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Office: 202-384-1520 • Website: www.wmsc.gov

March 24, 2022

Melonie Collette Barrington, Ed.D.
Director, Office of Safety Review
Federal Transit Administration
U.S. Department of Transportation

Dear Ms. Barrington,

Thank you for your letter dated January 11, 2022, which transmitted the Federal Transit Administration's (FTA) final report: the State Safety Oversight Audit of the Washington Metrorail Safety Commission (WMSC). That report required the WMSC to develop corrective action plans, which is the subject of this letter.

Background

On February 22, 2021, the FTA notified us that it would be conducting a triennial audit of the WMSC from April 26, 2021 to April 28, 2021. This audit took place as planned and concluded with two exit briefings: The first exit briefing was held on April 29, 2021, and the second exit briefing was held on May 24, 2021. After both exit briefings, the WMSC provided additional information and documents.

On December 7, 2021, the WMSC received your letter transmitting the draft report, which provided the WMSC with "10 business days to review the draft SSO audit report for errors of fact and to submit factual corrections to FTA." The WMSC responded with a letter from me dated December 20, 2021.

On January 11, 2022, the WMSC received the final report, as noted above. The January 11, 2022 letter and accompanying report provided the WMSC with 45 business days to develop corrective action plans in response to the FTA's 11 findings. Excluding two federal holidays, that resulted in a deadline of March 18, 2022, which was subsequently extended to March 24, 2022 through an email from Ruth Lyons dated February 18, 2022.

Resolution of Findings

Through conversations with FTA leadership on January 19, 2022, and in greater detail on February 14, 2022, the WMSC and FTA agreed on a general path forward to resolve the open findings. As a direct result of those conversations, the FTA closed three of the eleven findings (4, 9, and 10) and provided direction on how to resolve the remaining eight open findings (1, 2, 3, 5, 6, 7, 8, and 11).

Since the February discussion, the WMSC has carefully worked to address each of the remaining open findings. Attached with this letter, please find the WMSC's corrective action plans that address the eight remaining open findings. Based on these attached plans, the WMSC requests closure of the remaining findings.

The WMSC thanks the FTA for the opportunity to present these corrective action plans. Please feel free to contact me with any questions.

Sincerely,

David L. Mayer, Ph.D.
Chief Executive Officer

Enclosures:

Finding 1 Corrective Action Plan
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WMSC Finding 1

Corrective Action Plan



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Corrective Action Plan for the Washington Metrorail Safety Commission

On January 11, 2022, the Federal Transit Administration (FTA) issued its final report for the State Safety Audit of the Washington Metrorail Safety Commission (WMSC). That report detailed 11 findings, this corrective action plan addresses finding 1.

Finding 1: WMSC did not document the staffing levels needed for the SSO program.

Required Action: WMSC must develop, submit, and implement a revised workload assessment that reflects an appropriate staffing level for overseeing the WMATA.

Corrective Action Plan: As part of the Program Standard review and update (expected to occur at the WMSC's June 28, 2022 Public Meeting), new language will be added incorporating the workload assessment into the annual WMSC budget process or as needed based on programmatic changes.

WMSC Finding 2

Corrective Action Plan



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Corrective Action Plan for the Washington Metrorail Safety Commission

On January 11, 2022, the Federal Transit Administration (FTA) issued its final report for the State Safety Audit of the Washington Metrorail Safety Commission (WMSC). That report detailed 11 findings, this corrective action plan addresses finding 2.

Finding 2: WMSC did not have a documented process for review and approval of WMATA's PTASP.

Required Action: WMSC must develop, submit, and implement a documented process for reviewing and approving WMATA's PTASP.

Corrective Action Plan: As part of the Program Standard review and update (expected to occur at the WMSC's June 28, 2022 Public Meeting), the PTASP review and update section will be revised to clearly document the process for reviewing and approving WMATA's PTASP. This revision will also clearly require that both the WMSC and WMATA will use the FTA's SSOA PTASP Checklist during these annual reviews.

WMSC Finding 3

Corrective Action Plan



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Corrective Action Plan for the Washington Metrorail Safety Commission

On January 11, 2022, the Federal Transit Administration (FTA) issued its final report for the State Safety Audit of the Washington Metrorail Safety Commission (WMSC). That report detailed 11 findings, this corrective action plan addresses finding 3.

Finding 3: WMSC did not ensure that all elements of the PTASP were internally reviewed and that CAPs resulting from internal safety review findings were approved.

Required Action: WMSC must ensure that WMATA conducts internal reviews for all PTASP elements and that resulting CAPs are submitted, reviewed, approved, and tracked.

Corrective Action Plan: Please refer to WMATA's 3-year Internal Safety Review schedule with all PTASP elements mapped. (See Finding 3 CAP Attachment.)

WMSC Finding 3
Corrective Action Plan

Attachment

WMSC Finding 5

Corrective Action Plan



Corrective Action Plan for the Washington Metrorail Safety Commission

On January 11, 2022, the Federal Transit Administration (FTA) issued its final report for the State Safety Audit of the Washington Metrorail Safety Commission (WMSC). That report detailed 11 findings, this corrective action plan addresses finding 5.

Finding 5: WMSC did not ensure investigations were conducted for all accidents.

Required Action: WMSC must submit and implement a process that ensures all accidents are investigated as required.

Corrective Action Plan: The final report cited three investigation reports in Table 8.2 on p. 26:

7/17/19 (A-1) This corresponds to investigation report E19374 (See Finding 5 CAP Attachment A), which was adopted as part of the WMSC's March 12, 2020 Public Meeting consent agenda (see Finding 5 CAP Attachment C, meeting minutes are adopted at the subsequent public meeting).

7/23/19 (A-1) This corresponds to investigation report E19392 (See Finding 5 CAP Attachment B), which was adopted as part of the WMSC's March 12, 2020 Public Meeting consent agenda (see Finding 5 CAP Attachment C, meeting minutes are adopted at the subsequent public meeting).

12/16/20 (A-3) was adopted at the WMSC's December 16, 2020 public meeting. (See Finding 5 CAP Attachment D.)

WMSC Finding 5
Corrective Action Plan

Attachment A

Washington Metropolitan Area Transit Authority

Department of Safety & Environmental Management

FINAL REPORT OF INVESTIGATION A&I E19374

SMS 20190717#81543

Date of Event:	07/17/2019
Type of Event:	Customer Fatality
Incident Time:	13:50 hrs.
Location:	Dunn Loring, Track 2
Time and How received by SAFE:	13:51 hrs. 07/17/2019, SAFE Hot Line Phone
Safety Officer Response:	SAFE 704
Time of Safety Officer Arrival:	07/17/2019 – 14:57 hrs.
Time of Safety Officer Departure:	07/17/2019 – 16:45 hrs.
Rail Vehicle:	L7090 -91x7521-20x7472-73x7461-60T
Injuries:	Fatal Injury
Damage:	7090-TWC antenna was found broken
Emergency Responders:	Metro Transit Police Department (MTPD), Office of Car Maintenance (CMNT), Office of Rail Transportation (RTRA), Safety and Environmental Management (SAFE), Fairfax County Fire Department (FCFD)

Executive Summary

On Wednesday, July 17, 2019, at approximately 13:51 hrs., Rail Operations Control Center (ROCC) notified SAFE that at 13:50 hrs., Train ID 912, an outbound Orange Line train in the direction of Vienna station reported striking a person at Dunn Loring Station, Track 2. Fairfax County Fire Department (FCFD) personnel were on the scene and removed the Customer from the roadway at 14:43 hrs. The Customer subsequently succumbed to their injuries. The incident consist (7090-91x7521-20x7472-73x7461-60) was removed from service for post-incident investigation. The Train Operator (T/O) was transported to Inova Fairfax Hospital for further medical evaluation. Orange Line Train Shuttles were established between West Falls Church and Vienna Stations via Track 1 at 14:15 hrs.

On scene Safety Officer, performed an inspection of the station after the incident. There were no observable hazards associated with any of the station components that were identified as a causal factor in the event.

The consist was subsequently transported to West Falls Church Yard for post-incident inspection. The Crisis Management Center (CMC) was notified at 14:23 hrs.

Based on Closed Circuit Television (CCTV) recording playback of the Dunn Loring station platform, the following information was revealed:

- Customer stood at the entrance end of the platform
- When the train entered the station, the Customer intentionally placed himself in the path of the train.
- FCFD performed rescue efforts and removed the injured Customer from under rail Car 7090.

Considering all the salient facts, after platform video review, SAFE concludes, the Customer intentionally placed himself into the path of the oncoming outbound train that resulted in the oncoming rail vehicle making contact with the customer. While being transported to Inova Fairfax Hospital, the Customer succumbed to their injuries.

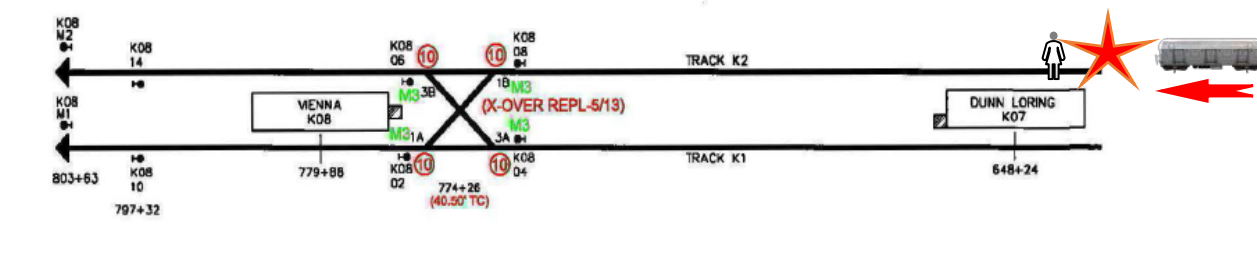
Notification

Title	Time	Comment:
WMSC	14:28 hrs.	Email Notification
CMC	14:23 hrs.	Phone Call

Incident Site

Dunn Loring, Track 2

Field Sketch/Schematics



Investigation

On Wednesday, July 17, 2019, Train ID 912, an outbound Orange Line train was on the approach to Dunn Loring station, Track 2. A Customer intentionally placed himself in front of the train as the train entered the station limits. According to Audio Recording System (ARS) radio communication playback, the T/O notified ROCC of the incident at 13:48 hrs. 3rd Rail power was de-energized at Dunn Loring, Track 2 at 13:49 hrs., according to Advance Information Management System (AIMS) data. ROCC instructed the T/O to perform a ground walk around and to check for signs of life if possible. An RTRA Supervisor present at Dunn Loring Station assisted onboard Customers in a controlled offload onto the station platform.

An MTPD Officer was also located at Dunn Loring Station and began to secure the perimeter of the accident scene. Fairfax County Fire Department (FCFD) arrived on the scene at 13:59 hrs. and the injured Customer was located under the first car 7090. The FCFD performed rescue efforts and subsequently transported the injured Customer to Inova Fairfax Hospital. During transport, the Customer succumbed to their injuries. Orange Line single-track operation commenced between West Falls and Vienna Stations via Track 1 at 14:02 hrs.

Reportedly after the accident event occurred, the T/O felt ill and requested medical assistance at 14:17 hrs. the T/O was subsequently transported to Inova Fairfax Hospital for further medical evaluation.

The RTRA Supervisor performed an exterior inspection and reported no apparent damage. The FCFD cleared the scene and relinquished authority to MTPD at approximately 15:25 hrs. MTPD and RTRA personnel deemed the affected consist safe

for movement and transported the affected consist to Vienna Station for preliminary inspection by CMNT personnel prior to transport to West Falls Church Yard. The CMNT personnel performed an exterior inspection and reported no apparent damage. The train was transported to West Falls Church Yard at 16:20 hrs. for post incident inspection and was stored on Track 1C. ROCC restored 3rd rail power to Track 2 At 16:18 hrs., and regular revenue service resumed.

The CMNT personnel performed under-car cleaning and inspection on car 7090 in the Service and Inspection Facility (S&I Shop) at West Falls Church Yard. During the inspection, a TWC antenna was found broken. CMNT personnel replaced and tested the TWC antenna and performed brake rates testing. All were found to be within WMATA specifications. Shop personnel performed an under-car inspection on event consist. No damage was found.

Interviews/Statements:

Office of Rail Transportation (RTRA)

Train Operator was not available for interview because the T/O requested medical assistance and was transported to Inova Fairfax Hospital.

Office of Car Maintenance

The Road Mechanic R/M was able to perform the walk-around inspection on the affected consist after ROCC personnel transported the train to Vienna and found no apparent damage. CMNT personnel transported the affected consist to West Falls Church Yard's S&I Shop for further investigation.

Closed Circuit Television

After a review of CCTV footage, SAFE determined there were no slip/trip hazards associated with this event. The Customer intentionally placed himself into the path of the oncoming outbound train.

Weather

At the time of the incident, the temperature was 97° F, and clear. SAFE has concluded that weather was not a contributing factor in this incident (Weather source: National Oceanic Atmospheric Administration (NOAA) – Location: Merrifield, VA.)

Findings

- CCTV recording shows Customer:
 - Standing alone at the entrance end of the Dunn Loring station platform and intentionally jumping off the platform and into the path of the oncoming train (landing on roadway)

Conclusion

Considering all the salient facts, after platform video review, SAFE concludes, the Customer intentionally placed themselves into the path of the oncoming outbound train that resulted in the oncoming rail vehicle making contact with the customer. While being transported to Inova Fairfax Hospital, the Customer succumbed to their injuries.

Corrective Action

No further actions recommended at this time.

WMSC Finding 5
Corrective Action Plan

Attachment B

FINAL REPORT OF INVESTIGATION A&I E19392**SMS 20190724#81713**

Date of Event:	7/23/2019
Type of Event:	Customer Fatality
Incident Time:	22:03 hrs.
Location:	Anacostia Station, Track 2
Time and How received by SAFE:	22:08 hrs., 7/23/2019, SAFE on Call Phone
Safety Officer Response:	N/A
Time of Safety Officer Arrival:	N/A
Time of Safety Officer Departure:	N/A
Rail Vehicle:	L7668 -7669.7547-7546.7430-7431.7573-7572
Injuries:	Fatal Injury
Damage:	N/A
Emergency Responders:	Metro Transit Police Department (MTPD), Office of Car Maintenance (CMNT), Office of Rail Transportation (RTRA), District of Columbia Fire Department (DCFD)

Executive Summary

On Tuesday, July 23, 2019, at 22:08 hrs., Rail Operations Control Center (ROCC) notified SAFE that at approximately 22:03 hrs., ROCC received a report of a person struck by Train ID 510 outbound Green Line Train at Anacostia Station, Track 2. Upon Close Circuit Television (CCTV) review, the customer was observed sitting on a bench and later walking towards the platform's edge of Track 2. As the train approached the station, the customer placed themselves within the dynamic envelope (front) of the oncoming train making contact with the left front carbody area. This action resulted in the customer being knocked back onto the platform after being struck by the train.

Third-rail power was de-energized. The incident train was offloaded and remained on the platform. The District of Columbia Fire Department (DCFD) personnel responded to the scene. Single tracking commenced between Navy Yard and Anacostia via Track 1. The customer was transported to Howard University Hospital and subsequently succumbed to the injuries.

Based on CCTV recording playback of Anacostia Station platform, it revealed the following information related to the customer struck by train event:

- The customer appeared to be traveling alone
- The customer was sitting on a platform bench, stood up as the platform edge lights started to illuminate, and waited for the oncoming train
- When the train entered the station, the customer intentionally placed themselves in the path of the oncoming train
- DCFD performed rescue efforts and removed the injured customer from the platform.

Considering all the salient facts, after platform video review, SAFE concludes, the Customer intentionally placed themselves into the path of the oncoming outbound train that resulted in the oncoming rail vehicle making contact with the customer.

The Anacostia Station Manager performed an inspection of the station after the incident. Reportedly, there were no observable hazards associated with any of the station components. In addition, there were no tripping hazards identified. All station Emergency Trip System (ETS) and Public Address (PA) system were reported operational by WMATA Communication Department.

The consist was transported to Branch Avenue (F99) Yard for post-incident inspection.

Crisis Management Center (CMC) was notified at 00:13 hrs.

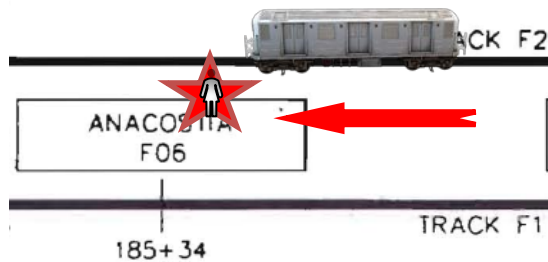
Notification

Title	Time	Comment:
WMSC	00:11 hrs.	Phone/Email Notification
CMC	00:13 hrs.	Phone Notification

Incident Site

Anacostia Station, Track 2

Field Sketch/Schematics



Investigation

On Tuesday, July 23, 2019, Train ID 510, an outbound Green Line Train was on approach to Anacostia Station, Track 2. As the consist entered the station, a customer intentionally placed themselves in the front of the train from the platform area. Upon further review of CCTV footage, the customer was observed sitting on a bench and later walking towards the platform's edge on Track 2. As the train approached the station, the customer placed themselves within the dynamics envelope (front) of the oncoming train and made contact with the left front carbody area. As a result, the customer was knocked back on the platform after being struck by the affected train.

The DCFD transported the injured customer to Howard University Hospital, where they succumbed to their injuries as a result of the incident.

CMNT personnel performed an exterior inspection on the affected car at Branch Ave Yard and identified no defects or anomalies that would have contributed to this event.

Office of Rail Transportation (RTRA)

After further investigation, RTRA determined the T/O actions were in accordance to Metrorail Safety Rules and Procedures Handbook (MSRPH). Therefore, RTRA excluded the T/O as a contributing factor for this event.

Office of Car Maintenance

CMNT personnel performed an exterior and interior inspection of the affected car, no anomalies found.

Closed Circuit Television

After a review of CCTV footage, SAFE determined that there were no slip/trip hazards associated with this event. The customer intentionally placed themselves within the dynamic envelope of the train.

Human Factors

Years of Service

The WMATA employee has 8 years of service. The T/O certification was current at the time of incident and possessed a valid Road Way Protection (RWP) Level 2 ID. The T/O did not have any operational incidents in the last 3 years and was familiar with the Green Line.

Fatigue

Based on SAFE's review of the T/O's 30-day work history, it was determined that the T/O'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*.

Post-Incident

After reviewing the T/O's post-incident 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, therefore, being under the influence of a controlled substance has been excluded as a contributing factor.

Weather

At the time of the incident, the temperature was 74°F above ground, and SAFE has concluded that weather was not a contributing factor in this incident (Weather source: National Oceanic Atmospheric Administration (NOAA) – Location: Washington, DC.)

Findings

- CCTV recording shows:
 - The customer appeared to be traveling alone
 - The customer was sitting on a bench, stood as the train approached the station and intentionally placed themselves in the path of the train

Conclusion

Based on the salient facts as part of this investigation, CCTV, footage, and interview, SAFE concludes, the customer intentionally placed themselves onto the roadway fouling the dynamic envelope of the train subsequently succumbing to their injuries as a result of this event.

In addition, SAFE further concludes that based on post incident inspection of the station performed by the Station Manager, there were no observable hazards associated with any of the station components or tripping hazards identified. All station Emergency Trip System (ETS) and Public Address (PA) system were reported operational by WMATA Communication Department.

In closing, CENV and CMNT performed a post-incident inspection of the affected-consist and no operational anomalies were identified. Considering all the facts gathered from this investigation, SAFE recommends closure of E19392.

Corrective Action

No Corrective Actions required.

WMSC Finding 5
Corrective Action Plan

Attachment C

WMSC Finding 5
Corrective Action Plan

Attachment D

WMSC Finding 6

Corrective Action Plan



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Corrective Action Plan for the Washington Metrorail Safety Commission

On January 11, 2022, the Federal Transit Administration (FTA) issued its final report for the State Safety Audit of the Washington Metrorail Safety Commission (WMSC). That report detailed 11 findings, this corrective action plan addresses finding 6.

Finding 6: WMSC did not formally adopt all investigation reports.

Required Action: WMSC must submit and implement a process that ensures accident reports are formally adopted.

Corrective Action Plan: Please refer to the corrective action plan and attachments for finding 5.

WMSC Finding 7

Corrective Action Plan



Corrective Action Plan for the Washington Metrorail Safety Commission

On January 11, 2022, the Federal Transit Administration (FTA) issued its final report for the State Safety Audit of the Washington Metrorail Safety Commission (WMSC). That report detailed 11 findings, this corrective action plan addresses finding 7.

Finding 7: WMSC did not have a process and criteria for conducting a complete audit of WMATA's compliance with its PTASP, particularly for auditing random drug and alcohol testing.

Required Action: WMSC must develop and implement a process and criteria for conducting a complete audit of WMATA's compliance with its PTASP at least once every three years.

Corrective Action Plan: The WMSC's process and criteria for conducting a complete audit of WMATA's compliance with its PTASP at least once every three years is as follows:

The WMSC bases its audits on verifying implementation of WMATA's PTASP through review of WMATA's existing plans and procedures, and by relying on the FTA's Best Practices for Conducting Three-Year Reviews and American Public Transportation Association standards.

The WMSC's audit criteria are specified in the Program Standard including specifically Section 5.C.2 of the June 1 Program Standard (which remains unchanged in the current version dated December 9, 2021). As required by 49 CFR Parts 673 and 674, these criteria specify, among other things, that the WMSC issues findings when Metrorail is not compliant with its own written requirements. The WMSC's audit criteria were informed by ISO 19011, Guidelines for Auditing Management Systems section 5.5.2 Defining the objectives, scope and criteria for an individual audit:

"The audit criteria are used as a reference against which conformity is determined. These may include one or more of the following: applicable policies, processes, procedures, performance criteria including objectives, statutory and regulatory requirements, management system requirements, information regarding the context and the risks and opportunities as determined by the auditee (including relevant external/internal interested parties requirements), sector codes of conduct or other planned arrangements."

These best practices are consistent with, and provide specificity to, the requirements set forth at 49 U.S.C. 5329(e) and (f) and at 49 CFR section 674.31.

The WMSC audits all aspects of WMATA’s Public Transportation Agency Safety Plan (PTASP) on a triennial basis. To achieve this, the WMSC conducts several distinct audits that are organized by topic area so that the WMSC can comprehensively audit all relevant portions of the effective safety plan(s) when meeting with that topic area’s relevant departments. For example, an audit of equipment maintenance includes discussion on the department’s methods for addressing hazards, trending of failures, and completing training—all of which span multiple elements of the SSPP as well as multiple components of the PTASP and SMS. Each audit covers several elements and elements may be covered by several audits multiple times but in different contexts. The WMSC tracks SSPP and PTASP “elements” as illustrated in WMSC finding 7 CAP Attachment. In addition, as part of the Program Standard review and update (expected to occur at the WMSC’s June 28, 2022 Public Meeting), the PTASP elements will be listed in the revised Program Standard.

WMSC Finding 8

Corrective Action Plan



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Corrective Action Plan for the Washington Metrorail Safety Commission

On January 11, 2022, the Federal Transit Administration (FTA) issued its final report for the State Safety Audit of the Washington Metrorail Safety Commission (WMSC). That report detailed 11 findings, this corrective action plan addresses finding 8.

Finding 8: WMSC did not conduct a complete triennial audit of WMATA's PTASP.

Required Action: WMSC must ensure that the triennial audit reviews all PTASP elements.

Corrective Action Plan: Please see WMSC Finding 8 CAP Attachment, which shows the SSPP and PTASP elements covered by each audit during the WMSC's first triennial audit cycle (2019–2022).

WMSC Finding 8
Corrective Action Plan

Attachment

2019-2022 Triennial Cycle 1 Elements Tracker

**WMATA's Transit Agency Safety Plan (i.e. PTASP) first took effect on December 31, 2020. The WMSC will consider elements for both the SSPP and the PTASP through the conclusion of this first triennial cycle based on the plan in effect at the time under evaluation.*

[illegible]

[illegible]

PTASP Elements

Yes	1. Safety Management Policy								
Yes	a. Safety performance targets								
Yes	b. Annual review and update of ASP								
Yes	c. Organizational SMS Accountabilities and Responsibilities								
Yes	d. Functional area common SMS responsibilities								

Yes	e. Functional area specific SMS responsibilities								
Yes	i. Executive level responsibilities								
Yes	ii. Technical Management level								
Yes	iii. Front Line and Represented Employees								
Yes	iv. Safety risk coordinators (key personnel)								
Yes	f. Accountable Executive responsibilities								
Yes	g. SMS documentation								
Yes	2. Safety Risk Management								
Yes	a. Safety Risk Management (SRM) process for all system elements								
Yes	b. Risk Assessment Process								
Yes	c. Risk assessment methodology								
Yes	d. Hazard identification								
Yes	e. Hazard investigation								
Yes	f. Hazard analysis and evaluation of safety risk								

Yes	g. Hazard resolution (mitigation, elimination)								
Yes	h. Hazard tracking								
Yes	3. Safety Assurance								
Yes	a. Systematic, integrated data monitoring and recording of safety performance								
Yes	b. Real-time assessment with timely information as to safety management and performance								
Yes	c. Internal safety reviews								
Yes	d. Departmental controls								
Yes	e. Compliance and sufficiency monitoring								
Yes	f. Document assurance activities								
Yes	g. Preventive, Predictive, and Corrective Maintenance								
Yes	h. Event reporting/investigations								
Yes	i. Change management								

Yes	j. Safety and Security Certification								
Yes	k. Corrective action plans								
Yes	4. Safety Promotion								
Yes	a. Training								
Yes	i. Competencies and Training								
Yes	ii. Employee Safety Training								
Yes	iii. Safety Rules and Procedures Training								
Yes	iv. SMS-specific training requirements								
Yes	v. Training Recordkeeping and Compliance with Training Requirements								
Yes	b. Contractor Safety								
Yes	c. Safety Communications								
Yes	d. hazard and safety risk information								
Yes	e. safety committees								
Yes	f. hazardous materials								

Yes

Yes

Yes

Yes

g. Environmental management

h. Drug and Alcohol Compliance

WMSC Finding 11

Corrective Action Plan



Corrective Action Plan for the Washington Metrorail Safety Commission

On January 11, 2022, the Federal Transit Administration (FTA) issued its final report for the State Safety Audit of the Washington Metrorail Safety Commission (WMSC). That report detailed 11 findings, this corrective action plan addresses finding 11.

Finding 11: WMSC submitted an annual report that did not accurately contain all required information.

Required Action: WMSC must review the 2020 annual report and ensure that the annual report contains all required elements.

Corrective Action Plan: The WMSC submitted its annual report via FTA's State Safety Oversight Reporting tool (SSOR) without errors on March 15, 2022 as required. Based on the accuracy of this submission, the fulfillment of all annual requirements, and the commitment to continue this result in future years, the WMSC has performed the required action.