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ATOC Guidance Note- Investigation of Station Stopping Incidents

Authorised by

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Synopsis

This Guidance Note provides advice on the investigation of station stopping incidents along with a suggested template form for capturing of the relevant information. In so doing, it seeks to encourage consistency across the industry.

ATOC Guidance Note - Investigation of Station Stopping Incidents

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Issue Record

This Guidance Note will be updated when necessary by distribution of a complete replacement.

It is issued formally in printed format as a Controlled Document and is also made available, upon request, in electronic format as an Uncontrolled Document. In this context, It should be noted that the content of Appendix A has been set up as a form which can, if desired, be completed on screen (using Word) as an alternative to hand written completion of printed copies.

Amendments made since the previously published version will be highlighted in the electronic version but NOT in the printed version.

Issue	Date	Comments
One	September 2006	First published version
Two	February 2013	Reviewed and amended to include Stop short and release doors and Wrongside door release
Three	April 2016	Reviewed and updated to include different methods of door operation and control

Responsibilities

Copies of this Guidance Note should be distributed by ATOC members to persons responsible for ensuring compliance with the appropriate Railway Group Standards.

Explanatory Note

ATOC produces ATOC Guidance Notes for the information of its members. ATOC is not a regulatory body and compliance with ATOC Guidance Notes is not mandatory.
ATOC Guidance Notes are intended to reflect good practice. ATOC members are recommended to evaluate the guidance against their own arrangements in a structured and systematic way. Some parts of the guidance may not be appropriate to their operations. It is recommended that this process of evaluation and any subsequent decision to adopt (or not to adopt) elements of the guidance should be documented.

Guidance Note Status

This document does not create legally binding obligations between train operating companies and it shall be binding in honour only.

Supply

Copies of this Guidance Note may be obtained from the ATOC members' website (www.atoc.org)

Part B

1. Purpose

This Guidance Note is intended to promote the adoption of standard procedures for the reporting and investigation of station stopping incidents across the industry, along with a common definition of what is meant by these terms. In particular, it provides a suggested template pro-forma for the capture of all data needed to support such investigations.

2. Scope

This Guidance Note applies to all ATOC Members.

3. Definitions

Station Stopping Incident: An overall term that covers Fail to Call, Station overrun, Stop Short and release doors and Wrongside door release incidents.

Operational platform: The term for the area of a level platform that is available for passenger use and has been identified as part of the train dispatch area and/or the operation of the train.

Staff responsible for door release: This could be the driver of a DOO service or guard, conductor, train manager etc responsible for opening the doors.

Fail/failure to Call: Failure of a train to make a booked station stop in cases where the driver has made no attempt to apply the brake.

Station Overrun Protected: Event in which a train which the driver is attempting to bring to a stand at a station stop proceeds beyond the designated stopping point such that any door(s) intended to be for passenger use at that station is no longer on the operational platform and the staff responsible for door release has not opened the doors or SDO or ASDO has prevented the incorrect doors from being opened in error.

Station Overrun Non-Protected: Event in which a train which the driver is attempting to bring to a stand at a station stop proceeds beyond the designated stopping point such that any door(s) intended to be for passenger use at that station is no longer on the operational platform and have been released or opened by the staff responsible.

Stop Short Protected: Event in which a train comes to a stand prior to the designated stopping point such that some carriages are not adjacent to the operational platform. The doors that are available can be used safely for passenger egress due to the staff responsible for door release not releasing or opening the doors or SDO or ASDO has prevented the incorrect doors from being opened in error.

Stop Short Non-Protected: Event in which a train comes to a stand prior to the designated stopping point such that some carriages are not adjacent to the operational platform and are released or opened by the staff responsible.

Wrongside Door Release: Event in which the train doors are released on the side of the train that is not adjacent to the platform.

Note : The above definition of station overrun excludes overruns at stations with short platforms where the designated stopping point is beyond the end of the platform (i.e. positioned so that the rear rather than front of the train is alongside the platform). As an example, if passengers on an 8 car train have been advised to alight from the rear 5 coaches at a particular station but bringing the train to a stand at the designated stopping point clearly does not constitute a station overrun, even though the front 3 coaches are beyond the platform. However if the train is brought to a stand beyond the designated stopping point such that any of the doors in these 5 coaches are no longer adjacent to the platform, then that constitutes an overrun.

4. Fail to Calls

It is recommended that failures to call be investigated in a similar manner to other station stopping incidents. While many such incidents will result from a failure on the part of the driver which has no direct safety implications (such as misreading of the train's schedule), there may be cases where there is ambiguity as to whether a particular incident was the result of a driver making no to attempt to stop at all, or alternatively failing to manage to do so correctly. The pro-forma is accordingly designed to be used for all station stopping incidents.

5. Significant Operating Incident Occuring as a result of a Station Stopping Incident

If a station stopping incident results in a significant operating incident such as a SPAD or a collision then the investigation procedures for these types of incidents should be applied rather than those referred to in this

document, however the contents of this document may be used as an aide memoire.

6. Action to be Taken Immediately Following a Station Stopping Incident

It is recommended that in the event of any reported station stopping incident the driver concerned should be seen by a responsible Manager at the first available opportunity and an interview carried out to determine

- the immediate cause (as reported by the driver)
- *for station overruns only :*
  - the distance overrun
  - whether the train set back, and if so, whether authority was requested/obtained from the signaller
  - whether the driver changed ends
- *for stop short and release doors, and wrongside door release:-*
  - Whether any passengers alighted from a passenger door that was not adjacent to the level platform.
  - Whether the area surrounding the train was checked for passengers that may have fallen/alighted from the train prior to any further movements taking place.

The staff responsible for the incident's fitness to continue duty should also be assessed.

The driver, along with other staff if appropriate, must complete a written report of the circumstances as soon as practicable after the incident and as a minimum prior to booking off duty.

7. OTDR

OTDR data must be downloaded when a station stopping incident has been reported.

8. Investigation

A competent person must be appointed to conduct an investigation into a station stopping incident. All relevant sections of the pro-forma provided as an Appendix to this Guidance Note should be completed.

When completed, it should be submitted for internal sign off according to individual Company procedures and also to Network Rail and other Industry Stakeholders for acceptance of the conclusion and any recommendations that may apply to them. Incident details and the investigation conclusions and recommendations must be input to SMIS.

9. Liaison with Network Rail and other Industry Stakeholders

The person appointed to conduct the investigation should liaise, as appropriate with Network Rail and other Industry Stakeholders, to establish and discuss the circumstances. In particular, the results of any Network Rail led investigations into the state of the infrastructure (swab test, eddy current test, etc.) can provide valuable evidence of railhead conditions and an indication as to the operation of on-train sanding equipment.

10. Sources of Evidence

In conducting the investigation, the person appointed to do so should consider the following as additional potential sources of evidence relating to the incident in addition to reports from staff involved:-

- OTDR data
- CCTV images from station and/or train internal CCTV
- Forward Facing/ Rear Facing CCTV
- Signallers' reports
- Witness reports, including Guards and Train Dispatchers
- Evidence of causes of distraction (internal/external)
    - Mobile phone records (for examples calls/ texts)
    - Authorised/ unauthorised cab visitors
- Voice recordings
- Employee Medical Results
- Railhead Swab Test results – this may need to be specifically requested from Network Rail
- Operation of RHTT on affected or adjacent lines
- Driver's schedule card/ train list being used
- Any Not to Stop/ Special Stop Orders that may have been issued
- P2/CCF replays
- Medical Examination
- Fatigue Risk Index data
- Competence Management System documentation
- TOC/FOC/Network Rail Control Centre Log Entry
- Fleet Engineering
    - A technical report must be obtained to substantiate any allegations of a defect on the train
    - Dependent on the nature and/or seriousness of the incident, consideration should also be given to requesting a download of data held in Train Management and Brake Control Systems (where this is available)
    - Correct operation and status of sanding equipment

APPENDIX

**TEMPLATE FORM FOR INVESTIGATION OF
STATION STOPPING INCIDENTS**

Please note the following form has been designed to be completed electronically as a Word form and formatted accordingly. It may also be readily adopted for manual completion. Where indicated, guidance text for completion of the form is provided with the instruction that it be deleted from individual completed report.

STATION STOPPING INCIDENT INVESTIGATION

type of incident
train details
location
date and time
driver and home depot
SMIS Ref:

Produced by:

_____

(Name, job title and location)

Authorised by:

_____

(Name, job title and location)

Date: _____

Station Stopping Incident Investigation

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Attachments: Appendices and supporting information

Appendix A - Insert title and add other appendices below as necessary

Type of Station Stopping Incident:

Part 1 - Incident overview

Date of incident:		**Time:**		**SMIS Ref. No.:**			
Location of incident:				**Line:**			
Train:	Train ID.:		Time:		From:		To:
Driver's name:				**Depot:**			
If other than booked driver, give details				No. of persons in cab:			
Stock:	Leading unit† no.:		Vehicle no.:		Nos. of other units† in train:		
Driven from:	Vehicle / cab No.:			How was incident reported?			
Weather Conditions:				**Visibility:**			
Overrun Distance:		*(metres)*		**Gradient:**			
Permissible speed:		*(mph)*		**Approach view (restricted/ open/ view station from braking point.)**			

Consequences: *(tick)*

Train did not return to the platform	☐	Train not permitted to return to the platform	☐
Train returned to the platform with permission	☐	Train returned to the platform without permission	☐
If train returned to the platform, was the correct cab used? (Y/N)	☐	*If No state reason*	

Level crossing involved (see below)	☐	Collision/ Near miss with another train*	☐

Collision with fixed infrastructure	☐	*If so, give details*	
Infrastructure Damage	☐	*If so, give details*	
Passenger/ employee Injuries	☐	*If so, give details*	

Station stop details:

Consider:
History of station stopping incidents –
What type of incidents and when.
Have these been highlighted to traincrew
Regular or irregular stopping point
Is this regular work for the traincrew/depot

† Set number(s) (for example BN54) for locomotive worked services.
* As a result of a station overrun at an occupied permissive platform.

Part 2 - Infrastructure details

Level Crossing: *If level crossing involved, state type and any consequences*

N/A	☐		
Whistle Board reacted to	☐		
AHB	☐	CCTV	☐
Manual gates	☐	Manual barriers	☐
Foot crossing	☐	Traincrew operated	☐
Other	☐	*If so, give details :*	
Level crossing closed to traffic	☐	Level crossing open to traffic	☐
Level crossing in process of closing	☐	Collision with road vehicle or crossing gates	☐
Near miss with road vehicle	☐	Injuries / fatality (including pedestrians)	☐

Railhead conditions Dry ☐ Wet ☐ Greasy ☐ Leaf ☐ Other ☐

reported by driver: *(tick)*		affected	contamination
	Was incident attributed to railhead conditions? (Y/N)		
If yes	Did Network Rail confirm poor railhead? (Y/N)		
	Does OTDR indicate poor railhead adhesion? (Y/N)		
	Was railhead swab/ eddy current tested (Y/N)		*If Yes state*
	Had railhead treatment been applied? (Y/N)		*If Yes state*
	Has RHTT/Water Jetting taken place on affected or adjacent lines (Y/N)		*If Yes state*

Date /Time railhead treatment applied prior to incident	Date		Time	
Are Traction Gel Applicators fitted near this location? (Y/N)			Where?	

Reason for poor railhead	
Is location a known poor railhead adhesion location, i.e. listed in Sectional Appendix? (Y/N)	
What time was the last rail movement prior to this incident of the section of line?	
Had there been any reports of LRA in this are in the preceding 24hours (Y/N)	
If yes, what actions were taken	

Station Infrastructure

Are there multiple stopping points? (Y/N)		If yes, give details	
Are the stopping points clearly visible to the driver of an approaching train? (Y/N)		If no, give details	
Is there any special stopping instructions for this location (for example stopping points beyond the platform)? (Y/N)		If so, give details	
Are stopping points boards on the same side as the platform? (Y/N)		If no, give details	
Is DOO equipment on the same side as the platform? (Y/N)		If no, give details	
Are station staff (dispatchers) provided at this location? (Y/N)			

	Was station lighting fitted, operable and sufficient? (Y/N)		If no, give details	

Overrun/ Stop Overrun Door Release, Stop Short Release Doors and Wrong Side Door Release Incidents

How many doors were not adjacent to the level platform when the doors were released?			
Did any passengers alight from the train to **other** than the level platform (i.e. alighted onto the platform ramp or ballast)? (Y/N)		If so, give details	
Was the immediate area surrounding the train checked following the incident and prior to any other train movements taking place? (Y/N)		If no, give details	
Is the train operator of the train involved in the incident the Station Facility Operator at the station concerned? (Y/N)		If no, give details	
How long were the train doors incorrectly released for.		(mm.ss)	
Was automatic SDO working correctly?			
Was manual SDO operated?		Give details	

Part 3 - Train detail

Type of brake:	Brake control		Type of brake gear	

Sanding Equipment	Sanding equipment fitted?		If Yes, which type?	
	Was sanding equipment functioning?			
	Is WSP fitted and is there evidence of its operation on the OTDR?			
	Date sanding equipment last examined (functional test)			
	Date and location sanding equipment last replenished			

On Train Safety Equipment	Was any on-train safety equipment defective or isolated at the time of the incident? (Y/N)		If so, give details	

Vehicle defects

For each unit/vehicle in the train formation, please enter details of any relevant safety related defects reported during the previous 14 days

Unit/Vehicle Number	Defect Details

Part 4a - Driver details

Date of birth | Date entered service | Date passed as driver

Has driver been involved in any safety of the line incidents in the previous 2 years, Is the driver PQA or currently on a CDP process and/or, currently participating in a Driver (Competence) Development Plan? (Y/N)

(Please enter details)

Was there a known defect on the train, or other issues with route or traction knowledge? (Y/N)

(If Yes, please state)

Was the driver adhering to the Company Driving Policy? (Y/N)

(If No, give reasons)

Details of hours worked during the previous 14 days

Please enter details of the hours and duties worked by the driver during the previous 14 days. *NOTE: If the Driver has been involved in a Safety of the Line incident during the period shown below, this must be recorded.*

Day	Date (dd/mm/yy)	No. continuous days worked	Time on duty (hh:mm)	Time off duty (hh:mm)	Activity (see below)	Duty No/Comments
Incident						
-1						
-2						
-3						
-4						
-5						
-6						
-7						
-8						
-9						
-10						
-11						
-12						
-13						
-14						

Activities: **A -** Annual leave | **B -** Booked Off | **D** - Worked rest day | **N** - Worked Sunday
O - Other | **R** - Rest day off | **S** - Sick | **V** - Worked overtime

W - Worked ordinary time	**X** - Special leave	**Z** - Worked Emergency call out

Fatigue Risk Index Assessment details	FRI Index:	Depot Average:	Did driver allege fatigue
Give details if there is technical evidence of fatigue (slow reactions identified on OTDR)			

Part 4b – Guard/ Train Manager/ Conductor details

Date of birth | Date entered service | Date passed as guard

Has Guard been involved in any safety of the line incidents in the previous 2 years, Is the guard PQA or currently on a CDP process and/or, currently participating in a guard (Competence) Development Plan? (Y/N)

(Please enter details)

Was there a known defect on the train, or other issues with route or traction knowledge? (Y/N)

(If Yes, please state)

Was the guard adhering to the Professional Guards Handbook? (Y/N)

(If No, give reasons)

Details of hours worked during the previous 14 days

Please enter details of the hours and duties worked by the guard during the previous 14 days. *NOTE: If the guard has been involved in a Safety of the Line incident during the period shown below, this must be recorded.*

	Day	Date (dd/mm/yy)	No. continuous days worked	Time on duty (hh:mm)	Time off duty (hh:mm)	Activity (see below)	Duty No/Comments
Incident							
-1							
-2							
-3							
-4							
-5							
-6							

-7						
-8						
-9						
-10						
-11						
-12						
-13						
-14						

Activities: **A -** Annual leave **B -** Booked Off **D** - Worked rest day **N** - Worked Sunday
O - Other **R** - Rest day off **S** - Sick **V** - Worked overtime
W - Worked ordinary time **X** - Special leave **Z** - Worked
Emergency call out

Fatigue Risk Index Assessment details	FRI Index:	Depot Average:	Did guard allege fatigue

Part 4c - Dispatcher details

Date of birth		Date entered service		Date passed as dispatcher	

Has dispatcher been involved in any safety of the line incidents in the previous 2 years, Is the dispatcher PQA or currently on a CDP process and/or, currently participating in a dispatcher (Competence) Development Plan? (Y/N) [ ]

(Please enter details)

Was there a known defect with station dispatch equipment? (Y/N) [ ]

(If Yes, please state)

Was the dispatcher adhering to the Company Dispatch Policy? (Y/N) [ ]

(If No, give reasons)

Details of hours worked during the previous 14 days

Please enter details of the hours and duties worked by the dispatcher during the previous 14 days. *NOTE: If the*

dispatcher has been involved in a Safety of the Line incident during the period shown below, this must be recorded.

	Day	Date (dd/mm/yy)	No. continuous days worked	Time on duty (hh:mm)	Time off duty (hh:mm)	Activity (see below)	Duty No/Comments
Incident							
-1							
-2							
-3							
-4							
-5							
-6							
-7							
-8							
-9							
-10							
-11							
-12							
-13							
-14							

Activities: **A -** Annual leave **B -** Booked Off **D** - Worked rest day **N** - Worked Sunday
O - Other **R** - Rest day off **S** - Sick **V** - Worked overtime
W - Worked ordinary time **X** - Special leave **Z** - Worked
Emergency call out

Fatigue Risk Index Assessment details	FRI Index:	Depot Average:	Did dispatcher allege fatigue

Part 5 - Additional information (*Fail to Call/Overrun only*)

Driver explanation of reason for failure to call/overrun: *(tick)* Misread timetable/schedule card ☐ Forgot ☐ Distraction ☐ Other ☐

If Distraction or Other, please give details

Type of schedule: *(tick)* WTT ☐ WTT Variation ☐ STP ☐ VSTP ☐ Control Arrangement ☐ Special Stop Order ☐

Part 6 - Summary of events

The information (evidence) presented should follow a sequence of events. The aim is to tell a logical story of what happened. This can be based upon a simple timeline to make sure key facts are included in the correct order.

Follow this up with any other factors that have emerged during the course of the investigation that do not naturally fit in the story. The information presented in this section should relate to, and support the conclusions.

Delete this box and text once this section is complete

6.1 Insert text as appropriate.

Part 7 - Factors for consideration

This section is to highlight for the reader how information has been correlated and cross-referenced in order to make sound judgements. It needs to highlight conflicting information and where information is missing.

Delete this box and text once this section is complete

7.1 Insert text as appropriate.

Part 8 - Conclusions and causes

Avoid using single line statements in this section where possible and make sure that the cause is properly described. This should cover two key elements, i.e.

1. *Immediate cause: An unsafe act and/or condition that directly resulted in the occurrence of the event. Concentrate on the people involved and the environment in which they work. There can be more than one such cause. (Make sure there is a 'because' and not just a statement of fact)*
2. *Underlying cause: This relates to the underlying conditions and issues which caused or allowed the unsafe act or condition to occur. Consider: management and supervisory practice, job planning, equipment maintenance and other human factor influences*

When stating and explaining the causes, there should be a focus on what needs to be improved as much as on what went wrong. This method softens the impact to the reader and removes any emotion from the report.

Delete this box and text once this section is complete

8.1 Insert text as appropriate.

Part 9 - Other factors

In this section, record any other issues that were noted in the summary of events, which needs improving, although it did not form part of the identified causes (Part 8).

Delete this box and text once this section is complete

9.1 Insert text as appropriate

Part 10 - Required action to address non-compliances

This section states the actions required to address issues of non-compliance. This is where an existing control measure is already in place and has not been followed (e.g. a rule, regulation or process).

Non-compliances differ significantly from recommendations, as the existing control measures are deemed adequate and robust. All actions stated under this section are mandated.

Make short two or three line statements.

Between this section and that containing the recommendations (Part 11), all the issues identified in Part 8 (causes) and Part 9 (other factors) must be addressed

Delete this box and text once this section is complete

10.1 Insert text as appropriate.

Part 11 - Recommendations

This section documents suggested changes that focus on improvement to existing controls or the introduction of new controls. Sometimes reasoning for your suggestions may be necessary.

Make short two or three line statements.

Always make sure the recommendation has a champion identified.

Between this section and non-compliances, all the issues identified in Part 8 (causes) and Part 9 (other factors) must be addressed.

Remember, recommendations should be SMART. (Specific, Measurable, Achievable, Realistic and Timely)

Delete this box and text once this section is complete

11.1 Insert text as appropriate.

Part 12 - Report compiled by

Name		**Signature**	
Job title		**Date**	

Professional Head of Operations verification

Name		**Signature**	
Job title		**Date**	

Network Rail acceptance of report (where applicable)

Name		**Signature**	
Job title		**Date**	

Other Stakeholder acceptance of report (where applicable)

Name		**Signature**	
Job title and Company		**Date**	