Local Investigation Report Template

Investigations should aim to gather and analyse information, which will include interviewing witnesses. The purpose of the investigation includes – discovering immediate and underlying causes with the aim to prevent or reduce recurrence, establish legal liability, gather data and identify trends. The purpose of the investigation is never to seek blame for any individual or group of individuals.

Local Investigation Report

Incident Title:
Train moved off without Passenger Service Agent on board

Incident Details:

Date: 28th July 2004	**Time: circa 13.25hrs**	**Ref No:39714**

Name of Investigator/s	**Position**
[redacted]	**Passenger Service Supervisor**

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"

1. Summary of Incident:

Passenger Service Agent (PSA) [redacted] was operating Run 44 between Tower Gateway and Becton when the train failed to dock at Custom House Platform 1. [redacted] was in the rear vehicle. On instruction from the Controller she made her way to the lead vehicle by way of the crew access. When [redacted] closed the crew access doors, the train moved off leaving her on the platform.

2. Details of Incident:

Passenger Service Agent (PSA) [redacted] was operating Run 44 between Tower Gateway and Becton when the train failed to dock at Custom House Platform 1. [redacted] was in the rear vehicle. On instruction from the Controller she made her way to the lead vehicle by way of the crew access. When [redacted] closed the crew access doors, the train moved off leaving her on the platform. She contacted the Controller who set the trains emergency brakes, however the train had already docked at Royal Victoria.

PSA [redacted] was operating a train on the opposite platform. She was instructed to inhibit her vehicles and take over run 44. There was an out of service train carrying technical staff, which was routed, to Custom House. [redacted] was instructed to board this train which was then routed to Royal Victoria where she took over the train vacated by PSA [redacted].

3. Conclusions:

PSA [redacted] failed to follow the procedures as laid out in **SOP/M-1.03** section **7.11**

“Vehicle operators are to inhibit their trains on automatic tracks before leaving by passenger, crew access or end doors”

4. Immediate Cause (what happened leading up to the event. Unsafe acts or conditions). Only consider the following suggestions if they are appropriate to the event:

Substandard Acts
Operating equipment without authority
Failure to warn
Failure to secure
Operating at improper speed
Making safety devices inoperable
Removing safety devices
Using defective equipment
Using equipment improperly
Failing to use personal protective equipment properly
Improper loading
Improper placement
Improper fitting
Improper position for the task
Servicing equipment in operation
Horseplay
Under the influence of alcohol
Under the influence of drugs

Substandard Procedures
Inadequate guards or barriers
Inadequate or improper protective equipment
Defective tools, equipment or materials
Congestion or restricted action
Inadequate warning system
Fire and explosion hazards
Poor housekeeping disorder
Hazardous environmental conditions
Noise exposure
Low temperature exposure
Inadequate illumination
Inadequate ventilation

Failure to comply with rules/procedures

5. Underlying Causes (why the unsafe act or condition occurred). Only consider the following suggestions if they are appropriate to the event:

Substandard Acts
Inadequate training / instruction
Inadequate supervision
Failure to provide / design a safe place of work
Failure to provide a safe system of work
Failure of work permit systems (e.g. Permit to Enter or Permit to Work)
Failure to control changes
Inadequate standard of maintenance
Employee unsuitable for job

Substandard Procedures

Failure to comply with established good practice
Failure to take account of hazard
Unsafe system for handling materials and equipment
Inadequate operating instructions/rules
Inadequate standard of design
Inadequate inspection
Inadequate standard of construction
Inadequate standard of installation
External forces outside SDL control (only to be assigned in rare circumstances)

6. Recommendations:

PSA [redacted]] has been advised of the importance of carrying out the relevant Standard Operating Procedures (SOP's). One to One refresher training with PSS [redacted] to be carries out covering depot & main line movements SOP's and general operation of LRV's

7. Action Plan (Arising from Recommendations):

No.	Recommendation	Responsible (whom?)	Timescale (When?)
001	PSA [redacted] has been advised of the importance of carrying out the relevant Standard Operating Procedures (SOP's). One to One refresher training with PSS [[redacted] to be carries out covering depot & main line movements SOP's and general operation of LRV's	[redacted]	Immediate
002	All PSA's in PSA [redacted] training group, the current trainees and future trainees are to be advised that under the Controllers instruction, when in the rear carriage. Emergency Shunt may be selected from the Lead Emergency Driving Position (lead EDP) at the rear of the vehicles. (unless rescinded under a future SOP)	[redacted] (for PSA's in [redacted] training group) [[redacted] & Trainers for current group and future groups	Ongoing
003			
004			
005			
006			
007			
008			

Remember to attach all relevant additional paperwork (statements, logs, IRF's, photos etc) as Appendices