Delay Attribution Board
Floor 8
1 Eversholt Street
London
NW1 2DN

Guidance No: DAB51

Attribution of Responsibility for Passenger Evacuation Initiated after a Shoe Gear Fire

1. Introduction

The Delay Attribution Board (the Board) received a Request for Guidance in connection with the attribution of a TRUST incident involving delays caused by the evacuation of passengers from a train after a shoe gear fire.

1.1. The Board received the Joint Request for Guidance from First MTR South Western Railway (SWR) and Network Rail; Wessex Route on the 21st October 2019.

1.2. Summary of the submission:

1.2.1. Guidance from the Board is sought for the resolution of an issue which has been progressed through the relevant process but for which no resolution has been achieved.

1.2.2 To provide guidance from the Board in relation to additional delays caused by an evacuation of passengers from a train initiated after a shoe gear fire.

1.2.3 For the Board to provide guidance on whether the responsibility for the incident should be allocated to Network Rail or to SWR.

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2 Factual Background to the Incidents

2.1 At 14:17 an emergency call was made by Woking Permanent Way to advise that 2F35 is on fire at Surbiton.

2.2 The train was reported to be about 80yards from Surbiton station.

2.3 Fitters were requested to attend from Wimbledon Park Depot at 14:27.

2.4 Fitters were en-route at 14:33 with ETA of 25 min (dependent on traffic)

2.5 Emergency Switch Off of current on down slow, down fast and down Hampton Court lines.

2.6 At 14:39 the Permanent Way Team, who were in the area, reported scorch marks on conductor rail and the shoe gear is welded to the con rail.

2.7 At 14:48 it was reported that the Driver has changed ends. The Driver was happy to power up and move train back into Surbiton platform.

2.8 At 15:05 the Guard advised that an evacuation of his train will take place as soon as sufficient staff to assist.

2.9 At 15:07 the Guard on 1P41 (stuck behind 2F35) reported he had opened all external windows and internal doors where possible due to the exceptionally hot weather conditions. He had advised passengers to move to the front of the train which is covered by the bridge and is partly shaded, and Passengers were very hot. Guard was asked if the situation is critical, which he said it was not but would like to move ASAP as won't be long before further issues occur. Guard further advised his train was moderately busy being approximately 50% full.

2.10 At 15:09 reported that the SWR Fitters were at Surbiton and would make their way to the Permanent Way yard and await arrival of the MOM.

2.11 At 15:13 Evacuation of train started.

2.12 At 15:20 the Fitter was denied access to the track by the MOM following conversations with Control and was told by MOM not to commence work until the train is detrained as PWay have deemed shoe welded to con rail and fitter will not be able to repair quickly.

2.13 At 15:22 SWR challenged the Incident Controller and Route Control Manager of the need to detrain as the Fitter had arrived. SWR were advised that passengers had been on the train too long and needed to come off as they were not sure that the fitter could rectify the unit.

2.14 At 15:40 it was reported that all passengers were off the train and the process of recharging the current quickly.

2.15 At 16:07 the Fitter was given access to make repairs to the unit had commenced.

2.16 At 16.13 the Fitter confirms shoe gear tied up, fuse removed, and he was happy for the unit to move.

2.17 At 16.18 Raynes Park Electrical Control recharged the down slow line.

2.18 At 16.21 Raynes Park Electrical Control recharged on all lines and block removed.

2.19 At 16:33 2F35 (now 5F35) was on move.

3. Requirement of the Board

3.1 The Delay Attribution Board is requested to provide guidance if the actions taken on the day were a failure to mitigate by Network Rail in not allowing the Fitter access to the failed train or a dispute in hindsight based on the findings of the Fitter when eventually allowed access to the train.

3.2 SWR request that a new Prime Cause incident should be created and attributed to Network Rail Control (OD/OQCC) as the decision to detrain the service and deny the fitter access, significantly extended the incident and therefore failed to mitigate the impact to the train service.

3.3 SWR contest that the agreed joint process was not followed and 2F35 was evacuated prematurely . Trains would have been moved 1 hour earlier, meeting the joint criteria for trapped trains and resolved the incident far sooner.

3.4 Network Rail Wessex Route believe that the attribution is correct and the decisions on the day were made with the information available in the best interest of passenger safety and no new Prime Cause occurred. The above points made by SWR are based on hindsight. Decisions were all made based on information from site at the time.

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4. South Western Railway's View

4.1 SWR believes The Fitter arrived at Surbiton at 15.09 and was denied access to examine and repair the train as Network Rail Control had made the decision to detrain 2F35 without any agreement from SWR.

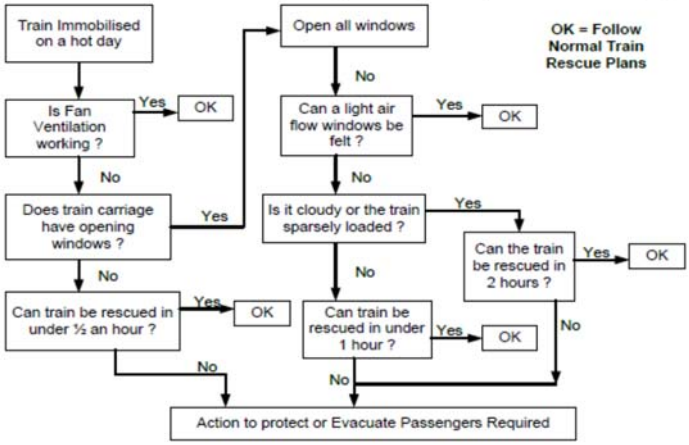
4.2 The decision to deny the fitter access to the train to examine goes against Standard Operating Procedures within the WICC where staff are routinely given access to faults occurring on network to provide an initial examination.

4.3 Once the Fitter gained access to the failed train at 16.07 the fitter had made the train fit to move by 16.13. The Route Control Manager was reliant on the report from sitethat the shoe gear was "welded to the conductor rail" and this was not the case.

4.4 The delay of 58 minutes between Fitter arriving on site and given access to the train should be attributed to a new Prime cause as a failure to mitigate which prolonged the denial of track access.

4.5 The Joint Emergency Process contains the following Flowchart

- The following flow chart from RSSB may be useful for the decision making process (the decision made and supporting rational needs to be recorded as it may form part of any subsequent review or inquiry):



4.6 The trapped train involved in the shoe gear incident, 2F35, had not raised any issues in terms of customers being vulnerable. The 455 stock on the train has opening side windows to allow ventilation and at no point was any detail logged to meet the criteria needed for a train evacuation.

4.7 The other train trapped, 1P41, formed of air conditioned 450 stock with no ventilation was logged at 15.07 as the situation was getting hot, the train 50% full and would need some action taken but no moves were made to evacuate this train as per the agreed process above.

4.8 The full trapped and stranded train process is in Appendix A of this document.

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5 Network Rail's View

5.1 Network Rail's view is that the correct decision was made in the interests of the passenger based on the information being reported from site at the time. P-Way were on site from the start as they were in the area and had advised control that the train was unlikely to move quickly as shoe gear welded to con rail (reported in good faith).

5.2 This was one of the hottest days of the year with temperatures reaching 29°C and passengers had already been stuck on the train for about an hour. The decision had already been made to detrain (which commenced at 15.05 prior to fitter arrival at Surbiton) and had been awaiting enough staff to carry this out safely. There was no accurate time of arrival for the fitter provided to the Signaller so there was no reason to rescind that evacuation decision.

5.3 Evacuation therefore commenced prior to fitter arrival which was as at 1509 at Surbiton and still had to make way to P-way yard to meet the MOM. Reversing this decision at this late point could easily have resulted in passenger self-evacuation.

5.4 The Rail Industry has been criticised for passengers being stuck on trains in the past particularly in hot weather, so Network Rail believes this was the priority action to be taken in this instance.

5.5 SWRs dispute is based purely on hindsight as to what the fitter found once access to the train was given.

5.6 Network Rail do not consider this a failure to mitigate. This was decision making and managing an ongoing issue in real time. Additionally, a failure to mitigate needs to follow the DAPR section D4 process and be challenged / highlighted on the day of occurrence.

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6. Locus of the Board

6.1 The Board reviewed its locus in respect of providing guidance on this issue. The Board's locus to provide guidance is set out in the Network Code Conditions B2.4.3 and B6.1.3.

6.2 The Board noted that while it could offer guidance to the Parties regarding how incidents of this nature should be attributed, this guidance was not binding on either Party involved. If either of the Access Parties were dissatisfied with the guidance provided, they could refer the matter to Access Dispute Adjudication (ADA).

6.3 If the issue was referred to ADA, then an Access Dispute Adjudication Panel (ADA Panel) would be formed to consider the dispute. In doing so, the ADA Panel would take account of the guidance provided by the Board but would not be bound by it. The ADA Panel would then make a determination that was binding on the Parties concerned. This document is therefore being prepared as the vehicle for providing the guidance and the reasons for how the Board arrived at its position both to the Parties and, if necessary, to the relevant ADA Panel.

6.4 The Board agreed that it should seek to provide guidance that meets with the delay attribution vision:

"For all parties to work together to achieve the prime objective of delay attribution – to accurately identify the Prime Cause of delay to train services for improvement purposes".

6.5 The Board would need to consider if, in providing guidance, an amendment to the Delay Attribution Principles and Rules should be proposed to improve clarity.

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7 Consideration of the Issues

7.1 The Board considered the Request for Guidance at its meeting on 17th December 2019 and took account of the following:

7.1.1 The facts provided by SWR and Network Rail in connection with the incidents disputed and the Joint Request for Guidance submission paper.

7.1.2 The additional information provided by SWR and Network Rail in response to questions raised by the Board prior to the Hearing (set out in Appendix A).

7.1.3 The additional information provided by SWR and Network Rail in response to questions raised by the Board at the Hearing (set out in Appendix B).

7.1.4 The guidance provided within the Delay Attribution Principles and Rules (as was in place at the time of the incident occurring) and any other related DAB Guidance documentation.

7.2 The Board regarded the following points as particularly relevant during discussion of the incidents:

7.2.1 That SWR had not challenged the decisions made or actions taken or raised the dispute for the alleged Failure to Mitigate against Network Rail on the day of the incident.

7.2.2 That DAPR 4.3 clearly sets out the criteria and associated timeframes for a party to challenge or raise a Failure to Mitigate against another party within the attribution process.

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8 Guidance of the Board

8.1 Based on the information presented, the Board agreed, unanimously, the following: -

8.1.1 That SWR is responsible for the incident raised as part of this submission in its entirety.

8.1.2 That the Delay Code applied to the incidents in this submission should reflect the unit failure and remain coded to MD.

8.2 In reaching its conclusion the Board also noted the following points:

8.2.1 That there was circa 20 minutes between the train failing and Permanent Way staff arriving on site in which time the Driver could and should have looked round the train and inspected the shoe gear.

8.2.2 That the Driver should have looked round the train prior to the evacuation and fitter's arrival as this may have changed the course of events (i.e. the decision to evacuate may not have been required or rescinded).

8.2.3 That decisions made in relation to any event are based on information available and the situation at any given time and the fact the fitter got the train moving shortly after his arrival was helpful but could not have been foreseen at the time. Judging the issue with the benefit of hindsight is inappropriate.

8.2.4 That the evacuation was already agreed and in the process of implementation when the fitter was effectively denied access to the train.

8.2.5 That utilising the provided Rescue Plan, the criteria would suggest that the train trapped in rear should have been evacuated first rather than the failed train (albeit the resources to do so were focussed on the failed train)

8.2.6 That the Rescue Plan had been reviewed and amended since this incident.

8.2.7 Points 8.2.1 to 8.2.6 notwithstanding, the considerations set out in 7.2.1 and 7.2.2 apply in the first instance.

This guidance was approved by the Delay Attribution Board on 14th January 2020	Richard Morris (Chair)
Signature:	

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APPENDIX A

Additional information provided by SWR and Network Rail in response to questions by Board members prior to the 17th December 2019 Hearing.

Question 1 Did the guard on 2F35 confirm that all the windows had been opened (as per Appendix A entry C4)

Response (SWR) - SWR haven't got that detail available.

Question 2 – The facts state that at 1448 the driver had changed ends to go back to Surbiton. Did the train actually move (hence indicating the shoe gear wasn't welded)?

Response (SWR) - The train did not move so they hadn't ascertained if shoe gear was welded or not.

Question 3 – The facts state that at 1505 the guard had advised an evacuation would take place (i.e. they had decided on that course of action) or should it read that the guard was advised……?

Response (SWR) – The Guard was advised that evacuation would take place and would not make that decision.

Question 4 - The TRUST incident shows the Failure to Mitigate dispute (albeit still pending the outcome of investigations) was subsequently added on the 2nd June (nearly a week after the incident) and not as part of the original dispute relating to the attribution of a FTS (which is not in line with DAB Process Guide PGD4) . Could SWR confirm if the Failure to Mitigate challenge was advised separately to Network Rail prior to this entry being made in TRUST?

Response (SWR) - It was discussed after the event in the Control but information was not passed onto the DA team.

Question 5 - This incident was attributed to SWR responsibility 26/06/18. The only dispute text entered prior to 02/07/18 was : "FTS ON 2L58 NEED TO GO TO POINTS FAILURE 143412". It would appear a failure to mitigate was not cited until 7 days after the event occurred. Do you think this is in-keeping with the DAPR or Track Access Contract. If so, please state the relevant sections?

Response (SWR) - There had been discussions about this incident on the day with the Control team but had not been advised to the DA Team until day 7. Hence the late dispute

Question 6 - Was a failure mitigate incident requested on the day it occurred? If so, will SWR supply the evidence?

Response (SWR) - It wasn't.

Question 7 - In the joint emergency process, would you mind highlighting the boxes/steps which you believe should have been taken?

Response (SWR) - The train involved had opening windows. The train trapped behind was a 450 Desiro with Air Con and no opening windows. Control should have followed the flowchart in C4 down the left hand side. It would not have been necessary to evacuate either train had the fitter been given access.

Question 8 - Who was appointed Trapped Trains Manager on the day the incident occurred?

Response (SWR) - There was a manager appointed but GDPR rules prevent names going into the log

Question 9 – Was the SWR Management Team made aware of the developing situation as it developed?

Response (SWR) – Yes. The Performance and Planning Director was involved in this incident and passed on the information to the Performance Team.

Question 10 - Why was a PWAY member of staff asked for their view of the fitness of 2F35? Were the Controllers decisions clouded by this information?

Response (NR) – P-Way were in the area when the train failed and gave their opinion from site. Fitter were en-route at 1433 with and eta of 25min. Control started to make decisions based on available information at the time rather that waiting for half an hour before starting to make a plan. Fitter arrived at the Station at 15:09 so still not on site

Question 11 - Why didn't you wait for the experts to comment on whether the failure could be quickly dealt with?

Response (NR) – incident occurred at 1417. Fitters en-route at 1433 with an ETA of 25min. It would not be appropriate to take no action for this length of time

Question 12 - Were there any concerns raised by on-board staff for the safety and well being of the customers on 2F35? If so, what information was received?

Response (NR) – Nothing was logged regarding this specific train. First mention of evacuating 2F35 is at 1505.

15:05 HY Guard of 2F35 advised that an evacuation of his train will take place as soon as there are sufficient staff to assist.

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Question 13 – Who was appointed Trapped Trains Manager on the day the incident occurred?

Response (NR) – Windsor TSM [SWR Controller]

Question 14 – Was SWR Management Team made aware of the situation as it developed? If so, who was being kept updated by whom?

Response (NR) – Nothing logged on CCIL to confirm who was contacted

Question 15 - The below is taken from the SWR Emergency Response Plan.

60 Minutes	INSTIGATE RESCUE PLAN.

The definition of instigate is: Initiate.

Do Network Rail believe this means the commencement of agreeing the rescue plan that is to be in place or physically commencing the agreed rescue plan at the 60 minute timeline?

Response (NR) – According to the SWR emergency response plan the Re3scue plan should be formulated at the 30minute mark therefore NR believe this means the rescue plan is physically commenced at this point

Question 16 - At 14:17 on 26th June 2018 a call was received to advise 2F35 was on fire.

In the Network Rail view of the incident it states the evacuation commenced at 15:05. Also, in the Network Rail view of the Request for Guidance: *This was one of the hottest days of the year with temperatures reaching 29oC and passengers had already been stuck on the train for about an hour*.

This is an inaccurate statement if the information within the log/timeline provided in the factual background is correct.

Please advise If the initial call was prior to 14:05 or at 14:17? Also, the temperature statement is not specific to the location of the train. This statement needs to be accurate to the location as it could be misleading if it was specific to a location miles away or at a different time of day.

Response (NR) – The control entry was logged at 14:17 evacuation commenced at 15:13 at stated in the facts which is about an hour. The decision to detrain was advised to the guard at 1505. The temperature stated was for the Surbiton area and was stated to give an indication of the temperature in the area. Also logged in CCIL was the fact they were moving people of one of the stranded trains (1P41) to an area of the train which was shaded by a bridge due to concerns over how hot is was. It was mentioned to provide context for the decision making

Question 17 - What efforts were made to contact the fitter for a location update and expected time of arrival?

Response (NR) – Fitters were driving and the estimate was based on the SatNav and allowance for traffic. Nothing logged regarding requested update from Fitters

Question 18 - What is the walking time from Surbiton PWAY yard to the location of 2F35?

Response (NR) – Unknown

APPENDIX B

Additional information provided for clarification purposes by SWR and Network Rail during questioning by Board members at the 17th December Hearing.

Question 1 – Paragraph 2.9 of the submission suggests there was issues reported with passengers on the train and so it was right to evacuate the train?

Response (SWR) – That entry relates to the train trapped in rear which had no opening windows and the air con had turned off.

Question 2 – Can SWR confirm who the Trapped Train Manager was

Response (SWR) – The person wasn't named in the log.
Response (NR) – It was the Windsor TSM (SWR Controller)

Question 3 – So why wasn't the train in rear evacuated if it met the criteria?

Response (SWR) – The evacuation procedure is based on the available staff to conduct the evacuation and they were concentrated on the failed train**.**

Question 4 – Did the driver of the failed train at any point get out and inspect the train either before or after the PWay attended and provided a view (either on his own volition or by request from Control – noting there was 20 minutes between the train failing and the PWay arriving?

Response (SWR) – No, the driver didn't examine the train. The feedback from the PWay staff once on site was taken as being correct.

Question 5 – So should the driver check the train or only if asked to do so?

Response (NR) – They would normally only do so if asked to.

Question 6 – Could SWR clarify the failure to mitigate claim?

Response (SWR) – The failure to mitigate is based on Network Rail preventing the fitter access to the train and commencing the evacuation. When the fitter did get access to the train then it was fixed relatively quickly so the evacuation would not have been required.

Response (NR) – However, Control had to make a decision as to evacuate or not as the fitters were about an hour away from site, so the procedure was carried out as planned.

Question 7 – Were the above mitigation challenges raised or challenged on the day?

Response (SWR) – They weren't logged and were advised subsequently to Network Rail after review.

Response (NR) – The failure to mitigate challenge was entered into TRUST on the 3rd July [incident occurred on the 26th June]

Question 8 – Do SWR have any agreement with Network Rail to raise disputes outside of timescales?

Response (NR) – No.