Delay Attribution Board

Guidance No. DAB-11

1. Introduction

1.1 The Delay Attribution Board (Board) received a request for guidance in relation to the Attribution of Delay to an incident (TRUST reference 894402), in which 2T86 0455 Three Bridges to Bedford service came to a stand over Metropolitan Junction. Subsequent investigations carried out by the parties revealed that no possible cause for the train's failure could be identified against either the unit involved or the infrastructure. This joint paper was received from Thameslink Rail Limited (Thameslink) and Network Rail Infrastructure Ltd (Network Rail) on January 3rd, 2006.

1.2 The Board considered this request for guidance at its meeting on January 24th, 2006.

1.3 This paper summarises the request for guidance received from Thameslink and Network Rail and the guidance provided by the Board.

2. Information Received

2.1 At 0540 on 01 September 2005, the driver of 2T86 0455 Three Bridges to Bedford Thameslink-service reported a passcom operation and came to a stand across Metropolitan Junction, blocking all lines as a result.

2.2 The driver of the unit advised at 0543 that he had subsequently discovered an air leak on unit 319008 and was investigating. At 0548, the British Transport Police ("BTP") advised there had been a theft on board the train, with Network Rail's Operations Delivery Manager being notified.

2.3 At 0602, the driver informed he had isolated the source of the air leak and was attempting to build enough pressure to enable the train to move. However, upon arrival at the site at 0617, the Network Rail MOM was advised by the driver that he had found the main res pipe leaking between the coaches and that he was unable to reconnect the pipes as the star valves were not working. Having isolated the main res, the driver began 'pumping up' in an attempt to get the train moving, but was unsuccessful as there was not enough air for the brake pressure.

2.4 Upon further examination, the main res pipe was found not to be connected correctly between the units' leading coaches and the valve handles were also closed between the second and third coaches. The MOM then successfully set about reconnecting the pipes and was able to open the valve handles, thus enabling the driver to make his brake application and get the train on the move at 0626.

2.5 At no time prior to the incident did the driver report striking an object on the line, nor was there any evidence to suggest the main res pipes had been struck or damaged. Subsequent fleet investigations revealed that the main res pipe, or hose, is extremely difficult to uncouple and for it to come apart whilst under pressure, is a very unusual event.

2.6 Total train delay minutes associated with the incident totalled 1,776 minutes, of which 332 were to Thameslink-passenger services.

2.7 Network Rail originally attributed the incident to delay code 'VH – Communication cord / emergency train alarm operated' following the report of the passcom operation, however, subsequently coded this 'M6 – EMU failure / defect / attention: other'. Thameslink have subsequently disputed this.

3 Summary of the position of Thameslink

3.1 Thameslink's original dispute centred on the specific comment made in its relevant fleet report namely, 'as this unit was the first over this section of track was there something thrown up that could have parted the hose (main res pipe)' and, therefore, the incident should be allocated in accordance with paragraph 5.2 (c) of Schedule 8 of the Track Access Contract (TAC) i.e. that 'Network Rail shall be allocated responsibility for an incident other than a planned incident, if that incident is caused wholly or mainly (whether or not Network Rail is at fault) by any act, omission or circumstance originating from or affecting the network (including its operation)…'.

3.2 However, having re-considered the circumstances following discussions with Network Rail, Thameslink is now of the belief that neither party could have either prevented this incident, or the circumstances that led to its creation. It would be unjustifiable to expect Network Rail to take responsibility when nothing can be reported amiss with the infrastructure, as it would be unreasonable for Thameslink to accept the incident following the findings from the investigations carried out by its fleet department. Therefore, in accordance with paragraph 5.4 (a) (ii) of Schedule 8, Thameslink now believes 'Network Rail and the Train Operator shall be allocated joint responsibility for… any incident in respect of which Network Rail and the Train Operator are equally responsible and for which neither Network Rail nor the Train Operator is allocated responsibility under paragraph 5.2 or 5.3'.

4 Summary of the position of Network Rail

4.1 Having established there is no evidence to suggest that the events leading to the creation of this incident were neither '…circumstances within (its) control..' nor 'originating from or affecting the network', Network Rail does not believe this incident warrants allocation in accordance with paragraph 5.2 (c) of Schedule 8 of the TAC, as Thameslink initially stated.

4.2 Thameslink's motives for possible attribution in line with the definition of a 'joint-responsibility' incident in accordance with paragraph 5.4 (a) (ii) of Schedule 8 are noted, with Network Rail certainly agreeing that neither party is to 'blame' for the train delay incurred. It does not, however, feel this approach would meet the very criteria for such a form of attribution as defined within the TAC. Indeed, AD39 clearly states: 'the process that… attributes an incident that causes Delay to one or the other contracting parties, is something totally different in kind from the discovery and attribution of the cause of that Incident'. Network Rail does, however, believe this definition to be crucial to identifying where the attribution should lie under Schedule 8.

4.3 Paragraph 5.3 (a) (iii) states 'a train operator shall be allocated responsibility for an incident… if that incident is caused wholly or mainly (whether or not the Train Operator is at fault) by any act, omission or circumstance originating or affecting rolling stock operated by or on behalf of the Train Operator (including its operation)…' and, therefore, Network Rail is of the view that as this instance can only appear to have 'originated from the rolling stock', it should be coded and attributed accordingly.

5. Locus of the Board

5.1 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 B2.4.3 and B6.1.3.

5.2 The Board noted that while it could offer guidance to the parties as to how incidents of this nature should be attributed, this guidance was not binding on any party. If one or both parties were dissatisfied with the guidance provided they could refer the matter to Access Disputes Committee (ADC).

5.3 If the issue were referred to ADC, then an ADC Panel would be formed to consider the dispute. In doing so, the ADC Panel would take account of the guidance provided by the Board but were not bound by it. The ADC 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 ADC Panel.

5.4 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"

5.5 The Board would need to consider if, in providing guidance, an amendment to the Delay Attribution Guide should be proposed, to improve clarity.

6. Consideration of the Issues

6.1 The Board at it's meeting on January 24th 2006 considered the request for guidance and took account of the following

i). The paper submitted by Thameslink and Network Rail setting out the issues and their respective positions;
ii). The wording in the Delay Attribution Guide;
iii). The answers to questions provided by both parties;

7. Guidance of the Board

7.1 The Board unanimously agreed that there was no evidence available to suggest that the air leak would have been detected at that time if the passenger emergency alarm had not been activated. The Board accepts that if a more thorough investigation had provided such evidence or if there was chronological separation of events then there would be reason to attempt to split the delays into separate incidents. However in this specific case and given all the evidence available it was determined that this incident should remain as a single incident the foundation being that it would have not occurred if the passenger communication alarm had not been activated.

7.2 The Board concluded that the most appropriate coding for this incident should be 'VH – Communication cord / emergency train alarm operated' as laid out in Appendix A15 Section V of the Delay Attribution Guide.

This guidance was approved by the Delay Attribution Board on 21st February 2006	John Rhodes (Chairman)
Signature:	