurate?	AWC	OB	OB	NC	It is true that there are some conditions that may account for fermentation, including diabetes and urinary tract infections. However, laboratories have confirmed that urine samples do take place. Still, breath testing is the preferred method of alcohol testing, but urine alcohol testing is a suitable and appropriate alternative. This is reflected in clause G 3.7.2 which mentions that urine alcohol testing is an alternative to those that find a breath-base test problematic, such as severe asthmatics.

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40	14	3.7.3 and 3.7.4	RSSB research report T133 (2004) provides information on common drug sampling and the suitability of different testing methods. It can assist transport operators in choosing suitable and cost-effective methods to fit their organisation's needs. RSSB research report T865 (2009) provides views on drugs to test for and the availability of tests for each drug. Isn't there any more up to date research which operators can be referred to. Things will have moved on since 2004/2009	Link to more up to date research.	TfL	OB	DC	NA	We agree that research report T133 is likely to be out of date due to improvements in laboratory processes and technology. However, it is beyond the scope of the review of this standard to update this research report. As a result, we have removed the clause that referred to RSSB report T133. RSSB's 2009 research report T865 still largely reflects the current situation for railway medicine and occupational health regarding possible drugs to test for, and available tests to detect their presence. However, accredited laboratories can advise transport operators on recommended and available tests for their workforce risk profile that meet the requirements of their testing programme. This is mentioned in G 3.7.1. Since the publication of T865, there has been an update to one of the key evidence sources used in the report, namely the UIMC (the International Union of Railway Medical Services). Their publication *UIMC Railway medical guidelines: Guidelines for medical fitness of railway personnel in safety critical functions* was published in the October 2019 version. Chapter 10 contains guidance on drugs and alcohol testing that still aligns with the guidance provided in RSSB research report T865. Therefore, that report is still a useful and valuable reference for RIS-8070-TOM issue two.
41	14	G3.7.3	Given the everchanging types of drugs being used as stated within the business case, 2.4 why reference reports that will be, by the time of publication, 13 and 18 years old	Withdraw these references.	Sct	OB	DC	NA	See response to comment number 40.
42	14	G3.7.3 and G3.7.4	Both these clause quote research papers from 2004 and 2009 respectively, with the changing nature of drugs abuse and availability are these research projects up to date and suitable for 2021?		LNER	OB	DC	NA	See response to comment number 40.

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43	14	3.8	Statistically valid? The guidance in G3.8.6 indicates there is an expectation that this means we should increase from 5% to 25-50%, yet there is no guidance on how to generate a "statistically valid" percentage.	Add guidance of how to generate a "statistically valid" percentage.	WMT	OB	DC	3.8.1 a) G 3.8.2 G 3.8.3 G 3.8.6 G 2.3.4 f) G 2.4.2	The clause proposed in RIS-8070-TOM issue 2, draft 1i required a statistically valid sample of safety-critical workers because under The Transport and Works Act 1992 operators are guilty of an offence unless they exercise all due diligence to prevent a person who performs safety-critical work from working unfit due to drinks or drugs. A statistically valid sample of safety-critical workers could provide evidence of due diligence in deterring from drugs and alcohol use (this rationale is reflected in G 3.8.2). For some transport operators, selecting only 5% of the population of safety-critical workers means that some employees have a minimal chance of being tested, and every employee should have a reasonable chance of being picked for testing. However, through this consultation, the industry has voiced challenges of increasing the percentage of tests. Therefore, we've changed clause 3.8.1 a), so the requirement is to test "a sample of safety-critical workers". The guidance (clause G 3.8.6) now mentions current industry practice, which is testing a minimum of 5%. In addition, we've redrafted guidance that helps generate a sample size that is large enough: G 2.3.4 f) as the proportion of random tests that return a positive result is data that can inform the review of the drugs and alcohol policy. G 2.4.2 which is the supporting rationale for monitoring the results of drugs and alcohol tests, as monitoring the results also helps deciding on the size of the sample to be tested. A few comments request adding guidance to generate the size of the sample. This will be put forward as a request for help to complement this standard, as an agreed approach would require further engagement with transport operators.
44	14	3.8	The guidance on percentage of testing is vague.	I would prefer to see an evidence-based recommendation (or minimum) quoted if we want to see a consistent approach across the industry.	LNER	OB	DC	As comment 43.	See response to comment number 43.
45	14	3.8.1	Separate terms and conditions apply with grade groups in some TOCS	Increasing the number of tests may have an impact on operational delivery due to those colleagues who are subject to notice for random testing, that must subsequently be carried out in an OH clinic setting rather than on operator site.	GA	OB	DC	As comment 43.	See response to comment number 43.

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46	14	G3.8.6	This section says that a statistically valid sample of staff that is large enough to draw conclusions for the testing / alcohol and drugs policy. No guidance is provided on what to consider when deciding the amount of tests to conduct. It then goes on, rather unhelpfully, to suggest that this should be between 25%-50% of staff. Currently the majority of TOCs test 5% of staff, going to even the 25% will cause extensive costs, create issues with suppliers and impact on train performance with more staff released for testing.	Guidance should be provided on how to determine the 'statistically valid' number and refence to the USA and 25%-50% should be removed. For WMT, going from 5% (c90) to between 450 and 900 is not deliverable. Also, suggesting between two such large percentages such as 25%-50% is not helpful in its self.	WMT	OB	DC	As comment 43.	See response to comment number 43.
47	14 & 15	G 3.8.6 - Random testing expectations	Section G 3.8.6 of the draft RIS note a proposed change in random testing from a fixed 5% of staff per year to "a statistically valid sample". No figures are mandated but examples of random testing rates between 25% and 50% in US transport sectors are mentioned. Such a change would mean a five to ten-fold increase in testing efforts and presumably similar increase in costs. Recent and ongoing changes in drug usage in GB society may warrant such an increase, but We can anticipate kickback e.g. from employers on costs of increased testing, and on the other hand maybe from unions on members' liberties etc. Is there decent evidence pointing towards testing rates more akin to the US rates mentioned rather than the current rate? is there any more guidance about how to decide what would constitute a "statistically valid" sample size? Easy to say, but what does it mean – we are likely to get drawn into arguments about whether particular testing rates are over-zealous or over-tolerant?		ORR	OB	DC	As comment 43.	See response to comment number 43.
48	15	3.8.6	Increasing number of random tests would improve statistical analysis but note comments above regarding differing terms within grade groups. This would be likely to require employee consultation process.	The volume of tests conducted would need to be considered locally per company (supporting a minimum level as currently is) to avoid distraction time / operational costs to accommodate those who are not subject to 'pure' random testing.	GA	OB	DC	As comment 43.	See response to comment number 43

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49	15	3.9.1	We are currently accredited to ISO 17025:2017 but not ISO 15189:2012. We do not believe that it is necessary to be accredited to both and effectively creates duplication. Within the laboratory industry ISO 17025 is considered to be the gold standard for laboratories; ISO/IEC 17025 General requirements for the competence of testing and calibration laboratories is the main ISO standard used by testing and calibration laboratories. In most countries, ISO/IEC 17025 is the standard for which most labs must hold accreditation in order to be deemed technically competent. | ISO 15189:2012 specifies requirements for quality and competence in medical laboratories. Common for pathology labs using blood/plasma/serum. The United Kingdom Accreditation Service (UKAS) has released a new publication, LAB 51 UKAS Accreditation of Laboratories Performing Analysis of Toxicology Samples and has been in place since June this year. The review had highlighted that the consistency of approach between laboratories in respect to areas such as selection, verification and validation of methods, ensuring on-going validity of results and control of data would benefit from further clarification by UKAS in regard to the expectations for compliance to ISO/IEC 17025 and ISO 15189 within this sector. All laboratories testing to 17025, or 15189, standards were required to be compliant with LAB51 by 1st September 2021. We were the first laboratory to be audited against, and undertake, the further stipulations of Lab51 and have done so successfully. We have spoken to our contacts within UKAS who have said, 'I can see little benefit in requiring laboratories to be accredited to both standards as accreditation in either indicates a competent laboratory' This seems to be the opinion of many within the industry. The requirement to hold ISO15189 applies to medical testing. ISO17025 is the appropriate standard held by all of the RISQS approved testing labs and is the standard stipulated in the EWDTS guidelines. If the proposal was to go ahead the current laboratories would need more than the stated date of March 2022 to be compliant. This seems an unnecessary waste of time, money and resources when our 17025 accreditation more than meets the requirements for quality and competency.	Remain as just ISO 17025 or should be ISO 17025 or ISO 15189	MD	OB	DC	3.1.9	We accept the suggestion to be accredited to one of either 17025 or 15189.

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50	15	3.9	ISO 1589 applies to any medical laboratory testing. All pathology laboratories in the UK would be accredited to ISO 15189, for instance. There is little benefit in requiring laboratories to be accredited to both standards as accreditation in either indicates a competent laboratory.		ExM	OB	DC	3.1.9	See response to comment 49 49.
51	15	3.9.1	States approved labs must hold ISO15189. This is not the correct standard to cite. Many of the laboratories providing the capacity for work place drug testing in the rail industry are not currently certified to this standard. ISO 17025 is the correct standard for work place testing laboratories to hold – ISO 15189 is for medical testing laboratories which is altogether different.	Do not cite ISO 15189 as the standard for work place testing labs – ISO17025 is the correct standard.	Ind	OB	DC	3.1.9	See response to comment 4949.
52	15	G 3.8.8	Separate terms and conditions apply with grade groups in some TOCS	Note comments above about differing terms and conditions which would affect selection.	GA	OB	NC	NA	Clause number 2.2.1 on how to inform employees of the policy. Also see response to comment number 43.
53	15	G3.8.6	The clause makes reference to a "statistically valid sample", it then refers to what is happening in the United States, 25% to 50% is quite a large range and do we have any data or reports from the drug issues in the US identifying it to be comparable to the drug issues in the UK thus requiring the same approach?		LNER	OB	DC	As comment 43.	See response to comment number 43.
54	15	G3.8.6	A statistically valid sample means a random sample of staff that is large enough to be able to confidently draw conclusions about the effectiveness of the drug and alcohol policy. For example, the mandated random testing rate for drugs is between 25% and 50% in transport sectors in the United States. Are there other transport bodies we can benchmark against. What would be a statistically valid sample? To go from 5-25% will have a big cost implication.	Some more clarity on suggested numbers would be helpful. Benchmark to wider range than just US.	TfL	OB	DC	As comment 43.	See response to comment number 43.
55	15	G3.8.6	Does quoting the 25-50% testing done in the US as statistically valid not mean that TOCs and FOCs would have trouble arguing that current levels of testing in the UK of 5-10% are statistically valid?	Remove this reference to US rates	Sct	OB	NC	G 3.8.6	See response to comment number 43**Error! Reference source not found.**. The OHAG has agreed that showing what other transport sectors do is a useful piece of information to have as guidance.
56	15	G3.8.6	It doesn't state what percentage we should be conducting.	I think there should be a recommended range here for guidance, i.e 10-20% of safety critical workforce.	AWC	OB	DC	As comment 43.	See response to comment number 43.
57	15	G3.8.6	Although it doesn't propose a new valid sample size, the inference that the USA comparator of 25-50% looks to be the example to be used which for our TOC will be disruptive from a resource point of view considering the current standard is 5% sample size.	Remain at the current sample size of 5%	Mer	OB	DC	As comment 43.	See response to comment number 43.

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58	16	4.1.1	Access to advice from a competent medical authority on the likely effects of medicine on a person's capability to undertake safety-critical tasks.	It would be helpful to have a consistent evidence based approach to this across the industry. Is this something RSSB could research and advise on?	TfL	OB	NC	NA	We will raise this comment at OHAG and TOM SC to determine if there is industry appetite.
59	16	4.2	Re support for staff – there should be a suggestion that D and A policies include what support the organisation will offer to people who come forward with a D and A problem.	Process for supporting people who declare D and A problem. Bearing in mind lack of accessibility of rehab on NHS and cost of private rehab a cross industry united approach to this with joint procurement of services could be helpful.	TfL	OB	NC	NA	This is an issue that the industry could look at separately. We will raise that with the OHAG and the wider Rail Wellbeing Alliance (RWA) which is OHAG's parent group.
60	17	4.3	I am concerned by 4.3.2 that someone who has failed a 'for cause' test could be allowed to resume after a negative test, or if it is suspected that they use the drug recreationally so that its use did not contribute to the accident or incident. In my view such use can quicky escalate and it could be foreseen that an individual may soon not be in control of their potential addiction and then use drugs in such a way as to be under the influence at work. In my view this is not due diligence.		GTR	OB	DC	4.3.1 4.3.2	We have switched the clauses around to add clarity as we see that may have cause confusion. That makes clear that transport operators should not allow a person to resume safety-critical tasks if a positive test is confirmed.
61	17	4.4	This subsection covers Employment after a positive result during testing, this is challenging to do for an operator, for train drivers the ORR register for TDLCR should alert the potential employer of a previous dismissal for D&A related issues but for Train Guard, Dispatchers and T&RS roles there is not the same mechanism	Consider adding in guidance on using the TDLCR database and transfer of safety related information to check for Drivers previous D&A issues and also consider adding in good practice to ask for this type of information to be disclosed at pre employment screening as a mechanism to capture Guard / Dispatcher / T&RS staff	LNER	OB	NC	NA	There are some GDPR implications that may impact sharing this type of information. However, this is a question that we can raise with the OHAG and the wider Rail Wellbeing Alliance (RWA) which is OHAG's parent group. There was also a suggestion to reference RIS-3751-TOM on train driver selection. After asking the Rail Assessment Centre Forum for their opinion we concluded that it wouldn't be wise to reference RIS-3751-TOM as medical information – including the results of drugs and alcohol tests for drivers – is not transferred from one operator to another. There can also be legal implications if an employment decision was based on someone failing a test with a previous operator.
62	17	4.4	RSSB guidance states 3 years before re employment, our current policy states 5 years. I think 5 years is more appropriate as anyone with a drug or alcohol issue, 3 years is a short time for them to re habilitate and have time to be recovered to be reliable in the safety critical position again.		AWC	OB	DC	4.4.1 a)	Noted, this is now 5 years.

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63	17	4.4.1	a) A minimum period of three years have elapsed since they returned a positive result; b) The individual is subjected to a drugs and alcohol test, with negative results, before resuming safety-critical tasks; and c) For a period, they are subjected to an individually tailored regime of unannounced testing.	Can you clarify what the rationale for this guidance is and what the legal basis for this is. Is it not for each operator to determine whether they will re employ someone who previously tested positive? Why 3 years? If this is following DVLA group 2 guidance some drugs they give an abstinence period of 1 year. You need evidence that they have had appropriate treatment as well.	TfL	OB	DC	4.4.1 a)	See response to comment number 62.
64	17	4.4.1	The period following a positive test before an individual can be permitted to work in the industry appears to be reduced from 5 years to 3 years. I think this will import additional risk to the railway and seems to conflict with the move for increasing the percentage of testing whilst reducing the consequence.	Leave the period at 5 years.	Ind	OB	DC	4.4.1 a)	See response to comment number 62.
65	17	4.4.1	Is this stating that re-employment to safety critical role is dependent on all 3 of the items listed within this clause?	Clarify that all 3 elements apply to return to a safety critical role or whether these are interdependent factors.	GA	OB	DC	4.4.1 a)	All the three elements apply, this is an exhaustive list written as a condition as it says 'Transport operators shall not re-employ an individual to perform safety-critical tasks who has previously returned a 'positive result' for drugs or alcohol testing **unless**' and then it lists the three elements that need to be fulfilled to meet the condition. Also, see response to comment number 62.
66	17	4.4.1 a)	What is the rationale for this given London fire brigade is also 5 years, and 10 years for blue light driving.	I suggest a change to 5 years.	OHAG	OB	DC	4.4.1 a)	See response to comment number 62.
67	18	G4.4.1.a	Suspension period minimum 3 years	Is it worth mentioning here that a Sentinel suspension for D&A test failure is 5 years (just to clarify severity)	NR	OB	DC	4.4.1 a)	See response to comment number 62.
68		G 4.4.1 a)	a) A minimum period of five years have elapsed since they returned a positive result;- is there sufficient evidence from industry to support this change? There is potential for kick back on this and potential legal challenge – just suggesting this requirement for this change can be evidenced.		ORR	OB	DC	G 4.4.2	GEGN8570 issue two mentioned that a period of 3 years should have elapsed before reemployment in safety-critical work can be considered. The same period of time was used for RIS-8070-TOM issue 2, draft 1i. However, during the consultation, stakeholders collectively expressed the view that 5 years was current practice or the preferred period. Section 2.1.3 emphasises that company policies include information for employees on their responsibilities and on the provision and access to support for those with drug or alcohol problems. Those returning a positive result in the absence of prior disclosure of their drug or alcohol use, or problem are likely to be subject to disciplinary actions as defined in the policy and this period reflects the severity of the employee's actions and their responsibility to be drug and alcohol free in safety critical roles.

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69	19	N/A	This guidance is factual to the components of substances but sets out no updated industry position.	It would be useful to incorporate guidance here that states that the use of cannabidiol oil (CBD) therefore runs a risk of returning a positive result which will be a matter for company policy to address.	GA	OB	DC	A.2.4	We have added references to 3.3.3 and added your suggestion to A2.4 and A2.5.
70	19-26	Appendices	It's great to see specific guidance on cannabis products and poppy seeds.	Re: cannabis products it would be of benefit if the guidance was more straightforward and less wordy	LNER	OB	DC	NA	See response to comment number 69. Also removed A2.6 as it was wordy and superfluous.
71	22		The flowchart in the appendix does not take into account if you suspect alcohol or drugs were a contributory factor. Also the mention in the standard about a public inquiry are no longer valid since the introduction of RAIB.		ORR	OB	DC	Figure 1 Clause B.1.2 b)	The flowchart now includes suspicion an employee is under the influence of drugs or alcohol. In doing so, we made improvements to the flowchart, so it is self-explanatory and therefore does not need supporting clauses.
72	22	Figure 1/B1.7	Whilst this flow chart is a really good idea, I am concerned that the list in B.2 covers signs of when a person is very much under the influence and so those just over the limit or habitual alcoholics will not be detected – especially during a telephone call.	Remove the option for this to be done by telephone, it must be face to face either with the responsible person themselves or a reliable 3rd party who will sign a declaration to that effect (to prevent their mate saying they are ok). Add more subtle indicators to the guidance if such things exist.	WMT	OB	DC	Figure 1	We made improvements to the flowchart so it is self-explanatory.