serco
rec'd 11/10/13

Local Investigation – Accident / Incident (level 3)

1. Assure reference #	LI 13 178
2. Date & Time of Event:	26/09/2013
3. Location	Stratford international station.

4. Description of Event:

At approximately 0059 on the morning of Sunday 29th September 2013 vehicles 91-24-93 were berthed at Stratford International Station (STI) platform 2. PSA 1 had exited the train onto platform 2 via the crew access door on the leading vehicle (91); the crew access door was left open whilst PSA 1 was on the platform. The Control Centre Controller (CCC) called PSA 1 to state that the train was being non-stopped to Stratford Regional Station (STR) to start the testing. PSA 1 proceeded to close the crew access door on vehicle 91 from platform 2 and proceed to the leading end of the train facing STR. Once the crew access door closed the train departed STI Station with PSA1 still on the platform. The train was stopped on route to STR and routed back to STI.

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).*

PSA1 was removed from the train and breathalysed.
PSA1 completed an IRF
A Q&A interview was completed to establish PSA1s actions
CCTV from the train and platform have been requested and viewed.
PSA1's roster and overtime record have been reviewed to see if fatigue was an issue within the incident.
A copy of PSA1's black book entry is attached
A copy of the welfare check carried out on PSA 1

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)*

PSA1's was breathalysed after the incident which provided a negative reading.

PSA1's IRF states that he believes that he placed the train into inhibit via the Door Control Panel (DCP) before exiting the train via the crew access door.

In interview PSA1 again states that he believes he did place the train in inhibit on the DCP but also stated that looking back cannot guarantee 100% that he did. PSA 1 was also asked what should be checked when placing the inhibit on a train from the DCP the answer given was to ensure the red inhibit lamp illuminates, when asked did they check for the illuminated lamp they stated "I can't answer that because I cannot remember if I did place the inhibit on the train or didn't".

When a train is inhibited via the DCP the train would not depart as this is a local application of the breaking system. There is no indication in the CC that the train is inhibited either on the SMC or the VCC when the train is inhibited via a DCP so the CC would not know the train would depart when a route is given.

The CCTV coverage from the platform corroborates the version given by PSA 1 however, the on train CCTV does not show any images of PSA 1 on the train so cannot give any indication as to whether the inhibit was place on the train before PSA 1 left the train via the crew access.

PSA1 had completed a run of four shifts prior to the incident. The testing started at midnight which was in the middle of their two rest days. In interview PSA1 stated that they had been given thirty six hours notice that they were doing the testing. They also state that they had had a normal night's sleep the

night before the testing was due to begin and four hours sleep prior to starting the testing shift. This would indicate that fatigue was not a contributing cause of the incident. PSA 1 has also stated that there are no outside issues that would have affected his performance.

There is no physical proof as to whether the inhibit was placed on the train however as the train departed on the indications given by the CCC would indicate the inhibit had not been placed on the train by PSA 1.

7. Causes

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

PSA did not inhibit the train via the DCP before departing the train.

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

Failure to follow SOP/M-1.03 General Rules for Train Operation, section 7.10

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.)*

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
PSA1 was removed from the train and brought back to the Poplar Offices to be breath tested.		Complete
PSA1 was stood down from safety critical duties and sent home after completing the IRF		Complete

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
	(name)	(date)

9. Investigation carried out by:

Name	Title	Signature	Date
[redacted]	Team Manager	[redacted]	11/10/13

10. Investigation verified by (Head or Department/GM):

Name	Title	Signature	Date
[redacted]	HOPS	[redacted]	11/10/13

11. Investigation accepted by (Departmental Director)

Name	Title	Signature	Date
[redacted]	Senior Ops	[redacted]	11.10.13