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Serco Docklands Incident Investigation

Local Investigation Ref: **LI 07/37**

Incident Title: **Incorrect Door Procedure**

Incident Details:

Date: 30th October 2007	**Time: 09.40**	**IRF Ref No: 15398/18185**

Name of Investigator/s	**Position**
[redacted]	**Patrol Team Leader**

Reviewed by Safety Services:

Manager:	**Signature:**	**Date:**

Accepted by:

EXECUTIVE/DIRECTOR:	***Signature:***	**Date:**

"The investigation has been conducted with the objective of determining the facts of the accident/incident, the immediate and underlying causes, and of making recommendations to prevent, or reduce the risk of recurrence. The report is for the use of persons with a direct responsibility for improving, or maintaining, railway safety.

The objectives of this investigation were not the allocation of blame and liability and thus the information contained should not be construed as creating any presumption of these"

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1. Summary of Incident:

At approximately 09:40 on 30th October 2007 the Passenger Service Agent operating run 17 (vehicles 75/78) docked at West India Quay platform 4. After servicing the station PSA pressed the close other doors (COD) button, and before she could continue was advised by a colleague that she was to be relieved due to a redetermination taking place. The PSA then removed her keys and stepped off the train. The effect of this was that the doors closed and the train departed towards West Ferry platform 2 without a vehicle operator on board, the train docked at Westferry and the passengers alighted the train. There was a delay to the service of 10 minutes.

2. Details of Incident:

Immediate facts of the occurrence

2.1 The occurrence:

- The incident took place at approximately 09.40 on the 30h October 2007 between West India Quay and Westferry stations.

- The Passenger Service Agent operating run 17 (vehicles 75/78) (PSA1) docked at West India Quay platform 4. After servicing the station PSA1 pressed the close other doors (COD) button, and before she could continue was advised by a colleague that she was to be relieved due to a redetermination taking place. PSA1 then removed her keys and stepped off the train. The effect of this was that the doors closed and the train departed towards West Ferry platform 2 without a vehicle operator on board, the train docked at Westferry and the passengers alighted the train.

- The PSA1 contacted the Control Room to advise them that the train had left West India Quay 4 without a vehicle operator onboard.

- The CCC instructed PSA 1to make her way to Westferry station in order to take over a train.

- The CCC allowed the train to proceed into WES 2 where the PSA operating a train in the opposite platform (Platform 1) (PSA2) was instructed to board LRV's 75/78 and proceed to Bank station.

- The mobile supervisor was called to attend Westferry station instructed to take a set of keys and another PSA3. PSA3 was to take over the train on Platform 1.

- PSA1 was met at Westferry by PTL, and brought back to Poplar where she was breathalysed and stood down from her normal PSA duties.

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2.2 The background to the occurrence:

- Staff and contractors involved and other parties and witnesses are available in an appendix to this report
  - PSA1, PSA2 and PSA3 Passenger Service Agents
  - Control Room Controller
  - Lead Control Room Controller
  - Relieving PSA.
  - Patrol Team Leader.(PTL)

2.3 Fatalities, injuries and material damage:

- There were no fatalities or injuries to passengers, third parties, staff, or contractors.
- There was no damage to property, rolling stock, infrastructure or the environment.

2.4 Record of investigations and inquiries

Testimonies have been provided by those involved, the interpretations of which make up this report. The actual reports are attached as appendices. Audio downloads of the radio are included in this report.

3. Discussion:

PSA Actions

The act of pressing the Close Other Doors (COD) button and then removing keys from the Door Control Panel (DCP) resulted in the final set of doors (those that were isolated by the presence of the PSA and the key) closing and the vehicle moving off on its journey. This is normal and in keeping with the design of the system. No mechanical fault is suggested nor identified.

The PSA should have re-enabled her doors from the door control panel then inhibited the train before stepping off to hand over the radio and keys,as per the SOP/M-3.03 Automatic Operations. Which states

5. Actions

5.1 Procedure at Stations

When it is time to depart, the RTD lamp lights and a fading chime sounds. The PSA then:

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- Visually checks inside and outside the train to ensure that doors are clear of obstructions.

- When necessary, gives an audible warning over the local Public Address system to stand clear of the doors.

When sure it is safe presses the Close Other Doors(COD) pushbutton while continuing to visually check outside and inside of train for obstructions.

When the doors are closed the PSA checks no customers or obstructions are trapped in the doors, then presses the Close this Door (CTD) pushbutton on DCP.

In addition, SOP/M -4.13 Passenger Service Agent Changeover states

5. Actions

5.1 PSA on train

5.1.1 PSA to be ready for changeover with all personnel belongings on approach to station where changeover is to take place.

5.1.2 On arrival at the changeover station, PSA to make themselves known to relieving PSA.

5.1.3 PSA inhibits the train via the DCP.

5.1.4 PSA is to inform the relieving PSA of all the relevant operations information.

5.1.5 PSA is to give the radio, and train keys to relieving PSA.

5.1.6 PSA is to return discharged batteries to be left on board the vehicle.

PSA Training

PSA [redacted] has been employed by Serco Docklands as a Passenger Service Assistant since the 25th June 2007. The training period was successfully completed on the 31st August, this training included two weeks shadowing with established PSA's

4. Conclusions:

PSA1 failed to carry out SOP

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- If the PSA had re-enabled the doors and then inhibited the train from the Door Control Panel before stepping off, the train would not have departed without a train operator on board.

- The PSA was unaware that her train had been redetermined and so was not expecting a crew relief; she was not in the lead carriage.

- An All calls should have been made to alert all Psa's that they should be ready for crew relief's as there was a redetermination in progress.

5. Immediate Cause

- Staff Error
- Failure to comply with rules / procedures.

6. Underlying Causes

- PSA1 was unaware that the system had been redetermined and therefore unaware that she would be relieved at WIQ 4.

7. Recommendations:

- PSA [redacted] to be advised of the importance of carrying out the correct procedure when alighting a train in service.
- PSA [redacted] to be provided with two extra days shadowing to ensure she is fully conversant with the correct door procedure.
- Consider reviewing SOP/M-4.13.
- Control Centre to send out an All calls when trains are to be re-determined so that crew reliefs do not delay the system and staff are informed.

8. Action Plan

Arising from Recommendations

No.	Recommendation	Responsible (whom?)	Timescale (When?)
	PSA [redacted] to be provided with two extra days shadowing to ensure she is fully conversant with the correct door procedure.	PTL [redacted]	Completed 31.10.07 and 01.11.07
	Review SOP/M-4.13 (changeovers are to take place onboard the LRV and not on the platform.)	Customer Service Manager ([redacted])	ASAP

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All calls to be made when trains are redetermined so that crew relief's do not delay the system	[redacted] Control Centre Manager	ASAP	

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9. Appendices

Appendix 1	**IRF 15398/18185 [redacted].**
Appendix 2	**IRF 15396 [redacted]**
Appendix 3	**Breath Test Result, [redacted]**
Appendix 4	**Breath Test Result. [redacted]**
Appendix 5	**PSD entry 206112/0001 dated 30.10.2007**
Appendix 6	**Fact Finding Question and Answer sheet**
Appendix 7	**Transcript of Audio Download(Radio)**
Appendix 8	**Transcript of Audio Download(Telephone)**
Appendix 9	**Memo [redacted] confirming extra shadowing.**

END