Delay Attribution Board

Guidance No. DAB-14

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 949912). The incident occurred on 26 April 2007 involving 3K21 empty stock from Moorgate to Bedford. In summary: 3K21 travelling from Moorgate to Bedford stopped abruptly just north of Elstree tunnel. It was established shortly afterwards that an air-filter was missing from the unit. This caused the train to lose air pressure, resulting in the unit coming to a complete stand.

1.2 The Board is asked to provide guidance as to whether the incident is being correctly coded currently as M6 – EMU Other and Responsible Manager Code MEGI TLINK HIRED 319, or should it be coded as per DAG 4.24.2 h.or i.

1.3 The Board received the joint request for guidance from First Capital Connect (FCC) and Network Rail Infrastructure Ltd, London North Eastern Route, (Network Rail) on 5th September, 2007 and subsequently received a range of supporting evidence on 7th September 2007.

1.4 The Board considered this request for guidance at its meeting on 2nd October 2007.

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

2. Information Received

2.1 The parties have discussed the issues relevant to this matter, in accordance with the agreed procedures for obtaining agreement in relation to a disputed attribution. However, they have been unable to reach a common position. The parties are, therefore, both agreed that the issues raised should be referred to the Board for guidance and have prepared a joint submission accordingly, incorporating their respective interpretations.

2.2 The Board is asked to give guidance in this reference as to which is the correct attribution, for delay attribution and Schedule 8 purposes, of an incident (TRUST reference 949912), in which 3K21 empty stock from Moorgate to Bedford incurred a 14-minute delay resulting in 136 minutes reactionary delay. The driver advised the signaller there was air escaping from the unit. After further investigation by the driver it was noted there was an air cock missing *(this fact was corrected at the hearing by FCC who explained it was an air filter that was missing and not an air cock)*. The driver isolated the doors and continued to St Albans. On arrival at St Albans the train was taken out of service and taken to Bedford for examination.

2.3 There is no suggestion that either party had failed to mitigate the impact of the incident, or that trains had incurred any form of avoidable delay not attributable to the situation described above.

2.4 FCC has provided extensive photographic evidence from its Engineering Fleet department showing the damage to the leading and second unit. Additionally, the voice tapes have been provided of the discussion between the Driver and the Signaller.

2.5 There are several other incidents of a similar nature in dispute on the GN and Thameslink routes, involving unit problems (allegedly) caused by an (unidentified) object 'on the network' whilst en-route. These involve unit pantographs; traction motors and 'trip-cock' activations.

2.6 The facts of this matter are: 3K21 travelling from Moorgate to Bedford stopped abruptly just north of Elstree tunnel. It was established shortly afterwards that an air filter was missing from the unit. This caused the train to lose air pressure, resulting in the unit coming to a complete stand.

3. FCC Position

3.1 FCC believe there is sufficient evidence to suggest that the unit struck an unknown object on or near the infrastructure. FCC believe the train was disabled because it had encountered an obstruction somewhere on its journey, and that that obstruction disturbed the air filter in a way that was beyond "the control of the Train Operator in its capacity as an operator of trains". In such a case the presence of an obstruction might be construed as a "circumstance originating from or affecting the Network (including its operation)", and an allocation of the incident and the resulting delay could be appropriate because prevention of obstructions was within the control of [Network Rail] in its capacity as operator of the Network.

3.2 In this particular case, extensive photographic evidence, Drivers report, voice tapes and an explanation from the Fleet Manager had been provided to Network Rail, but they had adhered to the determination in AD29.

3.3 Having listened to the voice tapes, the Driver advised the Signaller his air cock had "fallen off" and that there was a huge gap in the pipe work. On further investigation of the unit at Bedford Cauldwell depot, it was found to have impact marks down the left hand side, on coach 1 & 2. However, the driver could not have known the cause during his initial communications. Therefore, nothing should be read into the statement "fallen off" and this should be taken as not in position. Further investigation by the qualified "competent and assessed Traction Riding Inspector" (John Catterall), revealed clear evidence of impact damage.

3.4 When the Driver was patched through to Bedford Depot for verbal assistance from the fitter, to rectify the damage, Tom McCluckie (FCC Fleet Production Supervisor at Bedford Cauldwell depot) asked the Driver if he had hit anything. The Driver said "No". However, as explained in the fleet report, the Driver couldn't possibly have heard anything that happened 10 metres behind him, and neither would he have seen anything, as the problem is believed to have been in Elstree Tunnel. It is clear given speed and train noise that unless it was a significant line side obstruction it may not been possible for the driver to know whether an item has come into contact with the train.

3.5 An 'A' exam (an examination of a unit every 5000 miles to check safety critical system, wear and tear and visual inspection of unit and carry out any repairs arising).was carried out on unit 319007, 25th April 2007 (ie the day before the incident) which involved a full underframe inspection, as detailed in the 319 Vehicle Maintenance Instruction – Job number 601. The results of this inspection concluded there were no defects or damage to the underframe,

and neither were there any impact marks present to represent earlier contact damage and that the air filter was normal (ie damage free).

3.6 A possession was taken on the down fast line at Elstree at around 0215 hours 26 April 2007. Although three Midland Mainline (MML) services had passed through this area without event, 3K21 was the first 319 unit over the freshly maintained length of track. There have been instances of high ballast, tools and spare pieces of rail placed near the running rail, on the East Midlands area where trains have reported striking ballast or traction shoes have been dislodged.

3.7 After the ruling of AD29, extensive work was carried out on FCC 319 units, changing the direction of the air cocks to ensure they were not easily opened if struck by flying ballast. Also, another programme which was run in 2005, ensured all air cocks are key operated, rather than being hand operated. Therefore, FCC have done everything possible to ensure their units are robust and fit for purpose.

3.8 At no point was a Mobile Operations Manager (MOM) deployed to site.

3.9 FCC ask that the following be taken into consideration: If a train reaching high speed strikes an unidentified object, that object may not naturally come to rest on or near the track. It will often land in an adjacent field or on another part of the infrastructure. It is normal, for the following train to be requested to inspect the area for unknown object. However, it is often highly unlikely that the following train will identify any object that the damaged train is reported to have struck.

3.10 It is clear that in this and other cases referenced that these incidents have NOT been "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. Therefore AD29 (2003) does not apply.

4. Network Rail Position

4.1 Network Rail believes that the position adopted by FCC relates to their 'belief' that the incident was caused as 'something originating from... the network' (i.e. on the basis of probability...) and not a unit defect. Network Rail clearly notes the level of documentation presented by FCC, however, refers to previous Access Disputes Panel hearings to support its case. Indeed AD39 (2004) 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. Attribution to the right contracting party is a function of the operation of Schedule 8 in relation to quantified Delays that have occurred, and as such is the proper province of the TRUST Delay Attribution Guide. Establishing possible chains of casualty, relates, speculatively, to matters which may or may not have led to delay, and which are not therefore themselves Delay incidents; as such they have no part in the operation of schedule 8, nor are they within the province of the DAG".

4.2 In this particular case, the driver states that he was not aware of striking an object; nor did any of the MML services report any problems. It would therefore not be common practice for a MOM to be sent to site in such a scenario as this, particularly as there was no allegation of anything amiss.

4.3 Therefore, it is difficult to see as to how Network Rail can be deemed to have contributed to the incident in any way based on the actual facts to hand and

believes the correct attribution to be in accordance with Schedule 8 Paragraph Clause 5.3 (a) (iii) i.e. '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)...' in line with the conclusions of AD29 (2003).

4.4 Network Rail's view is that the incident is currently coded correctly.

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 2nd October 2007 considered the request for guidance and took account of the following:

6.1.1 The paper submitted by First Capital Connect and Network Rail setting out the issue and their respective positions.

6.1.2 Printouts of TRUST Incident 949912.

6.1.3 Photographs of damage to the unit.

6.1.4 Fleet engineering reports.

6.1.5 Side perspective photo of unit.

6.1.6 Voice tapes of Driver/Signaller radio conversation.

6.1.7 Driver's report.

6.1.8 Response to written questions/comments from the Board.

6.1.9 Access Disputes Determination 29.

6.1.10 Access Disputes Determination 39.

6.1.11 Board Guidance DAB-5.

6.1.12 The oral presentations made by the parties to the Board.

6.1.13 The wording in the Delay Attribution Guide.

6.2 In coming to its conclusion the Board regarded the following points as particularly relevant:

6.2.1 A period of some 15 hours had elapsed between the A examination of the unit and the unit coming to a stand.

6.2.2 As no object or obstruction was reported by any staff at the time of the incident Network Rail did not consider it to be common practice to send a MOM (Mobile Operations Manager) to inspect the site of the incident. The parties were not agreed on whether an investigation had been requested subsequently, but no evidence was presented to the Board that such a request had been made.

6.2.3 No OTMR download had been made which could have pinpointed the unit status and the precise time of the incident.

6.2.4 The reference in the papers to an 'air cock' was inaccurate as it was noted that the missing equipment from the unit was an air filter.

6.2.5 No other train passing through the tunnel prior to the incident or subsequently had reported any obstruction.

6.2.6 The Board were concerned that there appeared to be a significant gap in the audit trail following the identification of damage to the unit. No attempt had been made to find any external object which might have caused the damage or the missing air filter. If there were an obstacle which still remained present in the tunnel then it might have given rise to safety concerns. However, in the absence of any evidence as to the cause of the damage, the Board had no choice but to conclude that what the train had struck and the circumstances in which the damage was caused were matters of speculation. In those circumstances, the Board concluded that the determinations in AD 29 and AD 39 and the Board's own guidance in DAB 5 all pointed to the same conclusion – that the prime cause of the delay which occurred was the failure of the unit just outside Elstree tunnel.

7. Guidance of the Board

7.1 The Board agreed unanimously that the prime cause of the delay was the failure of the unit 3K21.

7.2 In this case the Board could see no reason why the incident could be construed as anything other than a 'circumstance originating from or affecting rolling stock operated by or on behalf of the Train Operator..'

7.3 The Board understood that until the unit failed there was no delay incident.

7.4 Any delay should be allocated to the fact of the unit failure and not to any speculation as to what had caused that failure.

7.5 On this basis it was unanimously agreed by the Board that the incident was coded correctly.

7.6 The Board concluded that there was no requirement to amend the Delay Attribution Guide.

This guidance was approved by the Delay Attribution Board on 30/10/07	John Rhodes (Chairman)
Signature: