



## **WMSC Commissioner Brief: W-0168 – Collision – Fort Totten Station – February 25, 2022**

*Prepared for Washington Metrorail Safety Commission meeting on June 28, 2022*

### **Safety event summary:**

A Metrorail train struck a rider who, while waiting on the Yellow and Green Line platform at Fort Totten Station, had leaned slightly over the edge of the platform apparently to look for the approaching train. However, the rider was not looking in the correct direction, and video shows Train 301 struck the rider in the back of the head.

The Train Operator had a restricted view approaching the station platform due to a curve that ends within the platform limits. The Train Operator was travelling at 31 mph entering the station, which is below Metrorail's 40 mph limit on station entry speed.

The Train Operator continued to the end of the platform, stopped the train and serviced the station. The Train Operator then reported that they had felt a thud against the lead car of the train, which they thought at first was from a passenger making contact with the operator's cab door. The Rail Traffic Controller instructed the Train Operator to investigate.

Riders on the platform and a Metro Transit Police Department (MTPD) Officer initially saw and attempted to assist the injured rider on the platform. The MTPD Officer requested medical assistance and reported to the Train Operator that the person may have been struck by the train. The ROCC Operations Manager notified the D.C. Office of Unified Communications (911 center) and a response for an injured person was dispatched approximately three minutes after the person was struck. Approximately nine minutes after the person was struck, the Rail Operations Control Center (ROCC) Operations Manager called to report a person struck by a train on the lower-level platform. The dispatcher alerted the units already dispatched to the station of the new information and dispatched a rescue alarm (which is a specific scale of response) to the station.

The person struck was released from the hospital the following day.

### **Probable Cause:**

The probable cause of this event was a Metrorail rider unintentionally leaning over the roadway as a train entered the station.

### **Corrective Actions:**

Metrorail made no specific corrective actions.

### **WMSC staff observations:**

Metrorail currently has mitigations throughout the system such as bumpy tiles and flashing lights in place. WMATA also makes periodic automated Public Address system (PA) announcements as trains are approaching the platform, asking passengers to stay behind the tactile strip/bumpy tiles until trains have come to a complete stop at the platform.



Washington Metro Area Transit Authority

Department of Safety (SAFE)

**FINAL REPORT OF INVESTIGATION A&I E22124**

<b>Date of Event:</b>	02/25/2022
<b>Type of Event:</b>	Person Struck by Train
<b>Incident Time:</b>	15:22 hours
<b>Location:</b>	Fort Totten Station, Track 2 Lower Level
<b>Time and how received by SAFE:</b>	15:25 hours, SAFE MAC
<b>WMSC Notification Time:</b>	16:43 hours
<b>Event Scene Release</b>	16:39 hours, WMSC
<b>Responding Safety Officers:</b>	WMATA SAFE: No WMSC: No Other: N/A
<b>Rail Vehicle:</b>	Train ID 301 L2065-2064.2060-2061.3000-3001T
<b>Injuries:</b>	One transport for medical attention, minor injury.
<b>Damage:</b>	None
<b>Emergency Responders:</b>	Office of Rail Transportation (RTRA), Metro Transit Police Department (MTPD), District of Columbia Fire and Emergency Services (DCFEMS), and Office of Car Maintenance (CMNT).
<b>SMS I/A Incident Number:</b>	20220225#8655MX

Fort Totton Station  
February 25, 2022  
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## Abbreviations and Acronyms

<b>AIMS</b>	Advanced Information Management System
<b>ATC</b>	Automatic Train Control
<b>ARS</b>	Audio Recording Service
<b>CAD</b>	Computer-Aided Dispatch
<b>CCTV</b>	Closed Circuit Television
<b>CENV</b>	Vehicle Program Services
<b>CSS</b>	Crime Scene Search
<b>DCFEMS</b>	District of Columbia Fire and Emergency Medical Services
<b>ER</b>	Event Recorder
<b>ESR</b>	Event Scene Release
<b>ICP</b>	Incident Command Post
<b>MAC</b>	Mission Assurance Coordinator
<b>MC</b>	Master Controller
<b>MOC</b>	Maintenance Operations Center
<b>MSRPH</b>	Metrorail Safety Rules and Procedures Handbook
<b>MTPD</b>	Metro Transit Police Department
<b>OSC</b>	On-scene Commander
<b>ROC</b>	Rail Operations Control
<b>ROCC</b>	Rail Operations Control Center
<b>RTC</b>	Rail Traffic Controller
<b>RTRA</b>	Office of Rail Transportation
<b>SOP</b>	Standard Operating Procedure
<b>VMS</b>	Vehicle Monitoring System
<b>WMSC</b>	Washington Metrorail Safety Commission

**Washington Metropolitan Area Transit Authority (WMATA)**  
**Department of Safety & Environmental Management (SAFE)**

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**Executive Summary**

At approximately 15:22 hours on February 25, 2022, a Yellow Line train [Train ID 301] on Track 2, traveling in the direction of Huntington Station, entered Fort Totten Station platform limits. Upon entering the platform, Train ID 301 struck a customer who unintentionally placed their head within the train's dynamic envelope while positioned near the approach end of the platform limits. The train traveled at approximately 31mph and properly berthed their train at the 8-car maker. At approximately 15:25 hours, the Train Operator of ID 301 notified the Rail Operations Control Center (ROCC) that they felt a thud against their train on the lead car. The Train Operator initially thought the thud was from a passenger making contact with the operator's cab door. The ROCC Radio Rail Traffic Controller (RTC) instructed the Train Operator to key down their train and investigate. Customers on the platform and a Metro Transit Police Department (MTPD) Officer initially responded to and assisted the injured customer, who remained on the platform after being struck. The Radio RTC established Standard Operating Procedure (SOP 1A) at approximately 15:28 hours.

The Train Operator notified the Rail Radio RTC that a person was unconscious with signs of life on the platform. MTPD reported that the person may have been struck by the train. Upon receiving notification from the Mission Assurance Coordinator (MAC), the Office of Safety Investigation (OSI) reviewed Fort Totten Station's platform Closed Circuit Television (CCTV) and determined the person was near the approach end of the station, leaned into the dynamic envelope of the train and appeared to be looking down the platform away from the train as it entered the platform.

The District of Columbia Fire and Emergency Medical Services (DCFEMS) communications dispatched EMS personnel to Fort Totten Station at approximately 15:25 hours. At approximately 15:35 hours, DCFEMS dispatched additional units for a person struck by a train after receiving a call from the ROCC Operations Manager (OM). DCFEMS transported the customer to a nearby hospital. The person was released from the hospital on February 26, 2022.

There were no reported injuries to persons aboard the train or WMATA personnel. RTRA removed the Train Operator from service for post-incident toxicology testing and subsequent MTPD interview. The Washington Metrorail Safety Commission (WMSC) authorized the Event Scene Release (ESR) at 16:39 hours. At approximately 16:46 hours, Train ID 301 was re-blocked to Train ID 701 and transported to Greenbelt Yard for post-incident investigation.

The probable cause of the Fort Totten Station person struck by train event was that a customer unintentionally entered the train's dynamic envelope near the approach end of the station entrance as the train was entering the station.

An analysis of data collected from the system data recording and documentation review determined that no safety deficiencies related to any WMATA station facility or rail vehicle failures contributed to the person being struck by the train. An examination of VMS data revealed that the Train Operator of Train ID 301 was operating at nominal speeds before striking the person.

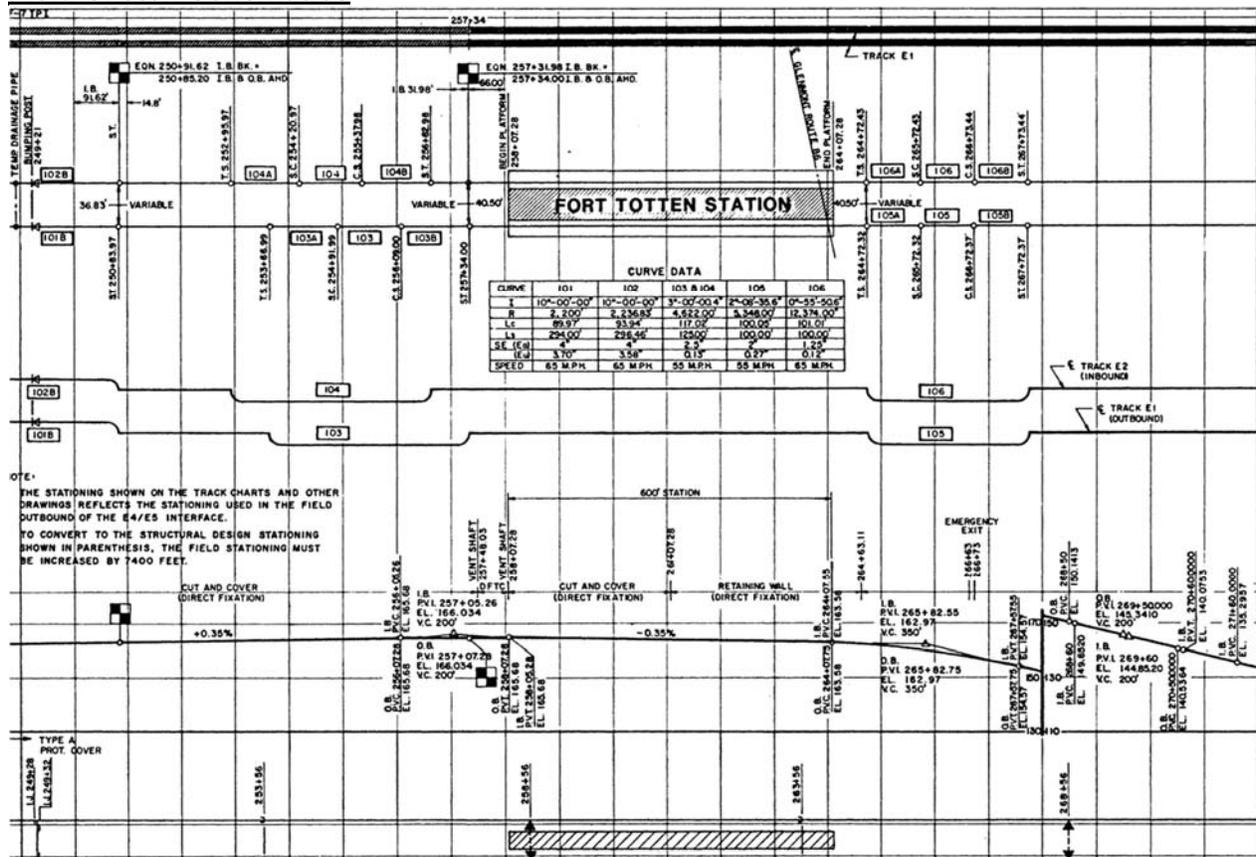
A review of the incident response actions revealed no challenges with the transfer of command between DCFEMS, MTPD and Rail. There were no significant findings related to non-compliance to the SOP1A Command, Control, and Coordination of emergencies.

## Incident Site

Fort Totten Station, Track 2  
 Direct Fixation Track  
 Length of Curve – 100.05'  
 The Radius of Curve – 5.348'  
 Elevation – 163.5  
 Point of Vertical Intersect – E2 - 265+82  
 Point of Vertical Curve – E2 - 264+07 Beginning of Platform Limits  
 Point of Vertical Tangent – E2 - 267+57

The WMATA Quick Access Guide shows a restricted view curve on the Fort Totten station [approach end] platform limits near E2-264+00. The vertical curve ends within the Fort Totten Station platform limits. Based on the system of record data, the Train Operator had a limited view of Fort Totten Station, Track 2, while on approach. Train ID 301 Train Operator traveled at 31 mph when they entered Fort Totten Station. At 31 mph, Train ID 301 traveled at a rate of 44 feet per second, which minimized the opportunity to prevent the collision.

## Field Sketch/Schematics



## Purpose and Scope

This incident investigation and candid self-evaluation aim to collect and analyze available facts, determine the probable cause(s) of the incident, identify contributing factors, and make recommendations to prevent a recurrence.

## Investigation Methods

The investigative methodologies included the following:

Formal Interview – SAFE reviewed one incident report with the following involved person as part of this investigation:

- Train Operator – [Written Statement received]

**\*\*Note:** On the date of this report submission, SAFE could not interview the Train Operator due to unscheduled worker compensation leave resulting from this event.

Documentation Review – A collection of relevant work history information and process documentation in Metro systems of record. These records include:

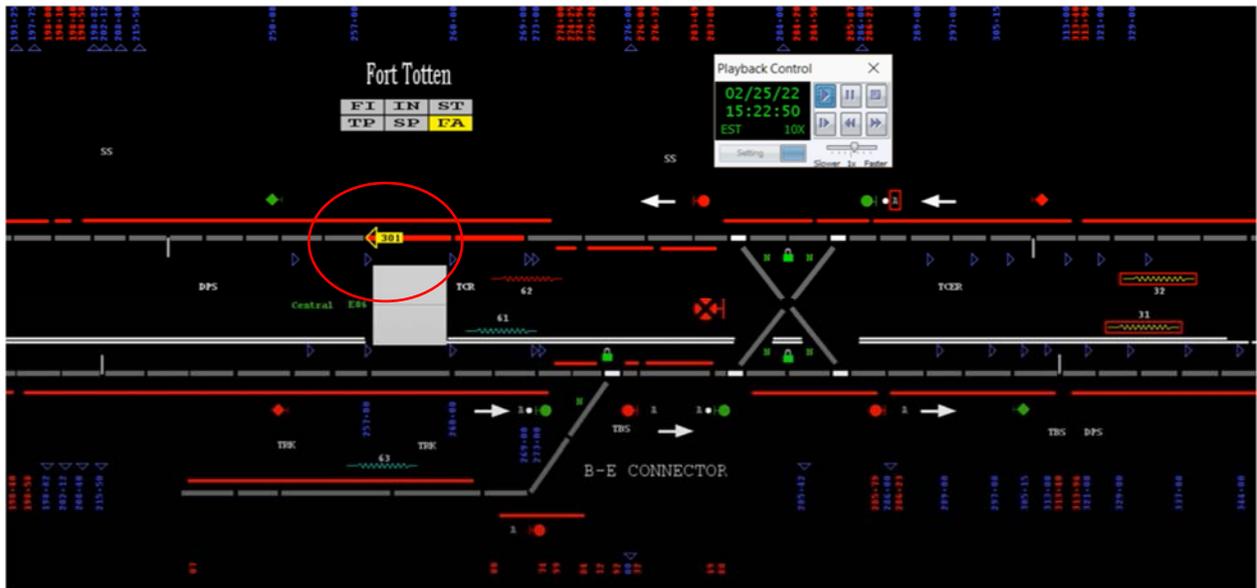
- Employee Training Procedures & Records
- Certifications
- The 30-Day work history
- Metrorail Safety Rules and Procedures Handbook (MSRPH)
- National Oceanic and Atmospheric Administration (NOAA)
- Office of Radio Communications (COMR)
- Vehicle Program Services (CENV)
- Office of Car Maintenance (CMNT) post-incident inspection data
- Metro Transit Police Department (MTPD) Incident report
- Computer-Aided Dispatch (CAD) report

System Data Recording Review – A collection of information contained in Metro Data Recording Systems and Open MHz. This data includes:

- Audio Recording System (ARS) playback [Radio and Phone Communications]
- Open MHz (DCFEMS)
- Closed-Circuit Television (CCTV) playback
- Advanced Information Management System (AIMS)

## Investigation

At approximately 15:22 hours on February 25, 2022, a Yellow Line train [Train ID 301] on Track 2, traveling inbound in Huntington Station's direction, entered Fort Totten Station platform limits at approximately 31mph and the Train Operator properly berthed their train at the 8-car marker.

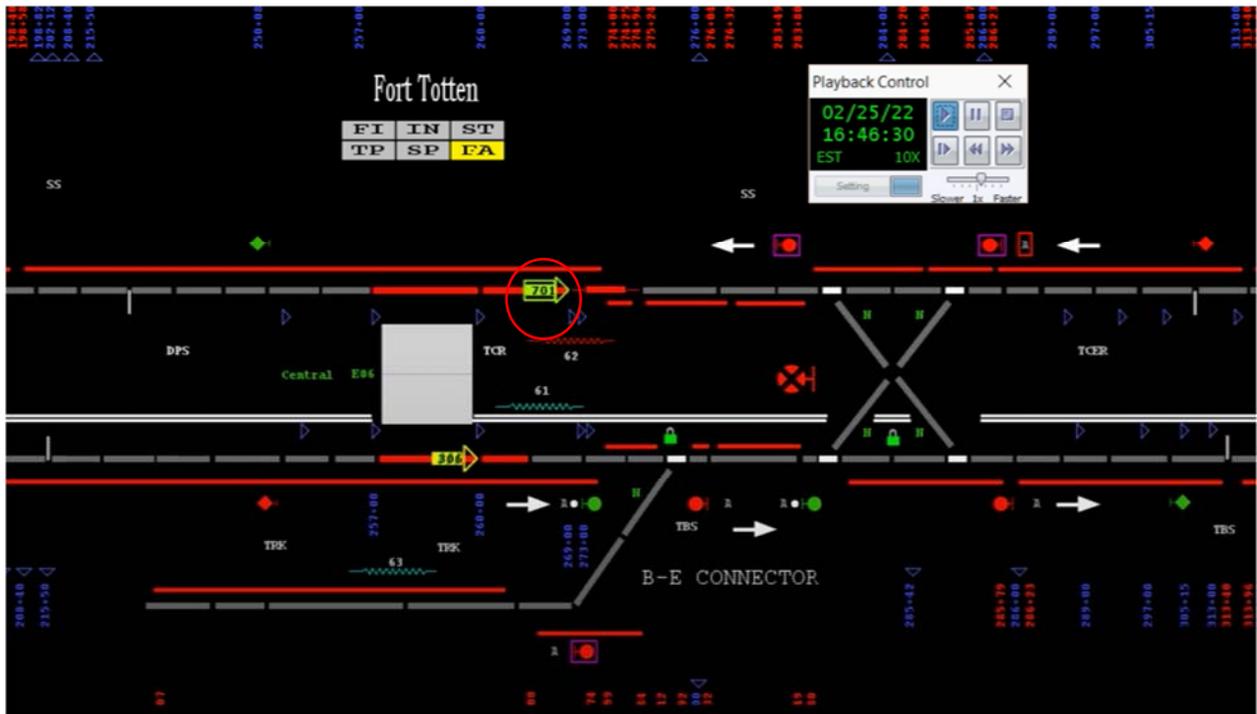


At approximately 15:25 hours, Train ID 301 Train Operator notified the ROCC that they felt a thud against their train on the lead car. The Train Operator initially thought the thud was from a passenger making contact with the operator's cab partition. The ROCC Radio RTC instructed the Train Operator to key down their train and investigate. Customers on the platform and a Metro Transit Police Officer (MTPD) initially responded to and assisted the injured customer, who remained on the platform after being struck. The Radio RTC established SOP 1A at approximately 15:28 hours.

The Train Operator notified the Rail Radio RTC that a person was unconscious with signs of life on the platform limits. MTPD reportedly stated that the person may have been struck by the train. Upon receiving notification from the MAC, the OSI reviewed Fort Totten Station's platform CCTV and determined the person was near the approach end of the station and appeared to be looking down the platform towards the train's direction of travel.

MTPD notified DCFEMS at approximately 15:25 hours. The DCFEMS communications dispatched EMS personnel to Fort Totten Station at approximately 15:25 hours. At approximately 15:35 hours, DCFEMS dispatched additional responders for a person struck by a train after receiving a call from the ROCC OM. DCFEMS transported the customer to a nearby hospital. According to MTPD reports, the person was released from the hospital on February 26, 2022.

There were no reported injuries to persons aboard the train or to WMATA personnel. RTRA removed the Train Operator from service for post-incident toxicology testing and subsequent MTPD interview. The WMSC authorized the ESR at 16:39 hours. At approximately 16:46 hours, Train ID 301 was re-blocked to Train ID 701 and transported to Greenbelt Yard for post-incident investigation processes.



An analysis of data collected from the system data recording and documentation review determined that no safety deficiencies related to any WMATA station facility or rail vehicle failures contributed to the person being struck by the train. An examination of VMS data revealed that the Train Operator of Train ID 301 was operating at nominal speeds before striking the unidentified person.

A review of the incident response actions revealed no challenges with the transfer of command between MTPD and Rail. There were no significant findings related to any non-compliance to the SOP1A Command, Control, and Coordination of emergencies. Data indicates commendable decision-making efforts to maintain single-tracking operations during the initial response, Train Operator well-being, and emergency responses.

### Audio Recording System (ARS) Chronological Event Timeline

A review of ARS playback, i.e., phone and radio communications and the MTPD Computer-Aided Dispatch (CAD) report, revealed the following:

Time	Description
15:25 hours	<p><u>Train ID 301 Train Operator</u>: "Central 301 at Fort Totten Track 2. I felt a thud against my train on the lead car. I do not know if I see anyone lying on the platform; I am at the 8-car marker."</p> <p><u>Radio RTC</u>: Confirmed the Train Operator's transmission. The Radio RTC instructed them to key down, make announcements to their customers, and perform a ground walk around. [Radio]</p>
15:25 hours	<p><u>MTPD</u>: Requested medics to respond to Fort Totten Station platform for customer injury.</p>
15:25 hours	<p><u>DCFEMS</u>: "EMS 14, Medic 14 respond to 201 Galloway Street NE Fort Totten Metro Station." [Open MHz]</p>

<b>Time</b>	<b>Description</b>
15:28 hours	<p><u>Train ID 301 Train Operator</u>: Provided the Radio RTC with an update and reported Transit was on the scene and there was a customer on the platform, and they did not know if the customer was hit or not.</p> <p><u>Radio RTC</u>: Confirmed the transmission and announced SOP1A in effect. [Radio]</p>
15:29 hours	<p><u>Radio RTC</u>: Instructed Train ID 301 to make announcements to offload their train and verify clear. Have them standby track 1 for single tracking. Train ID 301 Train Operator: Confirmed instructions.</p> <p><u>Radio RTC</u>: Asked Train ID 301 Train Operator were they okay; help was on the way.</p> <p><u>Train ID 301 Train Operator</u>: "Central, I'm just a little shaken up."</p> <p><u>Radio RTC</u>: Encouraged Train ID 301 Train Operator and advised that help was on the way. [Radio]</p>
15:31 hours	The ROCC Operations Manager notified DCFEMS of a person struck by a train at Fort Totten Station. [Phone]
15:32 hours	The Radio RTC made blanket announcements and adjusted headways on the railroad in between communication gaps. [Radio]
15:33 hours	<u>DCFEMS EMS</u> : Contacted DCFEMS communications and requested they contact MTPD to identify the location of the patient (upper or lower level). [Open MHz]
15:34 hours	<p><u>DCFEMS</u>: "EMS 14, Medic 14, be advised we have a second call for the Fort Totten Station Metro stating someone was hit by a train. I will send a rescue alarm to your location.</p> <p>Local alarm Engine 24, Truck 18, Battalion Chief special operations rescue squad 2 and 3, EMS 7, EMS 24, and Safety Battalion Chief respond to Metro rescue 201 Galloway Street NE Yellow line train." [Open MHz]</p>
15:34 hours	<p><u>Radio RTC</u>: Followed up with Train ID 301 and asked how they were doing. The Radio RTC assured Train ID 301 help was almost there and to update ROCC with any changes if they could. The Radio RTC continued to offer words of encouragement.</p> <p><u>Train ID Train Operator</u>: Reported they were okay and speaking with MTPD. [Radio]</p>
15:39 hours	<u>Battalion Chief</u> : Notified DCFEMS communications Engine 14 reported that the person hit by the train is not on the track bed; they are on the platform. Continue to hold the Medic unit and Engine 14 rest of the units can go into service, giving the tac channel back. [Open MHz]
15:46 hours	<u>Radio RTC</u> : Assigned an RTRA Supervisor Forward Liaison as they arrived at the ICP. [Radio]
16:01 hours	DCFEMS transported the patient to a nearby hospital. [Open MHz]
16:36 hours	MTPD transferred the scene to RTRA. [ROC report]

Time	Description
16:39 hours	WMSC issued the ESR to the MAC. [Phone]
16:46 hours	Train ID 301 was re-blocked to Train ID 701 and transported to Greenbelt Yard. Normal service restored. [AIMS]

*Note: Times above may vary from other systems' timelines based on clock settings.*

### **Closed Circuit Television (CCTV)**

SAFE reviewed video playback of the event. Prior to the event, the customer was seen attending to a bicycle that was leaned against the railing beneath the escalator. The customer then walked towards the platform edge, facing away from the direction of the incoming train. The train entered the platform seconds later, striking the customer and knocking them to the ground. The customer remained on the platform and other customers responded to check on their condition. An MTPD officer arrived on the scene shortly afterwards.

### **Metro Transit Police Department**

MTPD Officer Incident Report (adopted relevant sections)

“On February 25, 2022, I was at the Fort Totten Metro Station located at 201 Galloway Street, NE, DC, standing near the middle of the Fort Totten Station Platform. At approximately 15:22 hours, as Train ID 301 on the track 2 side entered the station in the direction of Branch Avenue, I heard a loud noise coming from where the train was entering the station on the platform. I walked towards where I heard the noise, and I observed two people standing over top of another individual who was lying on the platform near the elevator. I asked Witness 1 if she knew what happened, and she said she heard a loud noise and assumed that the individual had fallen down. I requested medics to respond. The individual on the ground was unresponsive, but he was breathing. I slid him back from the edge of the platform and put him in the recovery position. I noticed a small puddle of blood on the platform where his head had been.-

“At approximately 15:28 hours, Digital Video Evidence Unit (DVEU) advised that the individual had been looking over the edge of the platform and was struck by the incoming train. At approximately 15:32 hours, an MTPD Sergeant initiated Incident Command at the entrance to the station. Rail began single-tracking on Track 1 at 15:36 hours and began to assess the individual who was struck. At approximately 16:02 hours, DCFEMS Medic 14 transported the individual to Howard University Hospital in stable condition. The Criminal Investigation Division (CID) and Crime Scene Search (CSS) responded to the scene and to Howard Hospital.

“At approximately 16:51 hours, Incident Command was terminated, and Rail resumed normal operations. Medical evaluation at Howard University Hospital revealed a non-life-threatening head injury.”

### **Office of Car Maintenance (CMNT)**

CMNT technicians inspected the incident consist for damage and found no damage on Lead Car 3213. CMNT technicians performed Master Controller (MC) operational checks on the incident consist and did not find any abnormal condition with the MC. CMNT personnel performed brake rate testing and determined the readings were within acceptable ranges.

## Office of Chief Mechanical Officer (CMOR) Incident Investigation Team (IIT)

Based on available VMS data, the train departed West Hyattsville in the direction of Fort Totten on Track #2. The train operated as normal between stations, except for a single B4 brake application of 1,999 feet before Fort Totten Station. After braking for 689 feet, the train was placed in a P5 power mode and continued to Fort Totten station.

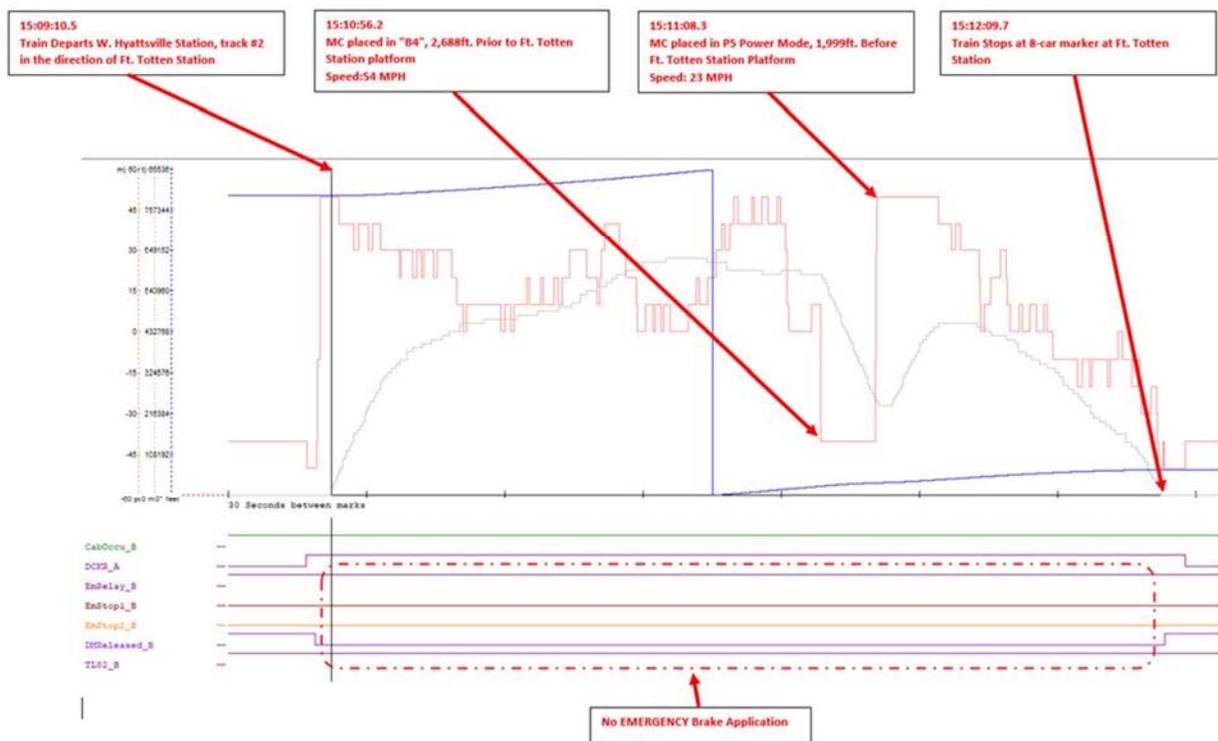
CENV analyzed data procured from Train ID 301 and determined that the ATC was not communicating on two of the three married pairs, and VMS did not record the trailing pair's marker signals.

The consist entered Fort Totten at 31 MPH with the Master Controller in "Coast" position. After applying adequate braking modes, the train came to a complete stop at Fort Totten 8-Car Marker.

Based on the VMS data, there was no emergency braking application during the reported time of this incident. There was no fault observed with the train that may have contributed to the cause of this incident. The train performed as commanded and as designed.

### Additional Findings:

- Car 2064-65 None of the FB subsystems are communicating with VMS.
- Car 2064 ATC subsystem not communicating with VMS
- Car 2064 VMS more than 10 min off.
- Car 2060-61 Only 1 of 4 FB subsystems communicates with VMS.
- Car 2060 ATC subsystem not communicating with VMS
- Car 3000-01 Only 1 of 4 FB subsystems communicates with VMS.
- Car 3000 ATC subsystem not fully reporting to VMS
- Car 3000 VMS more than 10 min off.



## Event Recorder (ER) Data Graph/Sequence of Events

Based on CENV's analysis of the downloaded VMS and ER, details from the data analysis are as follows:

Time	Description
15:09:10 hours	Train ID 301 departed West Hyattsville, Track #2, in the direction of Fort Totten
15:10:56 hours	Master Controller placed in "B4" Braking mode; Train was traveling at a speed of 54 MPH, 2,688 feet. prior to the Fort Totten Station platform
15:11:08 hours	After slowing to a speed of 21 MPH, the Master Controller is placed in "P5" Power Mode, 1,999 feet before Fort Totten Station Platform
15:11:46 hours	The train entered Fort Totten Station at a speed of 31 MPH with the Master Controller in the " <b>Coast</b> " Position
15:11:46 hours	Master Controller moved to "B1" Braking Mode, speed of 31 MPH, 9 feet onto Fort Totten station platform
15:11:51 hours	Master Controller moved to " <b>Coast</b> ," traveling at a speed of 15 MPH, 122 feet. from the 8-Car Marker
15:11:51 hours	Master Controller alternated between "B2" Braking and "B1" Braking Modes.
15:12:05 hours	Master Controller placed in a "B3" Braking Mode, Train speed of 10 MPH, 36 feet from the 8-car marker
15:12:09 hours	Master Controller moved to "B5" Braking mode, Train speed of 3 MPH.
15:12:09 hours	The train came to a complete stop at the 8-Car marker at Fort Totten station.

*Note: Times above may vary from other systems' timelines based on clock settings.*

## Office of Rail Transportation

"The subsequent investigation, which consisted of an employee written statement, i.e., incident report, verbal recollection, and a prewritten 29 question form for Post-Accident/Incident Interview Questionnaire, and review of station platform video equipment, [determined] that a trespasser came into contact with the side of Train 301 as it was entering Fort Totten station."

## Office of Radio Communication (COMR)

COMR conducted a comprehensive radio check on Track 1 and Track 2 at Fort Totten Station and did not identify any issues with the communication system. The communication system operated as designed.

## Interview Findings

As part of the investigation launched into the Fort Totten Station person struck by train event, SAFE reviewed MTPD and Train Operator incident reports via Safety Measurement System Incident/Accident module. These incident reports identified the following key findings associated

with this event. Findings detailed below include reported information from involved personnel and may conflict with other data sources contained in the report.

## Train Operator

“Upon arrival (entering) Fort Totten, I heard a loud thud and thought it was a person sitting behind the operator’s cab hitting against the cab door. I looked down the platform and thought I saw someone lying on the platform edge. I called central and informed them and was told to do a ground walkaround. At the end of the train, a police officer informed me someone was possibly hit by the train.”

## **Weather**

At the time of the incident, NOAA recorded the temperature at 42°F with clear skies. The incident occurred within a partially tunnel section of the rail system. The weather was not a contributing factor. (Weather source: National Oceanic Atmospheric Administration – Location: Washington, DC)

## **Human Factors**

### Evidence of Fatigue

Conditions at the time of the incident were evaluated to distinguish whether evidence of fatigue was present. Video of the involved person was not available to ascertain whether signs of fatigue were present.

Due to the employee’s leave of absence, SAFE was unable to interview the Train Operator following the incident. Therefore, the employee’s level of alertness and the presence of symptoms of fatigue in the time leading up to the incident could not be confirmed.

### Fatigue Risk

Incident data was evaluated for fatigue risk factors. The Train Operator’s work schedule indicated that the employee worked evening shifts, including one (1) 10-hour and 39-minute shift (13:39 - 00:18 hours), in the days leading up to the incident.

The off-duty period preceding the incident was 14.5 hours long, which provides the opportunity for 7-9 hours of sleep; however, the employee’s bed and wake times on the day preceding the incident and usual workday sleep durations could not be confirmed. The employee’s total number of sleep hours in the sleep period preceding the incident and hours awake at the time of the incident could not be determined.

Due to the lack of the above-noted sleep information, the presence of fatigue risk factors contributing to the incident could not be thoroughly evaluated with a modeling analysis.

## **Post-Incident Toxicology Testing**

WMATA’s Drug and Alcohol Program determined that the Train Operator was not in violation of the Drug and Alcohol Policy and Testing Program 7.7.3/6.

### **Mitigations Completed to Prevent Recurrence**

- RTRA removed the Train Operator from service for post-incident toxicology testing.
- RTRA removed Train ID 301 from service for post-incident inspection.

### **Findings**

- SAFE did not identify any slip or trip hazards that contributed to this event.
- Station lighting appeared sufficient within the Fort Totten Station Lower Level.

### **Probable Cause Statement**

The probable cause of the Fort Totten Station person struck by train event was that a customer unintentionally entered the train's dynamic envelope near the approach end of the station entrance as the train was entering the station.

### **Recommendations/Corrective Actions**

There are no recommendations for this person who was struck by the train because they unintentionally placed themselves onto the roadway fouling the train's dynamic envelope. The Train Operator, vehicles, and infrastructure were non-contributors to the incident.

## **Appendices**

### **Appendix A – Incident Statement / Interviews**

Train Operator

*The below narrative summarizes the written statement by the involved personnel. As such, times and details may conflict with the data contained in systems of record.*

The WMATA employee has three and a half years of experience as a Train Operator and seven years of service in various roles such as Bus Operator. The Train Operator record does reflect two safety violations for Station OVERRUNS in December of 2020 and July of 2018 within the last three years. The Train Operator was last certified on December 16, 2020 (QL-1)

“Upon arrival (entering) Fort Totten, I heard a loud thud and thought it was a person sitting behind the operator’s cab hitting against the cab door. I looked down the platform and thought I saw someone lying on the platform edge. I called central and informed them and was told to do a ground walkaround. At the end of the train, a police officer informed me someone was possibly hit by the train.”

### **Appendix B – Incident Response Non-Compliance of Rules and Procedures**

No non-compliances were identified.

# Appendix C – ROCC Report

## View Approved Incident Report

**INCIDENT ID: 2022056YELLOW2**

<b>DATE</b> 2022-02-25	<b>TIME</b> 1522	<b>LINE</b> Yellow	<b>ITEM</b> 2
<b>LOCATION (STATION/YARD)</b> Fort Totten (E06)	<b>LOCATION/CHAIN MARKER (If Applicable)</b>		<b>REPORTED BY</b> Train Operator [REDACTED] (C-99)
<b>TRAIN ID</b> 301	<b>DIRECTION</b> I/B	<b>TRACK NUMBER</b> 2	<b>DEPTS NOTIFIED</b> Everbridge Alert/Messaging
<b>CAR NUMBERS (XXXX-XXXX)</b>			
<b>Lead Car</b>			
2065-2064	2060-2061	3000-3001	-
Caused Issue <input checked="" type="checkbox"/>	Caused Issue <input type="checkbox"/>	Caused Issue <input type="checkbox"/>	Caused Issue <input type="checkbox"/>
<b>TRBL CODE</b> JUMP-JUMPER: PERSON HIT BY TRAIN	<b>RESP CODE</b> PUB		

**TYPE INCIDENT**  
Person Made Contact With Train

**ACTION PLAN**  
Dispatch RTRA Supervisor/CMNT/ERT, Bypass Station, Implement SOP1A, Single Tracking Procedures Implemented

DELAYS IN MINUTES					
LINE	INCIDENT	TRAIN	TOTAL DURATION		
29	29	82	0		

TRIPS MODIFIED					
PARTIAL	GAP TRAIN	LATE DISPATCHES	REROUTED	NOT DISPATCHED	OFFLOADS
2	0	0	0	0	1

FIVE PRIMARY CONSOLE INDICATIONS				
BCP	BRAKES ON ILLUMINATED	ALL DOORS CLOSED ILLUMINATED	AUTO\MANUAL ILLUMINATED	BPP
			AUTO	

Attachment 1 – ROC Report page 1 of 3

## View Approved Incident Report

INCIDENT CHRONOLOGY	
TIME	DESCRIPTION
1522	Train 301 Operator [REDACTED] reported feeling a bump while entering Fort Totten track two platform limits. Train 301 Operator instructed to make announcements to the customers, secure the cab, perform a radio check and conduct a ground walk around. Unit [REDACTED] RTRA Supervisor [REDACTED] and Unit [REDACTED], RTRA Supervisor [REDACTED] dispatched to the scene. Assistant Operations Manager, ROIC, MTPD, MAC and all concerned personnel notified
1529	Train 301 Operator reported signs of life on the platform track two Fort Totten. SOP 1A implemented. MTPD on the scene. MTPD Officer [REDACTED], Badge [REDACTED] deemed as On-Scene Commander.
1534	Train 505 was the first train to enter the single tracking area and service Fort Totten track one. Single tracking procedures implemented between Fort Totten and Georgia Avenue utilizing track one.
1535	DCFD unit 14 arrived on the scene.
1546	Unit [REDACTED] RTRA Supervisor [REDACTED] arrived on the scene was assigned the RTRA forward Liaison.
1551	Train 302 picked up Train 301 incident customers track one Fort Totten ending the longest customer delay.
1554	Unit [REDACTED] RTRA Supervisor [REDACTED] arrived on the scene, and assigned the RTRA Incident Command Liaison and instructed to report to the incident command post located at the front entrance kiosk.
1556	Gap Train 735 Operator instructed to re-block to revenue id 335 in service track two L'Enfant Plaza in the direction towards Huntington.
1601	DCFD unit 14 transported customer to nearest medical facility.
1636	Unit [REDACTED] RTRA Supervisor [REDACTED] reported the scene transferred back to RTRA
1645	Train 701 was given an absolute block to E06-06 signal red no closer then 10 feet, standing by for further instructions. Unit 20, RTRA Supervisor [REDACTED] reported track two Fort Totten not ready for revenue service.
1650	Train 701 moving non-revenue in the direction of Greenbelt yard for storage. Normal service resumed.

**MAXIMO TICKET#**  
8588404

REPORT PREPARED BY	NAME	CLICK TO SIGN
RADIO CONTROLLER 1	[REDACTED]	✓
BUTTON CONTROLLER 1	[REDACTED]	✓
RADIO CONTROLLER 2		
BUTTON CONTROLLER 2		

**SUPERINTENDENTS OR ASSISTANTS SECTION**

**ADDITIONAL FOLLOW-UP CORRECTIVE ACTIONS OR REMARKS**

**FOLLOW-UP INFORMATION OBTAINED FROM SUPPORT DEPARTMENTS**

**NOTIFICATIONS/PAGE GROUPS** #1/CEO  #2/DGM & BELOW

Attachment 1 – ROC Report page 2 of 3

## View Approved Incident Report

### ADDITIONAL NOTIFICATIONS MADE BY PHONE

APPROVED BY	NAME	CLICK TO SIGN
REPORT APPROVED BY SUPT. OR ASST SUPT.	XXXXXXXXXX	<a href="#">✓</a>

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Attachment 1 – ROC Report page 3 of 3

Incident Date: 02/25/2022 Time: 15:22 hours.  
Final Report Rev.1 – Collision  
E22124

Rev.1 Drafted By: SAFE 704 – 06/14/2022  
Rev.1 Reviewed By: SAFE 71 – 06/21/2022  
Rev.1 Approved By: SAFE 71 – 06/21/2022

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