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

Guidance No: DAB-25

1. Introduction

The Delay Attribution Board (the Board) received a request for guidance in relation to the Attribution of TRUST delay incidents (TDIs) 575635 and 575578 both occurring on the 18th November 2009.

The Board received the joint request for guidance from Chiltern Railway Company Limited (CRCL) and Network Rail Infrastructure Ltd, London North West Route, (Network Rail).

1.1. **The Board was asked to give guidance with regard to the correct attribution of TDIs 575635 and 575578 relating to train services being brought to a stand and delayed due to passengers fainting allegedly due to overcrowding.**

1.2. **Network Rail and CRCL asked that the Board provide guidance on whether the attribution of delays incurred by passengers fainting on board passenger operated rolling stock should be attributed to "VD", or, in the case of TDIs 575578 and 575635, whether the incidents should be re-attributed to a fatality incident on the same day on the WCML. Network Rail and CRCL also asked the Board to consider how this issue could be made clearer in the Delay Attribution Guide.**

1.3. **The Board considered this request for guidance at its meeting on the 17th May 2011**

1.4. **This paper summarises the request for guidance received from CRCL 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 formal 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 in accordance with Network Code Condition B2.4 and have prepared a joint submission accordingly, setting out their respective positions.**

2.2. **The parties provided the following factual background (summarised to highlight the relevant facts) in relation to the two TDIs.**

2.3. **At 15.35hrs on the 18th November 2009 a person was struck by a train on the West Coast Main Line (WCML) Route. This resulted in the line of route being closed to the passage of trains for a period of two hours. As a result of this closure, CRCL agreed that London Midland and Virgin Trains' passengers could travel to Birmingham on CRCL services via the London Marylebone to Birmingham line of route.**

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2.4. **At 1805hrs on the same date the driver of CRCL service 1B50 (1716hrs departure from London Marylebone) reported that his train had come to a stop in the Great Missenden area as a result of the passenger communication chord being activated. On investigating the issue, the driver found that the passenger communication chord had been activated as a result of a passenger fainting. A total of 13 minutes direct delay and 9 minutes reactionary (to another CRCL service) was caused by this incident. The delay was attributed by NR to TDI 575578 and coded to "VD" - "passenger taken ill on a train". The incident was later disputed by CRCL on the grounds that the passenger fainted due to the overcrowding caused by the additional volumes of passengers as a consequence of the WCML closure. CRCL have requested the incident to be merged to the fatality incident on the WCML on the grounds that DAG 3.1.5 applies.**

2.5. **At 1837hrs on the same day 1K53, the 1800hrs CRCL departure from Marylebone incurred 5 minutes direct delay (with a further 5 minutes reactionary delay) as a result of the train coming to a stand in the Saunderton area after reports of a medical emergency on board. On investigation of the issue, it was found that a passenger had fainted on board, allegedly as a result of the overcrowding. The delay was attributed by NR to TDI 575635 and coded "VD" - "passenger taken ill on a train". The incident was later disputed by CRCL on the grounds that the passenger fainted due to the overcrowding caused by the additional volumes of passengers as a consequence of the WCML closure. CRCL have requested the incident to be merged to the fatality incident on the WCML on the grounds that DAG 3.1.5 applies.**

3. CRCL Position

3.1. **CRCL believed that both incidents were coded incorrectly in that the delays were due to passenger illness resulting from extra numbers directly attributable to the fatality on the WCML. CRCL believe that this bears a direct relation to DAG 3.1.5, which states "if an operator's service is delayed due to overcrowding as a result of another operator's train being cancelled or delayed, any delay or cancellation is to be attributed to prime cause." CRCL believes that the illness in respect of these cases was caused by the overcrowding on CRCL services as a result of assisting in the movement of customers displaced from the WCML, and is therefore not simply a case of passengers becoming ill on CRCL services.**

3.2. **In the specific case of TDI 575635, the CRCL accident report found the symptoms and subsequent recovery of the passenger could be considered directly attributable to the extra passenger numbers being carried as a result of the fatality on the WCML. It specifies that the passenger fainted due to the heat, but that water and fresh air brought about her recovery.**

3.3. **In the specific case of TDI 575578, CRCL considered it reasonable to expect that, in a situation where a fellow passenger is seen to lose consciousness, other passengers will pull the passenger communication chord. Although the chord was pulled on CRCL rolling stock, CRCL believed the incident was due to the**

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overcrowding of the service resulting from the fatality on the WCML. CRCL believes it is unlikely that this incident would have occurred were it not for the overcrowding resulting from that prime cause.

3.4. **CRCL brought it to the attention of the Board that it operates a "turn up and go" railway and only takes measures to control the flow of passengers through the barriers at London Marylebone when platforms and/or trains are deemed to have reached an unsafe level of occupation. CRCL do not believe that the station or on-train crowding on the day in question were above a level of acceptability for the safe operation of the railway. CRCL has a defined capacity limit as set by the Department for Transport and this was not exceeded during these incidents. The fatality on the WCML did mean CRCL was carrying significantly more passengers than usual, which resulted in the two cases of passenger illness at issue.**

4. Network Rail Position

4.1. **Network Rail believed both incidents were coded correctly in that the delays were the direct result of passengers becoming ill on trains. Network Rail do not believe that this can be associated with DAG 3.1.5 as it is clear that in both cases the passengers were ill. Additionally, Network Rail believes that DAG 3.1.5 is specifically related to delays incurred at stations as a result of overcrowding i.e. passengers boarding / alighting from overcrowded services.**

4.2. **With specific regard to TDI 575578, Network Rail stated the delay was caused as a direct result of the passenger communication chord being activated due to a passenger on board 1B50 becoming ill and that Network Rail cannot be held responsible for the actions of passengers on board the rolling stock of CRCL operated services.**

4.3. **Network Rail believed that the only organisation able to mitigate the effects of overcrowding, and the wellbeing of passengers whilst in the environment of a train, is the Train Operator that is operating the service, in this case CRCL. With specific regard to these incidents, both services originated from London Marylebone which is a barrier controlled station. Therefore, CRCL could have mitigated any effects of overcrowding by controlling the amount of passengers boarding their services.**

4.4. **In these circumstances, Network Rail believed paragraph 5.3 a (ii) & (iii) of Schedule 8 of the Track Access Contract is applicable "(whether or not the Train Operator is at fault) by circumstances within the control of the Train Operator in its capacity as an operator of trains; or (whether or not the Train Operator is at fault) by any act, omission or circumstance originating from or affecting rolling stock operated by or on behalf of the Train Operator (including its operation), including any such act, omission or circumstance originating in connection with or at any station (other than in connection with signalling under the control of Network Rail at that station or physical works undertaken by Network Rail at that station), any light maintenance depot or any network other than the Network."**

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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 Conditions 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 any of the Access Parties were dissatisfied with the guidance provided they could refer the matter to Access Dispute Adjudication (ADA).**

5.3. **If the issue were referred to ADA, then an Access Dispute Adjudication 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 would be binding on the parties concerned. This document is therefore 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.**

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 its meeting on 17th May 2011, considered the request for guidance and took account of the following:**

6.1.1. The facts provided by both Network Rail and CRCL on the disputed incidents and their respective requests for guidance.

6.1.2. The guidance provided by the Delay Attribution Guide.

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

6.2.1. The parties had not disputed the facts of the incident.

6.2.2. That CRCL had offered to accommodate the displaced passengers of London Midland and Virgin on its services to Birmingham and remained in control of the passenger flows. The Board considered this indicated that CRCL had the opportunity to avoid undue overcrowding on its services.

6.2.3. That the parties confirmed that at other times during the period of disruption on the day the guidance given in DAG 3.1.5 had been applied to services delayed as a direct result of overcrowding, i.e. Late starts. This indicated to the Board that there were specific circumstances where DAG

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Section 3.1.5 was agreed as applicable guidance in circumstances where delay is caused by passengers boarding and alighting.

6.2.4. That the Delay Code VD is described in DAG Appendix A as 'Passenger taken ill on train' and there is no other guidance given for attribution of this cause of delay.

6.2.5. That, certainly with regards to TDI 575635, the passenger fainting had been alleged as being due to overcrowding as a consequence of the WCML closure but that this could not be verified and that CRCL had confirmed that at no point were DfT 'capacity standards' exceeded on the train services.

6.2.6. That CRCL belief that it is unlikely that these incidents would have occurred were it not for the overcrowding resulting from the West Coast incident, was not based on established facts.

6.2.7. That previous ADRC Determination (AD39) assisted the Board in understanding that even if the reason for the passenger fainting was as a result of overcrowding due to the West Coast incident, no delay was incurred until the passenger alarm was triggered and the train was brought to a stand. The assertion that the West Coast incident contributed directly to the disputed incidents was speculative and attempted to identify a 'root cause' that was somewhat removed from the delay itself.

7. Guidance of the Board

7.1. **The Board concluded that the prime cause of both incidents was that of the train operator response to passengers being taken ill on their train.**

7.2. **That whilst no specific guidance is given in the DAG in this respect, it was self-evident that the description associated with Delay Code VD matched the circumstances of these two incidents.**

7.3. **The Board concluded that there was no reason to disagree with the view of Network Rail and that the incident should be attributed to CRCL and coded 'VD'.**

7.4. **The Board concluded that the Guide was clear and unambiguous in this respect and that no amendments are required as a result.**

This guidance was approved by the Delay Attribution Board on 28th June 2011	John Rhodes (Chairman)
Signature: