Local Investigation – Accident / Incident (level 3)

1. Assure reference #	
2. Date & Time of Event:	Friday 29th March 2013 05:06
3. Location	Stratford Platform 4a

4. Description of Event:

Friday 29th March a number of vehicles were out-stabled across the system due to a closure between Canning Town and Beckton Station, for Cross-rail works. Four trains were out-stabled at Stratford Regional station (STR), one on each platform 4a, 4b 16 & 17. At 05:05 vehicles 45/99 departed STR platform 4a without a Passenger Service Agent (PSA 2) on board. The PSA2 was contacted by the Control Centre Supervisor (CCS) who made him aware that he was about to board the trains and the train departed. The train was stopped by the emergency brakes being applied and then returned to STR platform 4a. The PSA then boarded the vehicles and the trains departed. At no time were there any passengers on board the train.

5. Summary of Investigation: *(Include details of how the investigation was approached, eg. persons interviewed, reports collated, inspections or tests carried out, records scrutinised. The investigation should give consideration to any wider implications of the event, such as the potential for other failures across the company/fleet. Attach copies of any statements, photographs and other supporting information; plus details of any other evidence held for future reference/audit.)*

- A breath test was completed on the CCS who departed the train from platform 4a. The Control Centre Controller (CCC) and overnight vehicle babysitter were not breath tested, as it was only highlighted after they had left site of their involvement in this incident.
- IRF reports were requested from the Control Centre Supervisor (CCS), babysitter PSA (PSA1) and a report requested from the PSA2 and CCC.
- Radio communications for the incident and prior to the incident were downloaded and reviewed.
- CCTV from the trains and platforms was downloaded and reviewed.
- Fact-finding interviews were completed with the CCS, CCC and Overnight babysitter.
  A review was completed of SOP/M-3.12

6. Findings: *(Description of what happened in the lead up to, during and immediate aftermath of the event, including details of consequences or potential consequences)*

The findings have identified that this incident took place due to a lack of understanding between the PSA and the CCC, an additional instruction was given by the CCC, which is not present within the current Standard Operating Procedures (SOP's) and the PSA followed the Controllers last instruction to ensure that there was no inhibits on the train before leaving the vehicle. This meant the vehicle was not secured by the use of the Door Control Panel (DCP) or the emergency mushroom in the emergency driving position (EDP).

The instruction given by the CCC to the PSA1 who was babysitting the outstabled trains overnight was "I want you to request ATO on all the vehicles at Stratford, making sure they have ADC and no inhibits, over. Although this process is not stated in any of the current SOP's, it is common practise for the control centre staff to do this with trains outstabled overnight, to make sure that the trains have no faults and are ready for the start of service. If this process is left until the PSA who is taking the train into service arrives at the outstabled vehicles, there is the potential to delay the start of service, should they need to go through the fault-finding process to release any inhibits.

The misunderstand was in the request that was made by the CCC, that there were "no inhibits on the trains". This instruction was given as a fault finding instruction but this was not explained. As a result of no explanation for the instruction the PSA took the instruction literally and left all the vehicles at Stratford without securing them, as stated in SOP/M-1.03 General Rules for Train Operation, 7. Movement, 7.6. 'Vehicle Operators are always to inhibit their trains on automatic tracks before leaving by passenger, crew access or end door.

It would seem that there was not a clear understanding between the CCC and PSA, which should be achieved as per the Communications Procedure SOP/M-5.01. 2.3 Base Station Operator (BSO) 'To

come to a complete understanding with the Radio Handset User prior to authorising taking any action'.

The CCTV shows PSA2 who was taking the trains into service, arrive on a train at platform 4a. They alighted the train and made their way to the far end of the platform and started to carry out an inspection of the train's exterior. As he was about to open the crew access doors and board the vehicles, the trains depart.

The CCS confirmed that they had removed the platform hold at Stratford 4a via the SMC, as the train was scheduled to depart. They were not aware that the PSA had not boarded the trains and that an inhibit was not put on. Inhibits to secure the vehicles either by the Door Control Panel or the Emergency Mushroom does not show on the System Management Centre screen in the Control Centre. The CCS confirmed that after they had departed the train, they then called the PSA who should have been on the train, to confirm that if they were on the train.

After reviewing SOP/M-3.12 Outstabling, It would seem that although there was not breach of the written SOP by the CCC. The giving of an additional instruction "making sure you have no inhibits", is adding items into the SOP, which would constitute as a breach. This along with the CCS not confirming that the PSA was on board the train before departing, did contribute to this incident. A review on the outstabling SOP should be completed and items such as different types of outstabling e.g. overnight and pre-service, fault diagnosis, confirmation that the PSA is on board before departing and a checklist for those completing babysitting duties, should be added to prevent this type of incidents from happening again.

7. Causes

7.1 Immediate Cause(s): *(eg. Unsafe conditions or acts)*

Vehicles 45/99 on platform 4a at Stratford not being secured by the PSA when exiting the train. Due to a misinterpretation of an instruction given by the CCC, which is not in any Standard Operation Procedures.

7.2 Underlying / Root Cause(s) *(eg. Influencing factors, procedural weaknesses, management failings).*

Lack of explanation by the CCC and a misinterpretation of an instruction given by the PSA.

7.3 Other Areas of Concern *(Details of other issues/concerns highlighted during the investigation but did not actually cause the event, including any weaknesses in the incident response arrangements, aftercare of staff etc.)*

As part of the PSA's Fact-finding interview the PSA who was the overnight babysitter at STR confirmed he did not checklist any of the out-stabled vehicles at STR, due to not having any paperwork. At no time did he make the Control Centre aware that he did not have any paperwork.

Local Investigation – Accident / Incident (level 3) -Continued

8. Actions/Recommendations

8.1 Initial Actions

Details of initial actions that are to be taken, or have been taken, to prevent a recurrence.	Action by	Deadline
A Checklist for the PSA's when completing Babysitting duties.		May 2013
Briefing 016 sent to all CCS's & CCC's regarding Clarity of information given to staff when completing babysitting and securing outstabled trains.		July 2013

8.2 Recommendations Details of further recommendations to be taken to prevent recurrence. These should consider underlying and root causes in addition to the immediate causes.	Action by	Deadline
Review of SOP/M-3.12 Out-stabling. Consideration should be given to incorporating: • Fault diagnosis. • Confirmation of a PSA on board. • Babysitting checklist sheet. • Including the processes for different types of oustabling e.g. overnight and pre-service outstabling.	[redacted]	October 2013

9. Investigation carried out by:			
Name	Title	Signature	Date
[redacted]	Control Centre Duty Manager	[redacted]	August 2013

10. Investigation verified by (Head of Department/GM):			
Name	Title	Signature	Date
[redacted]	Control Centre General Manager	[redacted]	30/08/13

11. Investigation accepted by (Departmental Director)			
Name	Title	Signature	Date
[redacted]	Operations and Customer Service Director	[redacted]	30.8.13