

## Local Investigation – Accident / Incident (level 3)

**1. Assure reference #**

**2. Date & Time of Event:** 30<sup>th</sup> December 2012 – 05.45hrs

**3. Location** Poplar Platform 2

**4. Description of Event:**

Train departing for All Saints without anyone on-board.

**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 ).*

Following the incident the following items of evidence were requested/acquired.

- Incident Report Forms (IRF) from PSA1
- Results of Breath Test for presence of alcohol
- Standard Operating Procedure SOP/M -1.03

In addition PSA1 was interviewed by a Service Delivery Team Manager on Monday 31<sup>st</sup> December 2012 and Control Centre Supervisor (CCS) was interviewed by Control Centre Duty Manager on Monday 31<sup>st</sup> December 2012.

The background to the occurrence:

On Sunday 30<sup>th</sup> December 2012, there was a requirement to out stable trains at Poplar station platforms 1, 2, 3, & 4.

On the day of the incident, PSA1 was undertaking an overtime duty between 23.59 and 06.29. Their previous duty on 28<sup>th</sup> December 2012 ended at 01.30 on 29<sup>th</sup> December 2012.

At the time of the incident PSA1 would have been on duty for 5 hours 45 minutes. They had been operating a train in service from 00.10 to 01.30 after which the train was berthed on Poplar platform 1. PSA1 then selected all panels off on instruction from the Control Room Controller (CRC). PSA1 then carried out check listing on four trains berthed at Poplar platforms 1, 2, 3 & 4. During this time PSA1 was contacted by the CRC and instructed to carry out brake tests on all four trains, which required no movement. Once this was completed PSA1 was instructed to board the train berthed on platform 2, select Automatic Train Operation (ATO) and the train was then routed to Langdon Park in order to allow train movements through Poplar platform 2 and then routed back onto Poplar platform 2 where PSA1 was instructed by the CRC to select All Panels Off.

PSA1 then continued to carry out check listing until approximately 05.00. PSA1 then remained on vehicles 112/119120 on platform 1.

At approximately 05.45 PSA1 was instructed by the CRC to select ATO on all trains berthed on Poplar platforms. PSA1 carried out this function and left each train via the crew access door.

There had been no incidents of note in the PSA's shift prior to this incident.

The Control Centre Supervisor would have just started his duty 05:30. Their previous duty was on 30<sup>th</sup> December ended at 12:45. At start of shift he had two timed out trains and a failed loop from West India Quay 2 to Canary Wharf 3/4. 05:37 CCS requested PSA1 to reselect ATO all trains berthed on Poplar platforms. 05:47 PSA1 confirmed this that all trains berthed at Poplar platform have ATO selected. At 06:21 PSA2 contacted the control centre via the radio for radio check and confirm vehicles 124/123/127 are berthed at Poplar platform 3. CCS confirmed this information.

06:24 CCS routed train from Poplar 3 to All Saints 1. 06:26 PSA2 contacts control centre advising them there are no vehicles at Poplar 3.

#### External circumstances

The weather conditions at the time of the incident were dry, mild and dark due to the time.

The control centre was dealing with a loop failure around Canary Wharf at start of shift at 05:30. This caused delays and required manual intervention for the controllers and lasted for 90 minutes.

#### Incident Report form from PSA

This was not completed at the time, as Service Delivery was unaware of the incident until some time later as no one had informed them of the incident immediately.

#### Alcohol Test form

This was not carried out as Service Delivery was unaware of the incident until some time later; therefore, PSA1 had finished duty and left the premises.

#### Interview by Service Delivery Team Manager 31<sup>st</sup> December 2012

A full transcript of the interview signed by PSA1 is included as Appendix 1. The following are key points from the interview:

- PSA1 confirms they were carrying out, outstabling and checklisting duties at the time of the incident.
- PSA1 confirms they were instructed to select ATO on all trains berthed on Poplar platforms.
- PSA1 confirms that they are familiar with the SOP/M1.03.
- PSA1 confirms they had 12 hours between duties, had actually finished at 01.30 on 29<sup>th</sup> December 2012.
- PSA1 states that the inhibits were illuminated on all trains berthed on Poplar platforms when PSA1 alighted.

#### Interview by Control Centre Duty Manager 31st December 2012

A report from the CCS is included. The following are key points from the interview:

- CCS confirms instructing PSA1 to re-select ATO on all trains berthed at Poplar Station.
- CCS confirms receiving radio call from PSA2 confirming radio check & location of vehicles.
- CCS looked at SMC screen and vehicles in Poplar 3 had its closed door icon so assumed that PSA2 was on-board. CCS then routed train to All Saints 1.
- CCS apologised for not informing anyone straight away this was due to the CCS dealing with another incident at the same time.

#### Interview by Service Delivery Team Manager 9<sup>th</sup> January 2013

Some additional questions were asked of the PSA by the Service Delivery Team Manager of this report to understand any underlying cause. The main points made by the PSA in this interview were:

- Their journey to work is less than 20 minutes, they had adequate sleep overnight and were certain they were not fatigued.
- PSA1 confirms that they were not under any pressure to rush selecting ATO.

- PSA1 confirms that they had received training in the operation of trains, when they commenced employment with the company in March 2012 and in subsequent training days.
- PSA1 has been assessed for competency in this area.

## 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 had sufficient rest between duties (12 hours) and confirms that they were not fatigued: they had not had a reasonably long journey to or from work and had no incidents during their duty prior to this incident that could have distracted them. They had received training in the operation of trains and had operated trains since receiving the training. They demonstrated the correct theoretical knowledge of the procedure in securing trains after the incident.

PSA1 in interview confirms that they did not physically put an inhibit on as the train while it was awaiting ATO status as the inhibits were illuminated on all trains berthed on Poplar platforms when PSA1 alighted.

PSA1 has received training in the operation of trains, when they commenced employment with the company in March 2012 and in subsequent training days.

PSA1 has been assessed for competency in this area

CCS had a misunderstanding with PSA2. When PSA2 originally rang up for radio check and to confirm location of vehicles. CCS made assumption PSA2 was on-board which not the case, Consequently knowing CCS had spoken to PSA2 earlier and the SMC screen showing doors closed icon at Poplar 3. CCS routed train to All Saints 1.

## 7. Causes

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

CCS assumed PSA2 was on-board the train

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

PSA1 did not physically inhibit the train via the Door Control Panel.

### 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.)*

A traffic notice entry dated 19<sup>th</sup> May 2012, provides an amendment to SOP/M-3.12 which states:  
Note: - Securing a train means applying an Inhibit at a DCP before leaving the train via crew access door. However at the time of writing this investigation, the amendment has not been transferred to the SOP.

<b>8. Actions/Recommendations</b>			
<b>8.1 Initial Actions</b>			
Details of initial actions that are to be taken, or have been taken, to prevent a recurrence.		<b>Action by</b>	<b>Deadline</b>
PSA1 has been instructed to set an inhibit via a DCP whenever leaving a train on automatic tracks.		(name) [redacted]	(date) Completed
<b>8.2 Recommendations</b>			
Details of further recommendations to be taken to prevent recurrence. These should consider underlying and root causes in addition to the immediate causes.		<b>Action by</b>	<b>Deadline</b>
That SOP/M – 3.12 be updated to reflect Traffic Notice Entry 2.1 for franchise week 11 dated 19/05/12 (Note: Securing a train means applying an Inhibit at a DCP before leaving the train via crew access door).		(name) Control Centre	(date)
<b>9. Investigation carried out by:</b>			
<b>Name</b>	<b>Title</b>	<b>Signature</b>	<b>Date</b>
[redacted]	Control Centre Duty Manager		17 <sup>th</sup> Jan 13
<b>10. Investigation verified by (Head of Department/GM):</b>			
<b>Name</b>	<b>Title</b>	<b>Signature</b>	<b>Date</b>
<b>11. Investigation accepted by (Departmental Director)</b>			
<b>Name</b>	<b>Title</b>	<b>Signature</b>	<b>Date</b>