

Rail Accident Investigation Branch

Presentation to the London TravelWatch Board

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Ladbroke Grove, Oct 1999 – Cause: SPAD
Outcome: head on collision (130 mph)
31 fatalities, > 500 injuries



Why was the RAIB established?

- The public inquiry into the 1999 Ladbroke Grove accident recommended that an independent organisation should be established to investigate rail accidents
 - This should be independent of government, safety regulators, police and all industry parties
- UK legislation:
 - Railways and Transport Safety Act 2003
 - Railways (Accident Investigation and Reporting) Regulations 2005
 - Guidance for the use of the Regulations is published by the RAIB (www.raib.gov.uk)

The RAIB – Key facts

- Independent from all parts of the rail industry
 - Forms a part of the Department for Transport, although is functionally independent
 - Chief Inspector reports to Secretary of State on investigation matters
- Sole purpose to improve safety
 - Does not apportion blame or liability
- Acts as the lead party in most investigations
- Became operational in October 2005

RAIB's scope includes: Mainline, metros, trams and heritage rail



Key themes of our Annual Report for 2016

- Failure of earthworks and structures.
- Track worker safety.
- Condition and maintenance of freight and engineering rolling stock.
- Level Crossings.
- **Platform train interface (PTI).**
- Fatigue.
- Collisions in long work sites.



Platform Train Interface



Platform train interface risk

- There are 3 billion platform train interface interactions every year
- 1,245 injuries per year
- 48% of the total passenger fatality risk occurs at the PTI

What PTI incidents has the RAIB investigated?

Investigations since Oct 2005;

National rail network	9
LUL	3
DLR	1
Tyne and Wear	1

Of the 9 investigations on the national rail network;

- 8 related to train dispatch

Of the 8 train dispatch investigations on the national rail network;

- 4 were dispatched by drivers (incl. 3 trap and drag)
- 2 were dispatched by platform staff (incl. 1 trap and drag)
- 2 were dispatched by conductors (incl. 1 trap and drag)

RAIB PTI investigations since Oct 2005

(London incidents shown in red)

2006	Huntingdon (serious injury)	Trap and drag
2007	Tooting Broadway (LUL)	Trap and drag
2011	Brentwood	Train dispatched with person in platform edge gap
2011	Kings Cross	Trap and drag
2011	James Street (fatal)	Train dispatched with person in platform edge gap
2012	Jarrow - Tyne and Wear	Trap and drag
2012	Charing Cross (serious injury)	Person fell in platform edge gap after train dispatched
2013	Newcastle Central	Trap and drag
2013	Southend & Whyteleafe	Wheelchair and push chair rolled onto track
2014	Holborn (LUL)	Trap and drag
March 2015	Clapham South (LUL)	Trap, drag and fell down gap
April 2015	West Wickham (serious injury)	Trap, drag and fell down gap
July 2015	Hayes & Harlington	Trap and drag
Feb 2017	Bank (DLR)	Potential trap and drag

Important learning - for passengers

The PTI can be dangerous, special care is always needed

- ☐ slow down and step carefully
- ☐ good behaviour on crowded platforms
- ☐ any obstruction of the doors can be dangerous
- ☐ alcohol and drugs can exacerbate the risk



Important learning

- for passengers

Train doors do **not** behave like lift doors

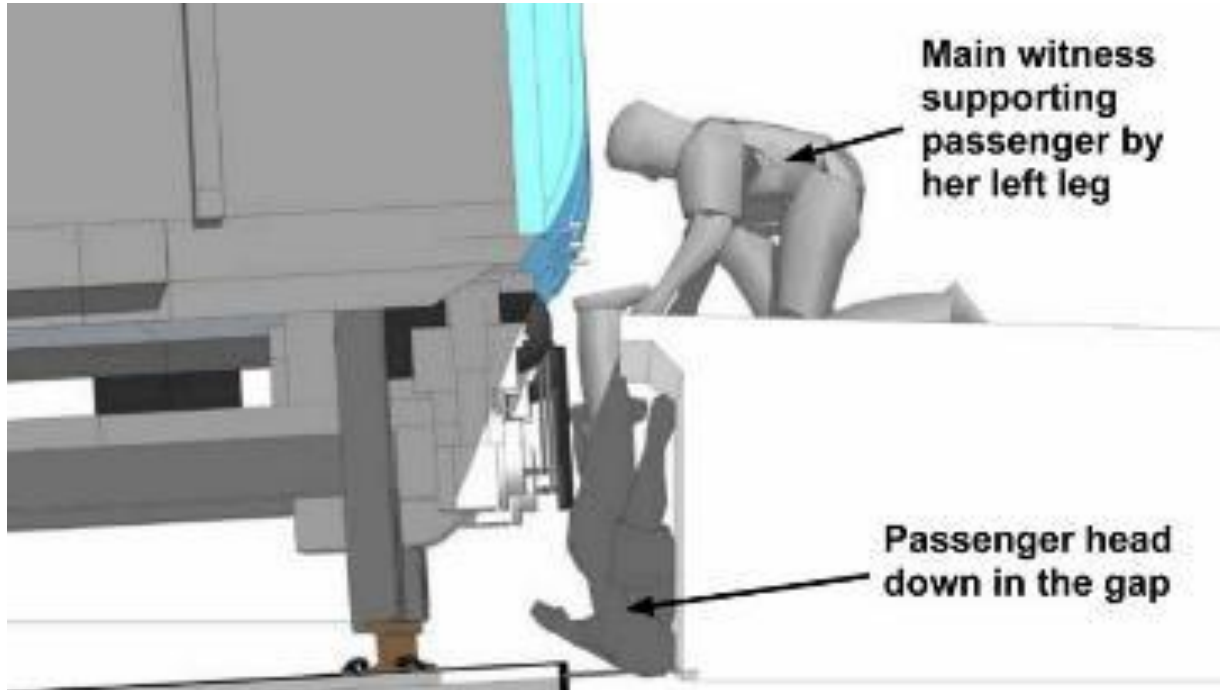
- ❑ they may not re-open when obstructed
- ❑ they have higher closing forces
- ❑ they may not detect small objects like fingers, straps, scarfs
- ❑ it can be harder to extract trapped objects
- ❑and much harder when the train starts moving

Important learning

- for dispatchers (drivers, conductors, platform staff)

- ❑ Where practicable, observing the doors as they close (looking for anything unusual)

[Brentwood 19/2011; West Wickham 03/2016; Hayes & Harlington 12/2016]



Important learning

- for dispatchers (drivers, conductors, platform staff)

- ❑ Always remembering that door interlock can still be obtained with a hand, or other small object, trapped between the door's leaves [Newcastle Central 19/2014; Holborn 22/2014; West Wickham 03/2016; Hayes & Harlington 12/2016]



Important learning

- for dispatchers (drivers, conductors, platform staff)

- ❑ Undertaking an adequate final safety check after doors are closed [Brentwood 19/2011; Kings Cross 09/2012; Jarrow 26/2012; Newcastle Central 19/2014; West Wickham 03/2016; Hayes & Harlington 12/2016]



Important learning

- for fleet engineers and rolling stock owners

- ❑ The need for a review of design of certain types of door control systems to prevent doors being opened by passengers after the driver has initiated the closure sequence

[West Wickham 03/2016]



Important learning

- for fleet engineers and rolling stock owners

- ❑ The need to ensure reliable operation of door detection systems [Jarrow (T&W Metro) 26/2012]
- ❑ The need to better understand the design of sensitive edge obstruction detection systems [Newcastle Central 19/2014]



Important learning

- for station managers and train operators

- ❑ Risk assessment of train dispatch arrangements, particularly when platforms are crowded, and the identification of suitable risk control measures (eg altered camera positions) [Brentwood 19/2011, Newcastle Central 19/2014 Clapham South (LUL) 04/2016]



Important learning

- potential improvements in the design of the PTI

- ❑ Adapting trains and/or platforms to reduce the platform edge gap [James St 22/2012; Charing Cross 10/2013]



Class 508 in 2011



1906 stock (in 1955)

Important learning

- potential improvements in the design of the PTI

- Ways of enabling dispatchers to stop trains quickly in an emergency (including after the signal to start has been given) [James St 22/2012; Charing Cross 10/2013]



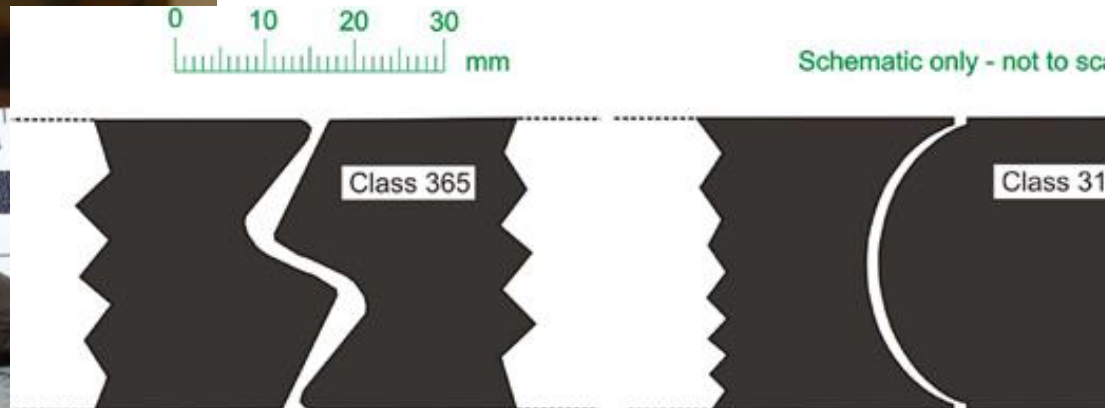
Important learning

- potential improvements in the design of trains

❑ Minimisation of force needed to extract an object from between door leaves

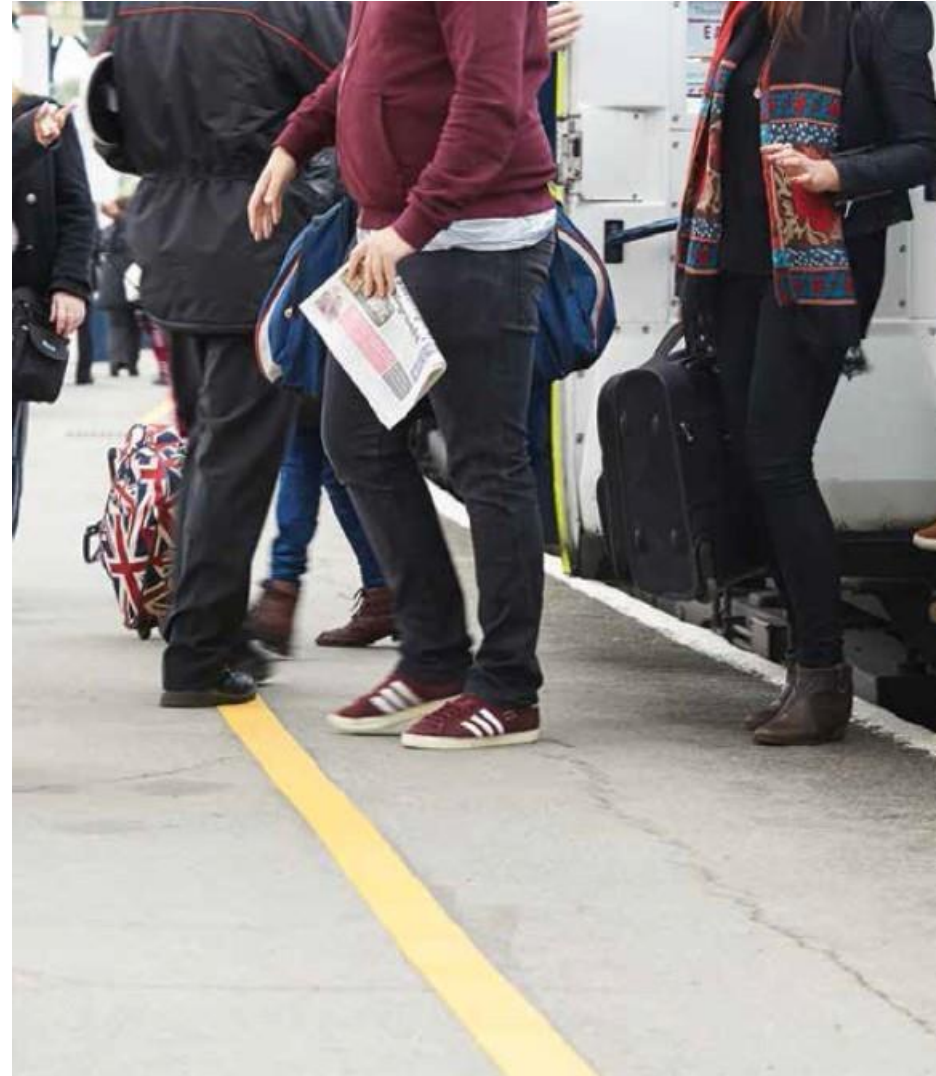
- Forces applied by doors and locking devices
- Design of seals

[Huntingdon 11/2007, Kings Cross 09/2012; Hayes & Harlington 12/2016]



Important learning - for the entire industry

- ❑ improved information on door trapping incidents;
- ❑ strategies to manage over-crowding
- ❑ continuation of the work of the PTI risk strategy group
- ❑ **how to engage the public on PTI safety**



PTI incident at Bank (DLR) (ongoing investigation)

At around 21:30 hrs on 6 February 2017

- A passenger became trapped by their coat, in the closing doors of a train preparing to depart.
- The passenger managed to quickly get out of the coat, which remained trapped.
- A short time later, the coat was dragged into the tunnel by the train



The investigation will consider:

- how the train was dispatched
- the design and operation of doors
- processes used by DLR to manage dispatch of trains from stations
- the adequacy of the train and platform equipment used for train dispatch
- any relevant underlying management factors

Overturning of tram at Sandilands jct, Croydon

9 Nov 2016: Fatal tram accident at Sandilands Junction, Croydon

- tram overturned at about 70km/h (43.5 mph) on curve with 20 km/h speed limit
- about 70 passengers + driver
- 7 deaths and 16 serious injuries
- driver appears to have been unaware of his proximity to the junction until shortly before the curve
- although there was some limited braking, the hazard brake was not applied



The ongoing investigation (1)

The tram was transported to RAIB/AAIB site at Farnborough for detailed examination and testing



The ongoing investigation (2)

The RAIB's ongoing investigation will include consideration of:

- the sequence of events before and during the accident;
- events following the accident, including the emergency response and how passengers evacuated from the tram;
- the way in which the tram was being driven and any influencing factors;
- the design, configuration and condition of the infrastructure on this section of the route, including signage;
- the tram's behaviour during the derailment and how people sustained their injuries;
- any previous over-speeding incidents at Sandilands Junction; and
- any relevant underlying management/regulatory factors.

Questions?