FINAL REPORT OF INVESTIGATION A&I E20125

March 4, 2020

Serious Injury

W-0031

Adopted by the Washington Metrorail Safety Commission at its meeting on June 18, 2020.

Washington Metrorail Safety Commission
777 North Capitol Street, NE, Suite 402
Washington, DC 20002

FINAL REPORT OF INVESTIGATION A&I E20125

SMS 20200304#86850

Date of Event:	3/4/2020
Type of Event:	Serious Injury
Incident Time:	02:35 hrs.
Location:	Chain Marker (CM) 407+00
Time and How received by SAFE:	15:15 hrs. – SAFE via email
WMSC Notification Time:	18:58 hrs. – Email
Responding Safety Officers:	WMATA SAFE: No WMSC: No Other: No
Rail Vehicle:	None
Injuries:	Fractured right ankle
Damage:	None
Emergency Responders:	None

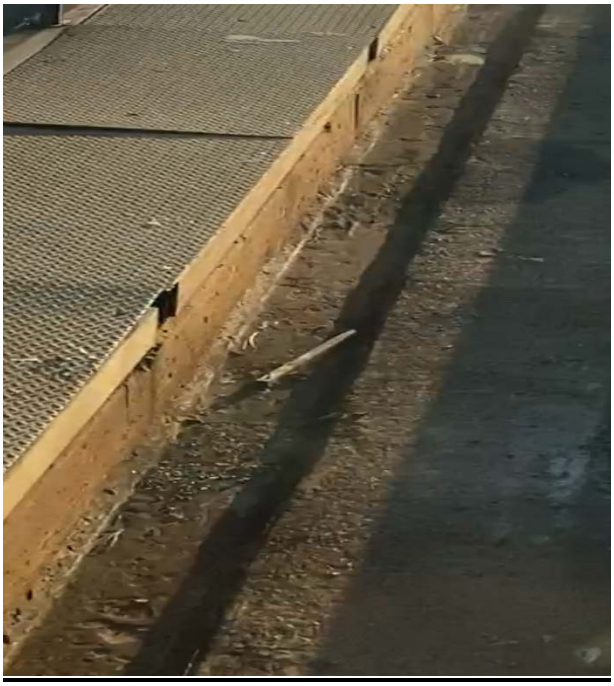
Executive Summary

On Wednesday, March 4, 2020, at 15:15 hrs., a Department of Information Technology (IT) Network Operations Supervisor notified SAFE via email that at approximately 02:35 hrs., an employee was injured in the performance of their duties. The employee tripped on debris while crossing over from Track 1 to Track 2 in the proximity of Chain Marker (CM) 401+00 while setting up track protection between Potomac Yard (C11) and Reagan National Airport Station (C10). The employee initially declined medical assistance and later self-transported themselves to Inova Fairfax Hospital Emergency Room for further medical evaluation, where it was determined the employee sustained a fractured right ankle. The employee subsequently notified the management of the physician's findings.

Based on further investigation, this event was not reported to the Maintenance Operations Center (MOC); however, the Department of Information Technology (IT) Supervisor did notify his management of the event.

Incident Site

Chain Marker (CM) 407+00 Between C10 and C11 Stations



Field Sketch/Schematics

N/A

Investigation

Department of Information Technology (IT)

IT Operations Supervisor

The one-year IT Operations Supervisor stated they were unfamiliar with procedures for reporting an injury incident. When the accident occurred, the Supervisor was located at the Jackson Graham Building. The Supervisor further stated that they did not normally oversee the injured employee as the injured employee was working overtime from another shift. Further investigation revealed the Supervisor notified management at approximately 04:32 hrs. detailing the events that occurred. This event was not reported beyond IT Management until 15:15 hrs., on March 4, 2020. Additionally, the Supervisor did not receive formal training on post-accident testing and Accident/Incident reporting.

IT Network Technician

The seven-year IT Technician's task was escorting contractors, and the Technician stated they were familiar with this task. A job safety briefing was conducted, and all required safety information was received. There were no distractions during this task, and the Technician stated the rain or uneven surface might have contributed to the accident.

NOTE: The IT Technician was wearing proper footwear at the time of the accident and had all the required PPE.

Audio Recording Playback (ARS)

There is no evidence to substantiate the event was reported to Maintenance Operations Control (MOC).

Findings

- IT Department Supervisory Staff were not aware of appropriate reporting procedures for accidents/incidents
- IT Technician was not aware of the height distance while transitioning from the safety walk to the ground

Weather

At the time of the incident, the temperature was 48°F, and SAFE has concluded that weather was not a contributing factor in this incident (Weather source: National Oceanic Atmospheric Administration (NOAA) – Location: Alexandria, VA)

Human Factors

Fatigue

Based on SAFE's review of the ATCM personnel 30-day work history, it was determined hours of service were per WMATA's Risk Management and Fatigue Policy 10.6 and Hours of Service Limitations for Prevention of Fatigue Policy 10.7.

Post-Incident Testing

The employee did not meet WMATA testing criteria; therefore, post-incident toxicology testing has been removed as part of this investigation.

Conclusion

Based on salient facts as part of this investigation, employee interviews, and photographs of the affected area, SAFE concludes procedures to report an injury on the job site were not adhered to. The Safety Walk presented a hazard to the employee when ascending and descending due to the height from the ground. Hazards such as these need to be addressed in the Job Safety Briefing prior to work commencing to ensure all workers are aware. The employee suffered an injury and was not aware of the policy to report injuries to management as they occur. Both management and the affected employee did not report to MOC as required following identification of the injury. After the injury occurred, the employee continued to perform duties relating to the job assignment. The event was communicated to Management when the injury became apparent to the employee.

Immediate Mitigation to Prevent Recurrence

- SAFE personnel attended the IT Department Local Safety Committee Meeting on March 4, 2020, and educated staff on proper procedures to report accidents, incidents, and injuries.

Corrective Action

1. The Department of Information Technology shall review and assess work instructions to ensure hazards are identified, mitigated, and instructions cover in detail the roles and responsibilities of supervision.