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WMSC Commissioner Brief: W-0048 – Fatal Collision, Self-Evacuation, Evacuation – Red Line – March 14, 2019

Prepared for Washington Metrorail Safety Commission meeting on September 22, 2020

Safety event summary:

A Metrorail customer who had been wandering the Fort Totten Station aimlessly for more than two hours left the Red Line platform via the platform end gate and began walking down the tracks toward Takoma Station around 9:54 p.m. on March 14, 2019. CCTV footage indicates the customer walked between the two tracks for a significant distance over several minutes before disappearing beyond the view of the camera.

At approximately 10:18 p.m., Shady Grove-bound Train 173 from Takoma Station struck the customer near Chain Marker B2-290+00. Based on forward-facing video, a post-accident interview, and the darkness at night along this outdoor section of track, the train operator could only identify that there was a person on the roadway in the moments immediately prior to the collision. The Rail Operations Control Center de-energized third rail power on that track at 10:19 p.m., and the train operator was instructed to do a ground walk around.

The train operator left the train to check on the condition of customer struck by the train and believed the person was showing signs of life. After checking on the customer, the train operator saw passengers moving through bulkhead doors on the train then requested permission to re-board the train and make announcements to passengers.

Data recordings demonstrate that the train operator did not make PA announcements to passengers before leaving the train.

D.C. Fire and EMS responded to the call for the collision, but the customer struck by the train had died when they arrived on scene at approximately 10:34 p.m.

At some point after power was de-energized, approximately 16 of the train's passengers self-evacuated by pulling an emergency door handle on the lead car, 7252. The train's forward-facing video did not record the evacuation or log the door handle release because the train was keyed down and third rail power had been de-energized (if either the train remained keyed up or the power remained up, recording would have continued and the PA system would have remained operational. Keying the train back up also restores the PA system and video recording).

After the operator returned to the train, other passengers informed the operator of this self-evacuation by through a side door. The train operator then gathered remaining passengers in the lead car to get a head count (59).

At 10:33 p.m., responding Metro Transit Police Department personnel encountered two self-evacuated passengers on the roadway near the station platform. The remaining 14 passengers were continuing to walk toward Fort Totten Station in the area between the two Red Line tracks from the train, which was approximately 824 feet from the platform.

After MTPD and Station Manager reported the self-evacuation to the ROCC, third rail power was de-energized on Track 1.

The Fort Totten Station Manager had not been informed of the collision just a few hundred feet outside of the station until MTPD officers ran into the station around 10:33 p.m., about 10 minutes after they were dispatched. No phone calls or announcements to the station manager had been provided by ROCC or ROIC.

The remaining 59 passengers and train operator were then led in an MTPD-controlled evacuation walk to the platform.

One customer reported a minor injury due to the evacuation.

Earlier, the Station Manager had assisted the customer who was later struck by the train with adding money to a SmarTrip card and directions to the Green/Yellow Line platform. The Station Manager stated they did not conduct station checks due to other duties.

Probable Cause:

A customer in Fort Totten station for hours went unnoticed, eventually accessing the roadway unnoticed, allowing a fatal collision to occur. A lack of clear communication to passengers on the train likely contributed to those passengers opting to self-evacuate into the roadway, further complicating the situation and introducing additional risks.

Corrective Actions:

The front right corner, underside, and inter-car barrier of the striking car, 7252, were examined, repaired and restored for service.

Metrorail also reviewed options for changes to load-shedding to keep 7000 Series recording systems energized if third rail power is de-energized and the car is keyed down during emergency events, however CENV determined this is not feasible.

WMSC staff observations:

This event highlights the importance of clear communication to customers and employees and the importance of vigilance in and around Metrorail property. When power is de-energized, WMATA must consider the status of the train (keyed up/keyed down) when sending personnel to the roadway.

Any type of evacuation onto the roadway creates risks for customers, but self-evacuation – particularly in the dark – can pose particular risks given unstable footing, the potential that some or all stretches of third rail could still be energized, and the lack of communication with other trains, work crews or the ROCC.

It is extremely important to provide customers with accurate and updated information so that evacuations only occur when necessary for life-safety reasons.

Metrorail could also consider additional measures, such as alarms or locks, to ensure that only authorized personnel access the roadway through platform end gates.

For vehicles, Metrorail should review 8000 Series planning to account for load-shedding improvements.

Staff recommendation: Adopt final report.

FINAL REPORT OF INVESTIGATION A&I E19135

SMS 20190315#78457

Date of Event:	March 14, 2019
Type of Event:	Collision
Incident Time:	22:18 Hrs.
Location:	Between Takoma (B07) and Fort Totten (B06), Track 2 Chain Marker (CM) B2-290+00
Time and How received by SAFE:	22:18 hrs., SAFE on Call Phone
Safety Officer Response:	Yes
Time of Safety Officer Arrival:	23:10hrs.
Time of Safety Officer Departure:	02:34hrs. 3/15/19
Train Consist:	**L**7252-53x7213-12x7282-83x7263-62**T**
Injuries:	1 - Fatality, 1 - Customer reported injury during evacuation via roadway
Damage:	None
Emergency Responders:	MTPD, DCFD, SAFE, CMNT, PLNT, ATC, TRST

Executive Summary

On Thursday, March 14, 2019, a female customer entered Fort Totten (B06) Station which is a transfer station with an upper and lower level platform that services Red, Green and Yellow lines trains at approximately 19:45 hrs. The B06 Station Manager assisted the customer with funding their Smartrip card to access the system via fare gate. After funding the Smartrip card, the Station Manager then gave the customer directions to the Green Line [downstairs] to board a train in the direction of Branch Ave Station. Thereafter, the Station Manager continued to provide customer service to other customers entering the station. The customer then proceeded to the Yellow Line platform and wandered aimlessly throughout the station for approximately three (2) hours. At 21:54 hrs. the customer enters the roadway via platform end gate on the upper level platform, Track 1 toward on-coming rail traffic.

22:18 hrs., inbound Red Line Train ID 173 on approach to B06 station destination Shady Grove, Track 2 reported to Rail Operations Control Center (ROCC) that his train made contact with a person on the roadway at Chain Marker (CM) B2-290+00. ROCC instructed the T/O to conduct a good radio check, key down his train, and perform a ground walk-around. Based on the ROCC Supervisory Control and Data Acquisition (SCADA) Advanced Information Management System (AIMS) event data log, 3rd rail power was de-energized at 22:19 hrs. Upon further investigation, a female customer was identified on the roadway unresponsive. MTPD personnel arrived on location and did not observe any signs of life from the customer and deemed the event a recovery operation.

Based on post incident inspection, Network Video Recorder (NVR), and event log data download, SAFE came to the following conclusion related to the rail vehicle involved:

- Forward-facing camera showed the customer had on dark clothing and lighting conditions were minimal through the affected outdoor area
- The T/O stated, during interview, while approximately 50 to 75 feet away it appeared to be a trash bag blowing on the fence line. However, when Train ID 173 closed distance, he saw it was a person.

Based on VMDS data analysis, the emergency release handles were not activated on car(s) 7252-53x7213-12x7282-83x7263-62 prior to 22:18 hrs. However, as a result of Third rail power removal in the affected area, the train Vehicle Monitoring & Diagnostic System (VMDS) did not capture any data after power was removed at 22:19:07 hrs. Therefore, as reported (by the T/O and customers aboard the affected car), it is most probable, the emergency release handle was activated after power was removed and customers subsequently self-evacuated from emergency Door #3 on lead car 7252 to the roadway.

The affected consist was removed from service for post-incident investigation and the T/O was subsequently removed from service for post-incident toxicology testing.

Service was subsequently restored at 2:34 hrs. on 3/15/19 approximately 4 hours and 16 minutes after the initial event.

Considering all the salient facts, SAFE concludes based on platform Closed Circuit Television (CCTV) review, the customer entered an unauthorized [employee only] access point leading down to the roadway walking in the direction of B07 station, Track 2. This action subsequently resulted in Train ID 173 in approach to F06 station strike the customer approximately 824 feet outside the station. There was no Vehicle Program Services (CENV) or NVR data to support an improper operation by the T/O of Train ID 173 nor were there any anomalies with the train that may have contributed to the customer struck by train incident.

However, after the accident with the customer, based on ARS playback, the T/O did not make proper announcements; notifying customers of the delay prior to entering the roadway. Additionally, based on VMDS data, there were no emergency release handles activated on the affected consist. The VMDS did not log any door opening events prior to 22:18 hrs. As a result of Third rail power removal in the affected area, the train VMDS powered off and did not capture any data after power was removed at 22:18 hrs. Therefore, it is most probable, the emergency release handle was activated after power was removed and customers subsequently self-evacuated from emergency Door #3 on lead car 7252 to the roadway for non-fire life safety reasons resulting in One (1) passenger injury.

At 22:33 hrs., ROCC received a report from MTPD that approximately sixteen (16) customers from the incident train had self-evacuated to the roadway and walked to the B06 Station. Based on review of the AIMS event data log, 3rd rail power was de-energized on adjacent Track 1 at 22:34 hrs. after report of customer self-evacuations.

Sixty (60) customers inclusive of the T/O of Train ID 173 were then escorted under a controlled evacuation by MTPD personnel to B06 station. At no time during this evacuation effort was a fire life safety concern a triggering event for either the self-evacuation or controlled evacuation event.

The affected consist was removed from service for post-incident investigation and the T/O was subsequently removed from service for post-incident testing.

Notification:

Title	Time	Comment:
FTA	12:52 hrs.	*FWSO Email notification *Accident occurred prior to WMSC Certification
WMSC	12:52 hrs.	Email
Other	11:10 hrs.	CMC Phone call

Incident Site

Between B07 and B06 Stations, CM B2-290+00, Track 2

Field Sketch/Schematics

Investigation

Chronological Timeline of Events

21:54 hrs. – The decedent enters the roadway via end gate Track 2 at B06 Station Via CCTV

21:55 hrs. – The decedent was seen entering the roadway unauthorized on Track 2 in the direction of B05 Station via CCTV

21:58:00 hrs. – The decedent was in between Track 1 and Track 2 walking in the direction of B05 Station Via CCTV

22:04 hrs. – The decedent eventually disappears from camera view 4 seconds after the above screenshot of the camera footage while walking between tracks 1 and 2

22:18 hrs. – Train ID 173 T/O notified ROCC Radio RTC he believed he came in contact with someone on the roadway. ROCC Radio RTC then instructed Train ID 173 to key down, give ROCC a radio check, and perform a ground walk around. ROCC Radio RTC then instructed Rail Transportation Supervisor (RTRA/S) at Metro Center to board the next train in the direction of B06 station

22:19 hrs. – Train ID 173 T/O performed a radio check with ROCC Radio RTC, ROCC Radio RTC confirmed good radio check. ROCC Radio RTC instructed the T/O to perform a ground walk around and keep ROCC notified with updates

22:20 hrs. – ROCC Radio RTC designated the T/O as the initial On Scene Commander (OSC) consistent with SOP 1A *Command, Control and Coordination of Emergencies on the Rail System*

22:22 hrs. – Train ID 173 T/O confirmed with ROCC Radio RTC there was a person on roadway against the fence line and appeared to be showing signs of life

22:23 hrs. – ROCC Radio RTC instructed CMNT Car equipment personnel to board the next train on Track 1 in the direction of B06

22:24 hrs. – ROCC Radio RTC then instructed Train ID 109 to use caution between B06 and B07 stations, Track 1

22:26 hrs. – ROCC Radio RTC instructed Train ID 109 to provide a CM after servicing B06 station for Train ID 173 on Track 2

22:28 hrs. – Train ID 109 confirmed, Train ID 173 was at approximately CM B2-290+00

22:30 hrs. – Train ID 173 contacted ROCC Radio RTC and stated when the first person (Rail Supervisor) arrives, can they board the train and update the customers. ROCC Radio RTC then instructed the T/O to board his train make announcements, move passengers to the lead car, and perform a head count

22:30 hrs. – ROCC began single tracking around the affected area crossing over from Track 2 to Track 1. Train ID 105 was the first consist to attempt to transverse around the incident area

22:34 hrs. – ROCC Radio RTC instructed 105 to stop their train. ROCC then notified Rail Supervisor (RS) 1 aboard Train ID 105 that customers exited Train ID 173 on Track 2:

- ROCC Radio RTC then instructed RS 1 to exit Train ID 105 and perform a track inspection
- Based on CCTV footage, District of Columbia Fire Department (DCFD) arrived on location at 22:34:30 hrs.
- RS 1 confirmed that ROCC wanted him to disembark at his current location and perform an inspection towards B06 station
- ROCC Radio RTC stated, “affirm” and notified RS 1 power was de-energized on Track 1 and Track 2
- ROCC Radio RTC then requested RS 1 provide CM for Train ID 105, RS 1 stated, B1-319+00
- ROCC Radio RTC then instructed Train ID 105 to key down and reverse ends

22:35 hrs. – ROCC Radio RTC confirmed RS 1 location and instructed RS 1 to exit the train and perform a track inspection

22:36 hrs. – RS 1 notified ROCC Radio RTC that he disembarked Train ID 105 and was standing by at B1 319+00. ROCC then gave RS 1 Foul Time to perform a track inspection from his location to B06. ROCC then instructed Train ID 105 to notify them when he keyed up on the Glenmont end

22:39 hrs. – Train ID 173 T/O reported to ROCC Radio RTC they had a head count of 59 customers (not including themself)

22:48 hrs. – RS 2 notified ROCC of his arrival at B06

22:49 hrs. – RS 1 notified ROCC, MTPD was on location. RS 1 notified ROCC that customer struck by train was not displaying any signs of life. RS 1 asked ROCC for foul time to cross back over from Track 2 to Track 1 to clear the scene to the platform

22:51 hrs. – ROCC instructed RS 1 to contact OSC to determine how passenger would be removed from Train ID 173

22:54 hrs. – ROCC granted RS 1 foul time to cross over from Track 2 to Track 1

22:58 hrs. – RS 1 reported to ROCC per MTPD report, customers were evacuated from the consist. (Further investigation revealed, one customer reported minor injuries as a result of the evacuation)

23:42 hrs. – Power RS 1 confirmed 3rd rail was de energized at B2-283+00, B2-284+00 and B2-292+00.

00:44 hrs. – DC Coroner arrived on the incident scene

01:38 hrs. – CMNT reported car 7252 had damage to TWC antenna and inter-car barrier damage

01:55 hrs. – RS 1 reported all personnel and equipment were clear of Track 2 (B06) and requested 3rd rail power be restored on Track 2 only. Power announcements were made in all OPS

02:01 hrs. – RS 1 requested a speed restriction no more than 3mph for incident Train ID 173 to move to B06 platform Track 2

02:08 hrs. – 3rd rail power confirmed energized on Track 2 (B06) and RS 1 was instructed to normalize incident Train 173 by preparing it for transport to Greenbelt Yard

02:12 hrs. – MTPD Liaison reported 3rd rail power could be restored on both Tracks 1 and 2 from B06 to B07

02:13 hrs. – 3rd rail power announcements made

02:14 hrs. – 3rd rail power restored both tracks one and two from B06 to B07

02:19 hrs. – RTRA Superintendent was appointed OSC and requested incident Train ID 173 hold on the platform Track 2 B06 for an additional inspection

02:23 hrs. – RTRA Superintendent reported incident Train ID 173 was to non-revenue to Greenbelt Yard

02:25 hrs. – Incident Train ID 173 moving non-revenue to Greenbelt Yard

02:34 hrs. – RTRA Superintendent reported all personnel and equipment were clear of the roadway and releasing Tracks 1 and Track 2 back to ROCC.

Vehicle Program Services

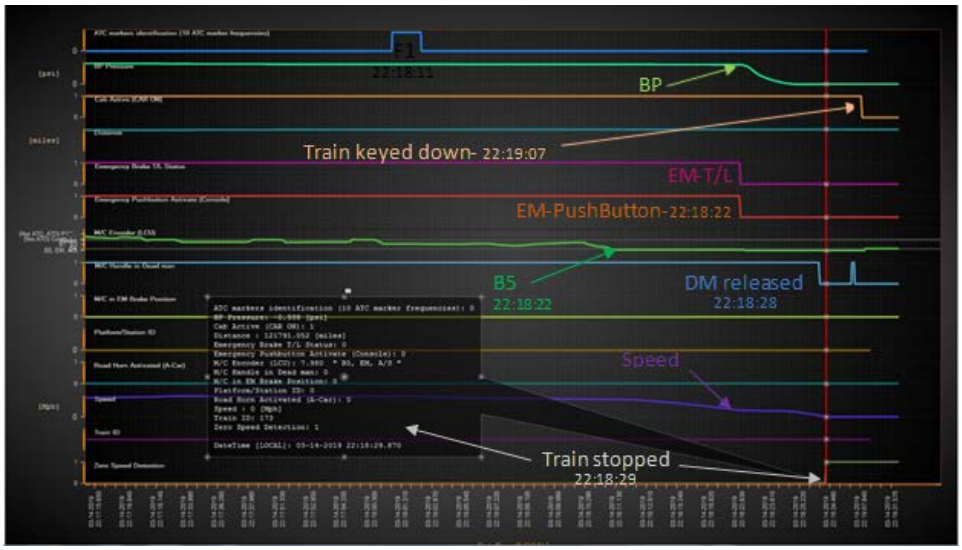
Train ID 173 (**L**7252-53x7213-12x7282-83x7263-62**T**) was taken to Greenbelt Yard where data from the Vehicle Monitoring & Diagnostic System (VMDS), Event Recorder (ER) and Door Monitoring & Control Units (DMCUs) was downloaded. Video imagery was also retrieved from the Network Video Recorders (NVR) on each car. However, no NVR data was captured after (10:18 hrs.) 3rd rail Power de-energized.

Note: Due to the NVR stoppage on Train ID 173 consist, the self-evacuation event was not captured on video. However, station video from B06 corroborated this accident event.

Based on VMDS data analysis, the emergency release handles were not activated on car(s) 7252-53x7213-12x7282-83x7263-62 prior to 22:19 hrs. However, as a result of Third rail power removal in the affected area, the train VMDS did not capture any data after 22:19 hrs.

Therefore, as reported (by the T/O and customers aboard the affected car), it is most probable, the emergency release handle was activated after power was removed and customers subsequently self-evacuated from emergency Door #3 on lead car 7252 to the roadway. All doors were tested operationally and found to be in proper working order. The VMDS did not log any door opening events.

NOTE: Radio and Passenger Announcements (PA)/Intercom System on the incident train car were tested and all found to be operational.



CMNT personnel performed an inspection of the affected consist and did not identify any anomalies with the brake rates, car-borne radio, or PA/intercom system. Refer to attachments 1-2.

NVR and VMDS

The specific circumstances of this incident triggered the CCTV and VMDS system to be de-energized as a function of load-shedding. When the T/O keyed down lead Car 7252 within the affected consist and 3rd rail power de-energized, keying down the car was the trigger for the cameras to stop recording. It was the combination of the car being keyed down and not having 3rd rail voltage that placed the car into Stage C Load-shedding. When the car enters Stage C Load-shedding, multiple systems are de-energized, including the CCTV system and the VMDS. The rail vehicle reacted as designed.

During an individual struck by train event, 3rd rail power is de-energized. Before performing a ground walk around, the T/O must key down. The 7K consist is designed to de-energize respective equipment. If the 3rd rail remained energized, the car would have continued recording. If the T/O remained keyed up, the car would have gone into Stage C Load-shedding when 3rd rail was de-energized, and these systems would have continued recording. If the operator had keyed up in the consist again after 3rd rail power was de-energized, the cars would have gone through a re-inauguration and once that was complete would have begun recording.

Note: Due to the NVR stoppage on Train ID 173 consist, the self-evacuation event was not captured on video. However, station video from B06 corroborated this accident event. 7K

programs reviewed the option to change the load-shed circuits to remain energized during a third rail power and key down during emergency events and CENV deemed this action not feasible per design of the rail vehicle(s).

Based on review of NVR, there is no factual evidence to substantiate the decedents actions e.g., the decedent attempting to move out of the path of the train, or actions prior to the train striking the decedent.

Office of Rail Transportation

Train Operator

The T/O stated during interview, while coming around the bend on approach to B06 station; the T/O saw what appeared to be a bag moving away from the fence line (as if a bag was blowing in the wind). Once the T/O make contact hearing a loud thump sound, the T/O assumed he made contact with a person, initiated full-service braking in conjunction with mushroom emergency braking application. After coming to a complete stop, the T/O notified ROCC of the event. ROCC instructed the T/O to perform a ground walk around to look for signs of life. The T/O stated, he keyed down, performed a radio check, and entered the roadway per ROCC instruction. The T/O further stated, the cab was secured prior to entering the roadway.

Once on the roadway, the T/O reported identifying a customer near the fence line in proximity of the fourth car within the affected consist. The T/O stated, he saw the customers' foot move which indicated to him there were signs of life. The T/O requested permission to re-board the affected consist to make announcements to the customers due to the activity (customers walking through the bulkhead doors in between coupled the consist) observed inside the train from the roadway by the T/O. After receiving permission from ROCC, the T/O stated, once he arrived back to the lead car, customers reportedly stated, an unknown number of customers exited through the side emergency door. The T/O further stated, ROCC Radio RTC instructed the T/O to move the customers to the lead car and perform a head count of all passengers. The T/O stated, there were 59-customers aboard the affected consist. MTPD arrived on location and instructed the T/O to move to the third car in the consist while they assumed control on the event.

Station Manager

During SAFE interview, the Station Manager stated the following. At approximately 2233 hrs. MTPD ran through the gate in the direction of the upper platform. MTPD told the station manager to come on. At this time, the station had no knowledge of the incident and no reports via. phone call or announcement from ROCC or ROIC. Once on the platform, MTPD informed the S/M a customer was reportedly hit by a train. The S/M performed a track bed inspection from the platform, on Track 1. MTPD performed an inspection on Track 2. The S/M stated,

once they identified where the event occurred, approximately 300 ft from the station, the S/M notified ROCC to de-energize power on track 2. The S/M further stated, MTPD identified customers on the roadway in approach to Fort Totten station and subsequently escorted the customers to the platform.

SAFE posed two questions during interview:

1. How often do you observe the camera(s)? Most of the time, I am outside the kiosk assisting customers.
2. Did you see the customer involved in the event? "I did, the customer was having trouble using her Smartrip card. While assisting her with adding money to her card, I asked her why she was out so late", the customer stated, "I am 74 years old, I can do what I want". The customer stated she wanted a bus to go to Anacostia station. The S/M stated, they informed the customer we did not have bus services going to that location. However, you can board the Green Line train in the direction of Branch Avenue Station." The S/M stated, he spoke with the customer for approximately 5 minutes and then directed the customer downstairs to the Green Line and continued to assist other customers. The S/M did state, "the customer was clear about what she wanted, and did not seem confused or disorientated."
3. Did you perform any station checks? **"**I do very few station checks at this location, this is a very busy location with a lot of public issues. 15 station checks are impossible to do with One S/M at this location. Therefore, I stay at the kiosk in case of an emergency."

Managerial Report

RTRA management did not find the T/O at fault as a result of this event.

Metro Transit Police Department

Case Summary:

On Thursday, March 14, 2019 at approximately 22:23 hrs., MTPD Communications was advised an adult female was struck on track 2 by a train. The victim was struck approximately 300 yards beyond the end gate at CM B1-290+00. The operator immediately stopped the train and contacted ROCC. ROCC immediately notified DCFD and MTPD. DCFD arrived and determined the victim showed no signs of life. MTPD arrived and investigated the facts surrounding the event.

Investigation revealed the following:

During the investigation, it was learned the victim exited a Metrobus and enters the B06 Station at approximately 19:45 hrs. Upon her entrance to the station she adds value to her Smartrip card. She attempts to scan her Smartrip card on several gates. She then enters through the fare gates and walks to the yellow line platform. She spends a significant period of time walking aimlessly around the station. She continues this behavior for approximately 3 hours. Note: This is a dual level station with a Mezzanine area (Upper level Red Line, lower level Green and yellow. At approximately 21:56 hrs., she enters onto the roadway via the emergency gate at the end of the red line platform (track 2 side) toward Takoma. She begins to walk northbound between the two track beds. She eventually walks out of camera range. At approximately 22:23 hrs., MTPD received a call from ROCC stating that the operator of train 173 believes he struck a person. Emergency response protocol was conducted. Passengers began to self-evacuate onto the roadway. Upon MTPD's arrival ICS was initiated. Patrons were escorted off the roadway, witnesses were identified, and a perimeter was established.

Once permission to enter the roadway was received DCFD and MTPD units located the decedent next to train car 7283. The decedent's body was laid to rest face down and on the fence side of the track 2. The striking car number was identified as car 7252.

See attached MTPD Report Attachment 3

Closed Circuit Television

Please refer to photos 1-7.

Human Factors

Post-Incident

After reviewing the T/O's post-incident toxicology testing results, it was determined that the T/O was not in violation of the Drug and Alcohol Policy and Testing Program 7.7.3/5.

Fatigue

Based on SAFE's review of the T/O'S 30-day work history, it was determined that the train operator's hours of service were in accordance with WMATA's *Fatigue Risk Management Policy 10.6* and *Hours of Service Limitations for Prevention of Fatigue Policy 10.7* .

Conclusion

Considering all the salient facts, SAFE concludes based on platform CCTV review, the customer entered an unauthorized access point leading down to the roadway walking in the direction

of B07 station, Track 2. This action subsequently resulted in Train ID 173 in approach to B06 station striking the customer approximately 824 feet outside the station. There was no CENV or NVR data to support an improper operation by the T/O of Train ID 173 nor were there any anomalies with the train that may have contributed to the customer struck by train incident.

However, post customer strike, the T/O did not make proper announcements; notifying customers of the delay prior to entering the roadway to perform a ground walk around. Consequently, customers self-evacuated onto the roadway for non-fire life safety reason subsequently resulting in one passenger injury.

Immediate Mitigation to Prevent Recurrence

- Affected consist was removed from service for post incident investigation
- CENV performed CCTV, ER, and VMDS download of affected consist
- T/O was removed from service for post-incident toxicology testing

Corrective Action Plan

No corrective actions were taken as a result of this event.

Photos

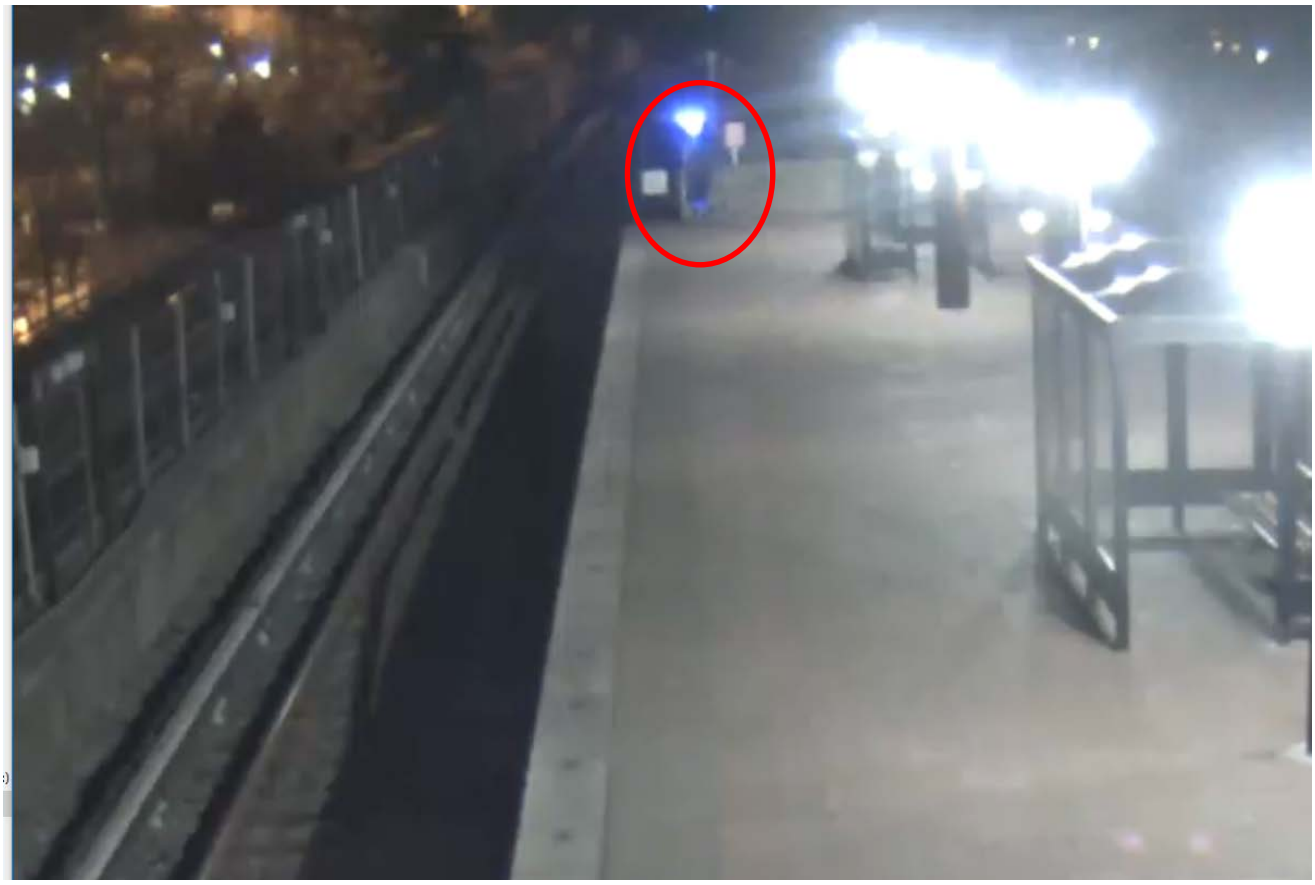


Photo 1 – 21:54:46 the customer enters the roadway via end gate Track 2 at B06 Station

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

Photo 2 – 21:55:20, the customer seen entering the roadway unauthorized on Track 2 in the direction of B05 Station

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

Photo 3 – 21:58:00 hrs., the customer was in between Track 1 and Track 2 walking in the direction of B05 Station

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

Photo 4 – 22:04 hrs., the customer eventually disappears from camera view 4 seconds after the above screenshot of the camera footage while walking between tracks 1 and 2

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

Photo 5 – 22:33 hrs., MTPD initial contact with first 2 self-evacuated customers

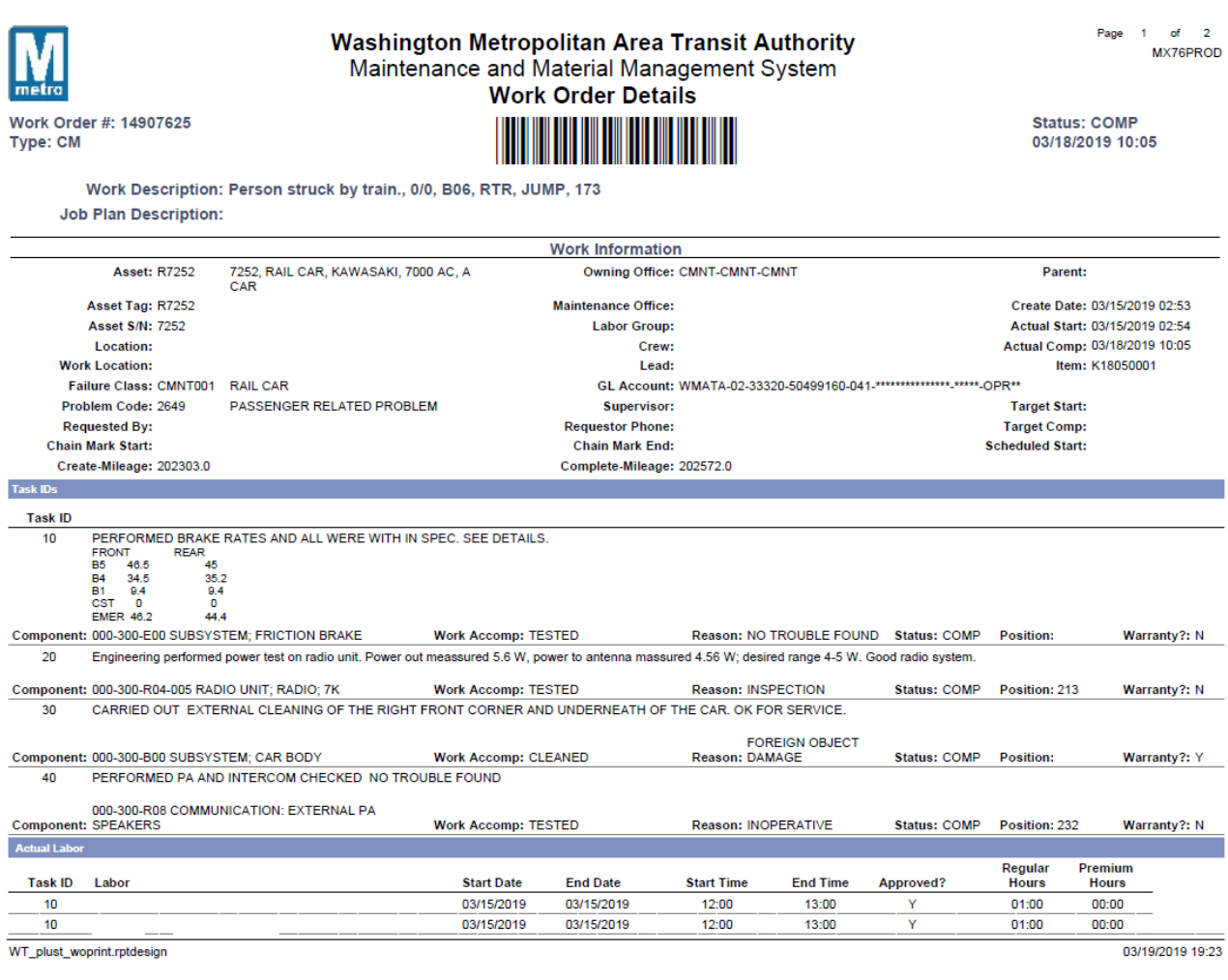
Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

Photo 6 – 14 remaining uncontrolled self-evacuated customers

Photo 7 – 22:58:00 hrs. Controlled evacuation of 59 customers

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

Attachments



Page 1 of 2
MX76PROD

Washington Metropolitan Area Transit Authority
Maintenance and Material Management System
Work Order Details

Work Order #: 14907625
Type: CM

Status: COMP
03/18/2019 10:05

Work Description: Person struck by train., 0/0, B06, RTR, JUMP, 173
Job Plan Description:

Work Information

Asset:	R7252	7252, RAIL CAR, KAWASAKI, 7000 AC, A CAR	**Owning Office:**	CMNT-CMNT-CMNT	**Parent:**
Asset Tag:	R7252		**Maintenance Office:**		**Create Date:** 03/15/2019 02:53
Asset S/N:	7252		**Labor Group:**		**Actual Start:** 03/15/2019 02:54
Location:			**Crew:**		**Actual Comp:** 03/18/2019 10:05
Work Location:			**Lead:**		**Item:** K18050001
Failure Class:	CMNT001	RAIL CAR	**GL Account:**	WMATA-02-33320-50499160-041-**********-*****-OPR**	
Problem Code:	2649	PASSENGER RELATED PROBLEM	**Supervisor:**		**Target Start:**
Requested By:			**Requestor Phone:**		**Target Comp:**
Chain Mark Start:			**Chain Mark End:**		**Scheduled Start:**
Create-Mileage:	202303.0		**Complete-Mileage:**	202572.0	

Task IDs

Task ID							
10	PERFORMED BRAKE RATES AND ALL WERE WITH IN SPEC. SEE DETAILS. FRONT REAR B5 46.5 45 B4 34.5 35.2 B1 9.4 9.4 CST 0 0 EMER 46.2 44.4						
	Component: 000-300-E00 SUBSYSTEM; FRICTION BRAKE	**Work Accomp:** TESTED	**Reason:** NO TROUBLE FOUND	**Status:** COMP	**Position:**	**Warranty?:** N	
20	Engineering performed power test on radio unit. Power out meassured 5.6 W, power to antenna massured 4.56 W; desired range 4-5 W. Good radio system.						
	Component: 000-300-R04-005 RADIO UNIT; RADIO; 7K	**Work Accomp:** TESTED	**Reason:** INSPECTION	**Status:** COMP	**Position:** 213	**Warranty?:** N	
30	CARRIED OUT EXTERNAL CLEANING OF THE RIGHT FRONT CORNER AND UNDERNEATH OF THE CAR. OK FOR SERVICE.						
	Component: 000-300-B00 SUBSYSTEM; CAR BODY	**Work Accomp:** CLEANED	**Reason:** FOREIGN OBJECT DAMAGE	**Status:** COMP	**Position:**	**Warranty?:** Y	
40	PERFORMED PA AND INTERCOM CHECKED NO TROUBLE FOUND						
	Component: 000-300-R08 COMMUNICATION: EXTERNAL PA SPEAKERS	**Work Accomp:** TESTED	**Reason:** INOPERATIVE	**Status:** COMP	**Position:** 232	**Warranty?:** N	

Actual Labor

Task ID	Labor	Start Date	End Date	Start Time	End Time	Approved?	Regular Hours	Premium Hours
10		03/15/2019	03/15/2019	12:00	13:00	Y	01:00	00:00
10		03/15/2019	03/15/2019	12:00	13:00	Y	01:00	00:00

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Attachment 1 – CMNT post-incident inspection workorder page 1 of 2.

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

Washington Metropolitan Area Transit Authority
Maintenance and Material Management System
Work Order Details

Work Order #: 14907625
Type: CM

Status: COMP
03/18/2019 10:05

Work Description: Person struck by train., 0/0, B06, RTR, JUMP, 173
Job Plan Description:

Actual Labor

Task ID	Labor	Start Date	End Date	Start Time	End Time	Approved?	Regular Hours	Premium Hours
20		03/15/2019	03/15/2019	12:30	13:30	Y	01:00	00:00
30		03/15/2019	03/15/2019	16:30	17:30	Y	01:00	00:00
40		03/15/2019	03/15/2019	23:00	23:15	Y	00:15	00:00
						Total Actual Hour/Labor:	04:15	00:00

Related Incidents

Ticket	Description	Class	Status	Relationship
8402441	Person struck by train., 0/0, B06, RTR, JUMP, 173	SR	RESOLVED	ORIGINATOR

Failure Reporting

Cause		Remedy		Supervisor	Remark Date
2476	NO DEFECT; NORMAL SERVICES PERFORMED	3192	TESTED / INSPECTED		03/18/2019
Remarks:	ALL NECESSARY CHECKS PERFORMED AND COMPLIED WITH.				

Attachment 1 – CMNT post-incident inspection workorder page 2 of 2.

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

Washington Metropolitan Area Transit Authority
Maintenance and Material Management System
Work Order Details

Work Order #: 14913014
Type: CM

Status: INPRG
03/18/2019 10:14

Work Description: FRONT END COWLING DAMAGE OPERATORS SIDE
Job Plan Description:

Work Information

Asset: R7252	7252, RAIL CAR, KAWASAKI, 7000 AC, A CAR	**Owning Office:** CMNT-CMNT-CMNT		**Parent:** 14907625	
Asset Tag: R7252		**Maintenance Office:** CMNT-SDYG-INSP		**Create Date:** 03/18/2019 10:05	
Asset S/N: 7252		**Labor Group:** CMNT		**Actual Start:** 03/18/2019 10:14	
Location:		**Crew:**		**Actual Comp:**	
Work Location:		**Lead:**		**Item:** K18050001	
Failure Class: CMNT001	RAIL CAR	**GL Account:** WMATA-02-33320-50499160-041-**********-*****-OPR**			
Problem Code: 1025	ACCIDENT/COLLISION/DERAIL	**Supervisor:**		**Target Start:**	
Requested By:		**Requestor Phone:**		**Target Comp:**	
Chain Mark Start:		**Chain Mark End:**		**Scheduled Start:**	
Create-Mileage: 202572.0		**Complete-Mileage:** 0.0			

Task IDs

Task ID	
10	INSPECTED FRONT END FOR DAMAGE TO COWLING

Component: 000-300-B03-004 FRONT END; CAR END **Work Accomp:** INSPECTED **Reason:** FOREIGN OBJECT DAMAGE **Status:** INPRG **Position:** 213 **Warranty?:** Y

20	REPAIR FRONT END COWLING DAMAGE ALL WORK C/W

Component: 000-300-B03-004 FRONT END; CAR END **Work Accomp:** REPAIRED **Reason:** NO FAILURE **Status:** INPRG **Position:** 213 **Warranty?:** Y

Actual Labor

Task ID	Labor	Start Date	End Date	Start Time	End Time	Approved?	Regular Hours	Premium Hours	Line Cost
10		03/18/2019	03/18/2019	06:00	08:00	N	02:00	00:00	$67.25
20		03/19/2019	03/19/2019	06:00	14:00	N	08:00	00:00	$268.99
20		03/19/2019	03/19/2019	06:00	14:00	N	08:00	00:00	$268.99
20		03/18/2019	03/18/2019	08:00	14:00	N	06:00	00:00	$201.74
						Total Actual Hour/Labor:	24:00	00:00	$806.97

Failure Reporting

Cause		Remedy		Supervisor	Remark Date
1929	FOREIGN OBJECT DAMAGE	2825	REPAIRED		03/18/2019

Remarks: INSPECTED AND REPAIRED ALL FRONT END COWLING DAMAGE ALL WORK C/W

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Attachment 2 – CMNT repair work-order 14913014 page 1 of 1.

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METRO TRANSIT POLICE
CRIMINAL INVESTIGATION DIVISION

Executive Briefing

Person Struck by Train

MTP: 2019

CFS:

Location: Fort Totten Metro Station (track 2 roadway, chain marker B290+00)
550 Galloway Street, NE Washington, DC 20011

Date: Thursday, March 14, 2019

Time: 2223 Hours

Lead Agency:
Metro Transit Police

CID Detective(s):
Lt.
Sgt.
Det. (Lead Detective)
Det.
Det.

On Scene Commander:
Capt.

CSS Technician:
Officer
Officer
Officer
Officer
Officer

Reporting Officer:
Officer

Additional MTPD Personnel:
Captain
Sergeant
Sergeant
Officer
Officer
Officer

Attachment 3 – MTPD Page 1 of 3

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019

METRO TRANSIT POLICE
CRIMINAL INVESTIGATION DIVISION

Executive Briefing

Assisting Agency:
Metropolitan Police Department (MPD)

Case Summary:
On Thursday, March 14, 2019 at approximately 2223 hours, MTPD Communications was advised an adult female was struck on track #2 by a train. The victim was struck approximately 300 yards beyond the end gate at chain marker B290+00. The operator immediately stopped the train and contacted Rail Operations (ROCC). ROCC immediately notified DC Fire (DCFD) and Metro Transit Police (MTPD). DCFD arrived and determined the victim showed no signs of life. MTPD arrived and investigated the facts surrounding the event.

Investigation revealed the following:
During the course of the investigation, it was learned the victim exited a Metrobus and enters the Fort Totten Station at approximately 1945 hours. Upon her entrance to the station she adds value to her Smartrip card. She attempts to scan her Smartrip card on several gates. She then enters through the fare gates and walks to the yellow line platform. She spends a significant period of time walking aimlessly around the station. She continues this behavior for approximately 3 hours. At approximately 2156 hours she enters onto the roadway via the emergency gate at the end of the red line platform (track 2 side) toward Takoma. She begins to walk northbound between the two track beds. She eventually walks out of camera range. At approximately 2223 hours MTPD CD received a call from ROCC stating that the operator of train 173 believes he struck a person. Emergency response protocol was conducted. Passengers began to self-evacuate onto the roadway. Upon MTPD's arrival ICS was initiated. Patrons were escorted off of the roadway, witnesses were identified, and a perimeter was established.

Once permission to enter the roadway was received DCFD and MTPD units located the decedent next to train car 7283. The decedent's body was laid to rest face down and on the fence side of the track 2. The striking car number was identified as #7252. The video from the striking car was recovered by CSS.

DC Homicide Detective was notified of the incident. Based on the preliminary information known at the time Sergeant deferred investigative authority to MTPD.

A DC Identification card matching the physical characteristics of the decedent was located in a fanny pack in close proximity of the body.

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Approval By: SAFE 70 – 07/11/2019

METRO TRANSIT POLICE
CRIMINAL INVESTIGATION DIVISION

Executive Briefing

The Office of the Chief Medical Examiner was notified and three personnel responded to FTTO for processing. Forensic Investigator provided the case number of . The remains of the decedent were then transported by the OCME from the scene.

On 9/18/18 her had contacted MPD to report he was concerned about the safety of his mother.

and responded to the decedent's residence and made a next to kin notification to the decedent's , , and , - at 0230 hours on March 15, 2019. The family reported the decedent had no ongoing physical or psychological issues.

Victim Info:

Drafted By: SAFE 704 – 06/11/2019
Reviewed By: SAFE 701 – 06/26/2019
Approval By: SAFE 70 – 07/11/2019