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WMSC Commissioner Brief: W-0216 – Collision – Anacostia Station – December 11, 2022

Prepared for Washington Metrorail Safety Commission meeting on April 11, 2023

Safety event summary:

A Green Line train toward Branch Avenue Station struck and killed a rider who had deliberately placed themselves in the path of that train as the train entered Anacostia Station on December 11, 2022 at 7:36 a.m.

The Train Operator properly reported the collision and Metrorail dispatched personnel including Metro Transit Police. Third rail power was de-energized.

During the response, Metrorail personnel experienced radio communications issues that affected the overall response and emergency management but did not contribute to the outcome for the person struck by the train.

These communications issues impeded communications to personnel in the field for items such as confirming that third rail power had been de-energized.

Probable Cause:

The probable cause of this event was a person placing themselves in the path of a train.

Corrective Actions:

Examples of other related open CAPs include

- In development:
  - C-0217 addressing that Metrorail personnel are not effectively communicating, responding to and identifying issues related to trouble calls pertaining to communications systems (Expected completion date May 2025).
- Ongoing:
  - C-0180 addressing that Metrorail does not assess and communicate radio system outages to Metro Transit Police Department officers (Expected completion date April 2023).

WMSC staff observations:

The report of no trouble found despite the documented issues in this case is another example of the need for Metrorail to implement CAP C-0217, and supports the WMSC's finding issued on September 29, 2022, as part of the WMSC's communications system audit.

Washington Metropolitan Area Transit Authority
Department of Safety (SAFE)
Office of Safety Investigations (OSI)

FINAL REPORT OF INVESTIGATION A&I E22804

Date of Event:	December 11, 2022
Type of Event:	A-3 Collision
Incident Time:	07:36 hours
Location:	Anacostia Station
Time and How received by SAFE:	07:37 hours – Mission Assurance Coordinator (MAC)
WMSC Notification Time:	09:08 hours
Responding Safety Officers:	WMATA: Office of Emergency Preparedness (OEP) WMSC: None Other: Metro Transit Police Department (MTPD), District of Columbia Fire and Emergency Medical Services Department (DCFEMS)
Rail Vehicle:	Train ID 506 L7256/57 X 7496/97 X 7144/45 X 7503/02T
Injuries:	One (1) fatality
Damage:	None
SMS I/A Incident Number:	20221211#104803MX

Anacostia Station – A-3 Collision

December 11, 2022
Table of Contents

Abbreviations and Acronyms

ARS	Audio Recording System
CAP	Corrective Action Plan
CCTV	Closed-Circuit Television
DCFEMS	District of Columbia Fire and Emergency Medical Services
MAC	Mission Assurance Coordinator
MSRPH	Metrorail Safety Rules and Procedures Handbook
MTPD	Metro Transit Police Department
NOAA	National Oceanic and Atmospheric Administration
OEP	Office of Emergency Preparedness
RTRA	Office of Rail Transportation
ROCC	Rail Operations Control Center
SAFE	Department of Safety
SMS	Safety Measurement System
WMATA	Washington Metropolitan Area Transit Authority
WMSC	Washington Metrorail Safety Commission

Executive Summary

Note that all times listed are approximate and may contain minor variations due to differences between systems of record.

On December 11, 2022, at 07:36 hours, the Train Operator of Train ID 506 (L7256/57 X 7496/97 X 7144/45 X 7503/02T) notified the Rail Operations Control Center (ROCC) that a customer leaped in front of the train at Anacostia Station, track 2. The Train Operator reported that the train struck a person within the platform limits. At 07:37 hours, the Train Operator reported two cars were within the station's platform limits.

At 07:38 hours, the Button Rail Traffic Controller (RTC) advised the Metro Transit Police Department (MTPD) of the incident. At 07:39 hours, an MTPD Dispatcher directed multiple MTPD units to Anacostia Station in response to the event.

At 07:42 hours, MTPD Digital Video Evident Unit (DVEU) reviewed video footage and advised that the customer intentionally placed themselves in front of Train ID 506 at Anacostia Station. At 07:44 hours, MTPD units reported that they were on scene attempting to locate the victim

At 07:48 hours, the Mission Assurance Coordinator (MAC) advised MTPD that power was de-energized on track 2. At 07:51 hours, MTPD inquired if the MAC was receiving radio communications and requested confirmation that Bus and Rail Supervisors were en route to the location, which was confirmed. The MAC advised the Office of Emergency Preparedness (OEP) On-Call Personnel of communication issues and advised power was de-energized on track 2 and that Train ID 506 was offloaded.

At 07:52 hours, MTPD located the customer under the second car of the train. MTPD could not determine if the victim had signs of life at that time. At 07:57 hours, District of Columbia Fire and Emergency Medical Services Department (DCFEMS) arrived and pronounced the customer deceased. Recovery efforts were then initiated.

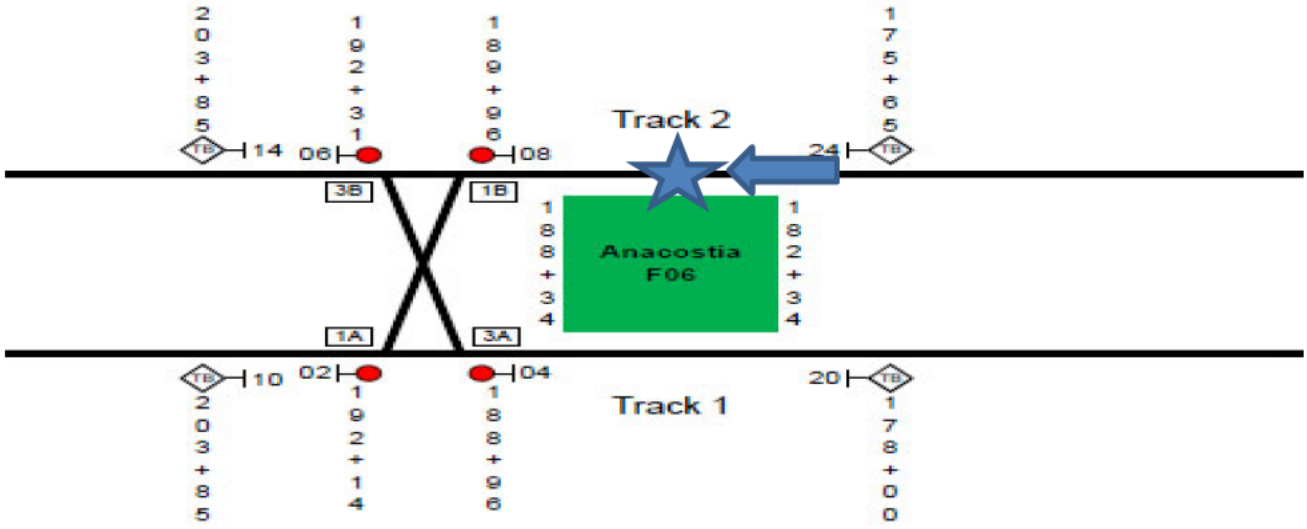
The Office of Rail Transportation (RTRA) removed the Train Operator from service for post-incident toxicology testing, per Standard Operating Procedure 102-1, Removing an Employee from Service. The incident train was removed from service for post-incident investigative efforts.

The probable cause of this event was a person's action to place themselves on the roadway for unknown reasons, which resulted in their death. There were no significant findings of deficiency with the vehicle, infrastructure or human factors related to this event.

Incident Site

Anacostia Station, track 2.

Field Sketch/Schematics



***Note: Sketch not to scale. Arrow indicates the direction of travel.*

Purpose and Scope

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

Investigative Methods

Upon receiving notification of the Collision event on December 11, 2022, SAFE team members worked with relevant Washington Metropolitan Area Transit Authority (WMATA) subject matter experts to review the incident's facts and data.

The investigative methodologies included the following:

- Physical Site Assessment

- Documentation Review – Collection of relevant work history information and process documentation contained in WMATA systems of record. These records include:
  - Metrorail Safety Rules and Procedures Handbook (MSRPH)
  - National Oceanic Atmospheric Administration (NOAA)
  - Rail Operations Control Center (ROCC) Incident Report
  - Maximo Data

- System Data Recording Review – Collection of information contained in Metro Data Recording Systems. This data includes:

- ARS (Audio Recording System) playback [Radio and Landline Communications]
- The Office of Chief Mechanical Officer (CMOR) Incident Investigation Team (IIT) Vehicle Monitoring and Diagnostic System (VMDS)
- Closed-Circuit Television (CCTV)

Investigation

On December 11, 2022, at 07:36 hours, the Train Operator of Train ID 506 (L7256/57 X 7496/97 X 7144/45 X 7503/02T) reported to ROCC that a customer leaped in front of the train at Anacostia Station, track 2. The Train Operator reported the train had struck a customer within the platform limits.

The Audio Recording System (ARS) playback revealed that at 07:37 hours, the Train Operator reported two cars were within the platform limits within the station. At 07:38 hours, the Button RTC advised MTPD of the incident. At approximately 07:39 hours, an MTPD Dispatcher directed multiple MTPD units to Anacostia Station in response to the event.

At 07:42 hours, MTPD DVEU reviewed video footage and advised that the customer intentionally placed themselves in front of Train ID 506 at Anacostia Station. At 07:44 hours, MTPD units advised that they were on scene attempting to locate the victim. At 07:48 hours, the MAC advised MTPD that power was de-energized on track 2. At 7:57 hours, the District of Columbia Fire and Emergency Medical Services Department (DCFEMS) arrived at the location to assist.

After reviewing the Closed-Circuit Television (CCTV), it was revealed that an unidentified individual was pacing along the platform minutes before Train ID 506 entered the Anacostia Station, and intentionally leaped onto the roadway in front of the train.

At 07:51 hours, MTPD inquired if the MAC was receiving radio communications and requested confirmation that Bus and Rail Supervisors were en route to the location, which was confirmed. The MAC advised the OEP On-Call Personnel of communication issues and reported that power was de-energized on track 2 and that Train ID 506 was offloaded.

At 07:52 hours, MTPD located the customer under the second car of the consist. MTPD could not determine if the victim had signs of life at that time. At 07:57 hours, DCFEMS arrived and pronounced the customer deceased; recovery efforts were initiated.

At 08:01 hours, the SAFE On-Call Director contacted the MAC and requested additional information and circumstances surrounding the event. At 09:08 hours, the MAC notified the Washington Metrorail Safety Commission (WMSC) via telephone about the incident.

At 09:13 hours, the MAC advised the On-Call Director that Train ID 506 was moved, the customer was recovered and pronounced deceased. The Train Operator was interviewed by an MTPD Officer and provided a statement.

The Office of Vehicle Program Services (CENV) performed a download and analysis of the incident car data and determined the following:

“CENV downloaded and finalized the Event Recorder (ER) Data Analysis and VMDS data review.

Train ID 506 consist L7256 X 7496 X 7144 X 7502T, was traveling from Navy Yard Station on track two (outbound) in route to Anacostia Station.

At 07:36:11, the train passed over ATP markers F2F8 (front of the lead car R7256 at 1,125 feet from the center of the platform) at 49.79 mph in coast mode towards Anacostia Station (track 2). At 07:36:23, the train was at 32 mph, decelerating with the master controller in brake position B1 to B3 approaching the platform at 398 feet from the center of the platform. At 07:36:24, the emergency brake was applied via master controller, and the road horn blasted two times. The train was at 31 mph, rapidly deaccelerated in emergency, while the front of car R7256 was 367 feet from the center of the platform. At 07:36:33, the train came to a full stop 200 feet from the center of the platform. The master controller remained in emergency position and the brake pipe dumped with full brake service indication. The VMDS data log was reviewed, and no brake faults were reported during the incident time."

Chronological Event Timeline

A review of ARS playback, i.e., phone and radio communications, revealed the following timeline:

Time	Description
07:36:43 hours	Train ID 506: Train Operator of Train ID 506 reported "Emergency, Emergency, Emergency" and that a customer jumped in front of their train on track 2 of Anacostia Station. [Radio Ops 3] Radio RTC: Advised the Train Operator to stop Train ID 506 and determine how many Train Cars were within the platform limits. [Radio Ops 3]
07:37:08 hours	Train ID 506: Train Operator Train reported they had two cars within the platform limits. The Radio RTC acknowledged and advised the Train Operator to place the handbrake on. [Radio Ops 3] Train ID 506: The Operator advised Central they were not comfortable checking for signs of life after the Radio RTC inquired if they were able to do so. [Radio Ops 3]
07:37:14 hours	Button RTC: Made notifications to required personnel about the event at Anacostia Station. [Phone ROCC Y/G 1]
07:38:29 hours	Button RTC: Advised MTPD Dispatch of the incident. [Phone ROCC Y/G 1]
07:39:29 hours	MTPD: Dispatcher directed multiple MTPD units to Anacostia Station. [Radio MTPD 1X]
07:40:01 hours	Third Rail power de-energized. [RTRA Report]
07:42:14 hours	MTPD: MTPD reviewed camera footage and advised that the customer had intentionally placed themselves in-front of Train ID 506 at Anacostia Station. [Radio MTPD 1X]
07:42:30 hours	MAC: Advised OEP On-Call of the incident. The OEP On-Call stated they were en route to the scene. [Phone ROCC ASST PWR SUP]
07:44:41 hours	MTPD: MTPD Officer advised they were on scene and attempting to locate the injured customer. [Radio MTPD1X]
07:46:00 hours	MTPD: MTPD attempted to contact the MAC, however, inaudible. [Radio MTPD 1X]

07:47:02 hours	MTPD: MAC advised MTPD Dispatcher that they were not able to contact units on scene via radio. [Phone SOCC Console 5E]
07:48:31 hours	MAC: Advised power was de-energized on track 2 and was acknowledged by the MTPD Dispatcher. MAC asked if track 1 was required to be de-energizing, but MTPD did not respond. [Radio MTPD 1X]
07:51:26 hours	MTPD: MTPD asked the MAC if they had received the radio traffic and could confirm if bus and rail supervisors were en route to the location. The MTPD Dispatcher advised the MAC on receiving radio traffic and further stated that bus and rail supervisors were en route. [Radio MTPD 1X]
07:51:58 hours	MAC: Advised OEP On-Call of communications issues and advised power was de-energized track 2, Train offloaded. [Phone ROCC ASST PWR SUP 1]
07:52:25 hours	MTPD: MTPD Officer reported locating the customer under the second car of the consist. MTPD Officer advised that they were uncertain of signs of life for the victim. [Radio MTPD 1X]
07:53:25 hours	MTPD: MTPD officer reported locating the customer under the second car. MTPD was uncertain of signs of life. [Radio MTPD 1X]
07:56:05 hours	MTPD: MTPD Dispatcher requested the DC Chief Medical Examiner's Office to send a Medical Examiner for a fatality from the collision event. [Phone SOCC Console 5E]
07:57:03 hours	DCFEMS arrived to the location. [RTRA Report]
07:57:41 hours	MAC: Advised the On-Call Director of the incident. [ROCC ASST PWR SUP 1]
08:21:12 hours	MAC: OEP contacted the MAC and had discussions regarding EAP (Employee Assistance Program). [ROCC ASST PWR SUP 1]
09:06:39 hours	On-Call Director called the MAC and inquired about "where are we at with notification." The On-Call Director asked if the MAC had contacted WMSC. [ROCC ASST PWR SUP 1]
09:08:31 hours	MAC: Made notification to the WMSC of the incident at Anacostia Station. [ROCC ASST PWR SUP 1]
09:13:42 hours	MAC advised the On-Call Director that the train was moved, and the body had been recovered. The victim was pronounced deceased. [ROCC ASST PWR SUP 1]
10:27:02 hours	Track 1 opened for service single tracking. [RTRA Report]
11:17:10 hours	Third rail power was energized on Track 2. [RTRA Report]

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

Advanced Information Management System (AIMS)

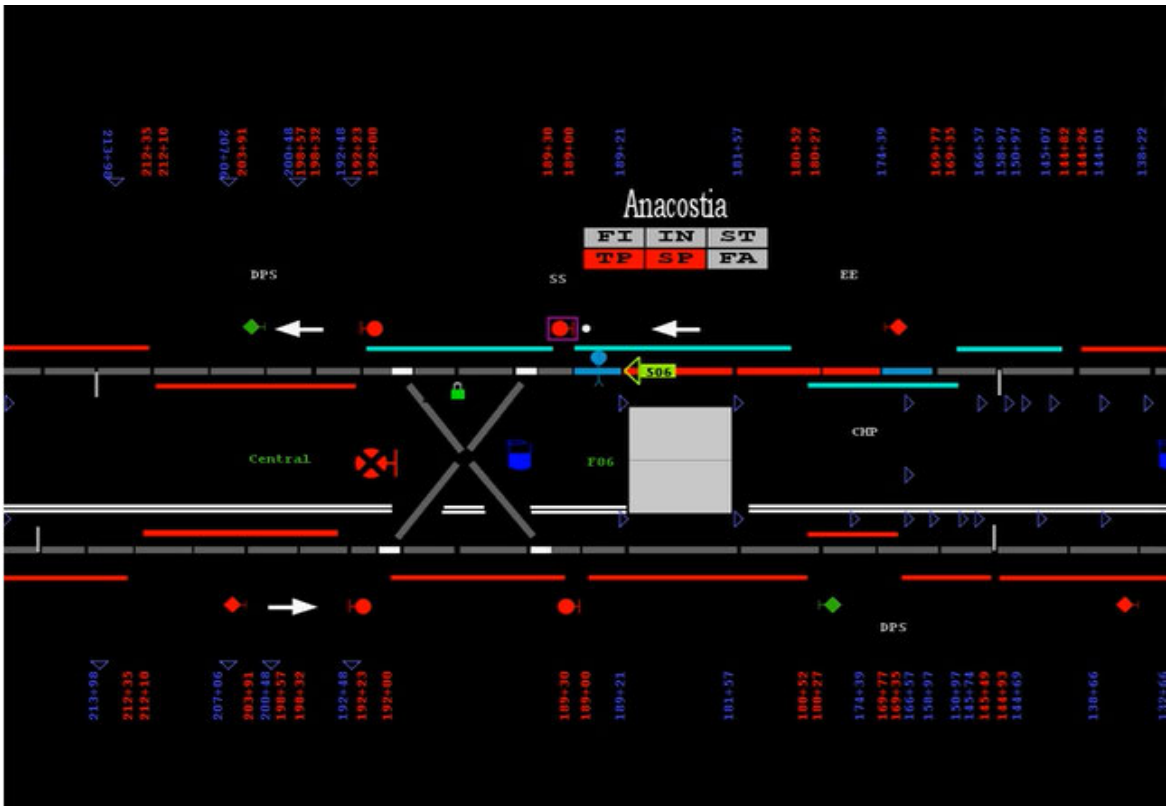


Figure 1 - AIMS Train ID 506 located at Anacostia Station at 07:36 hours.

Office of Systems Maintenance, Office of Radio Communications (COMR)

The Office of Radio Communications conducted comprehensive radio checks (TX/RX) at Anacostia Station on tracks one and two. No trouble was found.

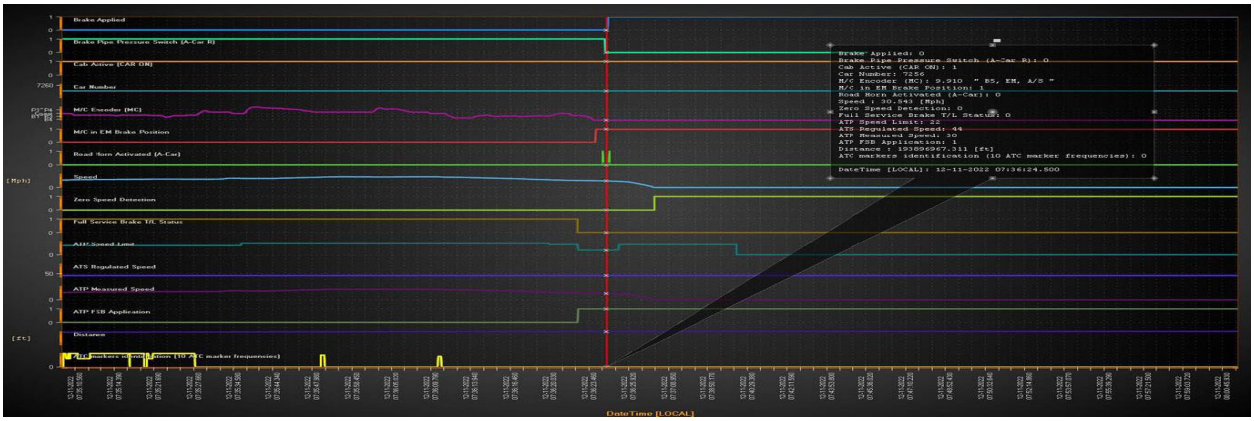
Office of the Vehicle Program Services (CENV)
Adopted from CMO-IIT report:

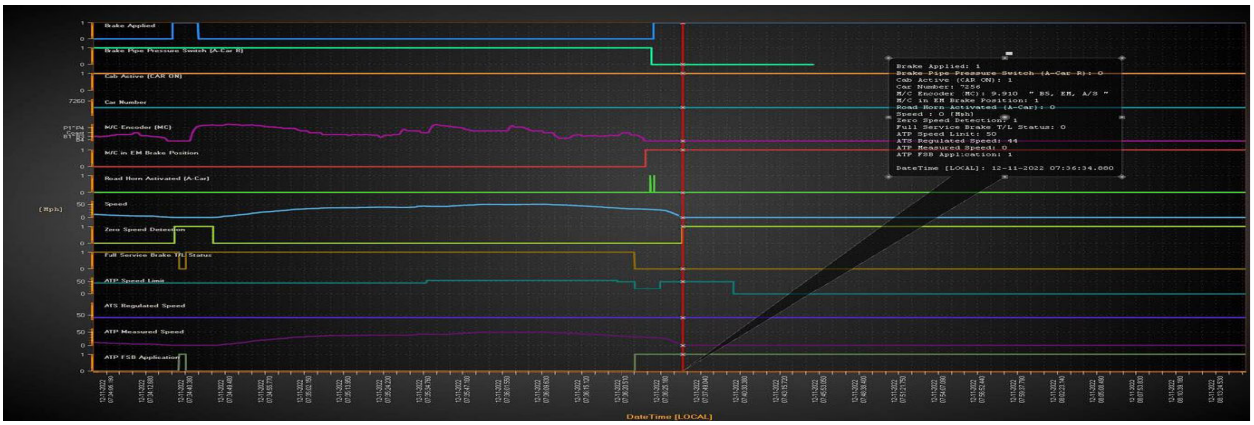
"The Office of Vehicle Program Services (CENV) performed a download and analysis of the incident car data and determined the following outlined in the time of events below:

- Train ID # 506 consist L7256 X 7496 X 7144X X 7502T was traveling from Navy Yard Station on track 2 (outbound) en route to Anacostia Station.
- 7:36:11 hours Train ID 506 traveled over Automatic Train Protection (ATP) markers F2F8 (front of the lead car R7256 at 1,125 feet from center of the platform) at 49.79 mph in coast mode towards Anacostia Station, track 2.
- 7:36:23 Train ID 506 at 32 mph, decelerating with the master controller in brake position B1 to B3 approaching the platform at 398 feet from the center of the platform.

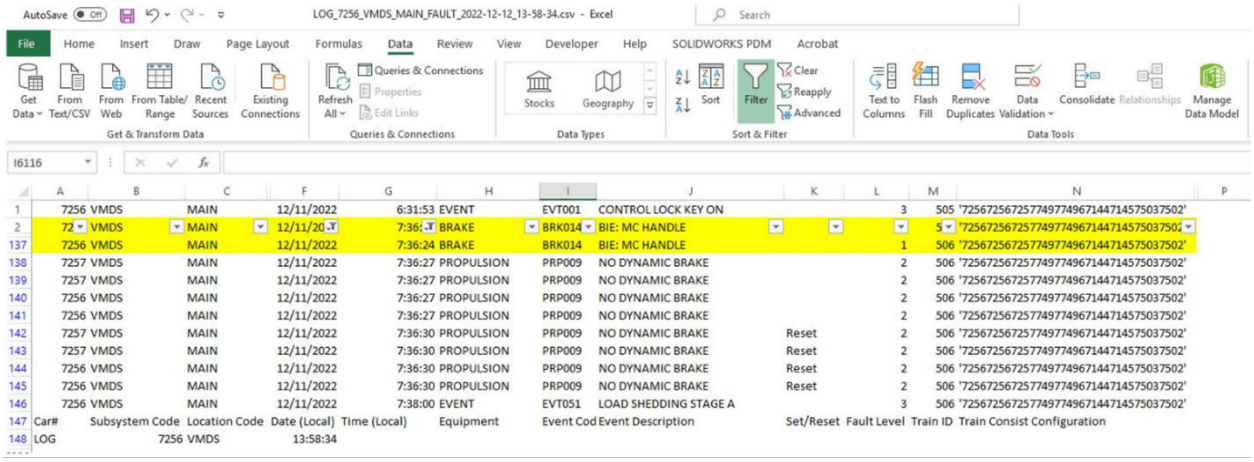
- 7:36:24 hours emergency brake is applied, and the road horn blasted two times. Train ID 506 at 31 mph, rapidly decelerating in emergency mode, front of the car R7256 at approximately 367 ft from the center of the platform.
- 7:36:33 hours Train ID 506 full stop at 200 feet from the platform's center (before reaching the center of the platform). The master controller remained in emergency position, the brake pipe was dumped, and the full brake service indicated.

The EMR braking was performed as indicated by the specifications. The Vehicle Monitoring and Diagnostic System (VMDS) data logged was reviewed, and no brake faults were reported during the incident.





The VMDS data log was reviewed, and no brake faults were reported during the incident time."



Interview Findings

As part of the investigation launched into the event, SAFE attempted to interview the Train Operator; however, they were on leave as a result of this event. A review of their written statement was conducted.

Train Operator

- Train Operator of Train ID 506 was not available for an interview and was on leave after the traumatic event.
- Train Operator did make statements to responding MTPD officers and provided a written statement to RTRA.
- In the written statement, Train Operator indicated that upon entering the Anacostia Station, an individual jumped from the platform in front of the train.
- Train Operator stopped the consist, notified ROCC of the incident and assisted customers in disembarking the train.

Weather

On December 11, 2022, at the time of the incident, NOAA recorded the temperature as 40° F, with clear skies. The weather was not a contributing factor in this event (Weather source: NOAA) – Location: Washington, DC.)

Human Factors

Evidence of Fatigue

Conditions were evaluated at the time of the incident to distinguish whether evidence of fatigue was present. The Train Operator reported feeling fully alert at the time of the incident. Reference is made to Appendix D. The Train Operator reported experiencing no symptoms of fatigue in the time leading up to the incident.

Fatigue Risk

The incident data was evaluated for fatigue risk factors for the Train Operator. Risk factors for fatigue were not present for the Train Operator. Since fatigue evidence and risk factors were absent, the biomathematical fatigue modeling application (SAFTE-FAST Web SFC) was not applied.

Post-Incident Toxicology Testing

WMATA's Drug and Alcohol Program determined that the Train Operator complied with the Drug and Alcohol Policy and Testing Program 7.7.3/6.

Work History

The Train Operator has not had any safety violations in the last three years. The 30-Day work history did not reflect any indications of fatigue risk.

Findings

- The train entered the station while in a braking mode and below the maximum allowed speed of 40 mph.
- The Train Operator took immediate action to decelerate the train upon observing the person in the roadway.
- The event was due to a person's action to place themselves on the roadway for unknown reasons, which resulted in their death.
- Issues with radio communications experienced.

Immediate Mitigation to Prevent Recurrence

- The Train Operator was removed from service during the initial investigation.
- Train ID 506 was removed from service for inspection.
- Emergency Response Team (ERT) inspected the tracks for any hazards before restoring revenue service; none were observed.

Probable Cause Statement

The probable cause of this event was a person's action to place themselves on the roadway for unknown reasons, resulting in their death. There were no significant findings of deficiency with the vehicle, infrastructure or human factors related to this event.

Recommended Corrective Actions

There were no significant findings of deficiency with the vehicle or human factors or the emergency response. No Corrective Actions are recommended.

Appendices

Appendix A – Interview Summary

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

The Train Operator of Train ID 506 was not available for an interview and was on leave due to the traumatic event. The Train Operator did make statements to responding MTPD officers and provided a written statement to RTRA (Please see Appendix B). In the statement, the Train Operator reported that upon entering Anacostia Station, an individual jumped from the platform in front of the train. The Train Operator stopped the consist, notified ROCC of the incident, and assisted the customers in disembarking the train.

Appendix B – Employee Statement

Witness or Employee Statement Form TO BE COMPLETED AND
Washington Metropolitan Area Transit Authority DISTRIBUTED WITHIN 24 HOURS

Involved Person or Witness (Use this Block for Non-WMATA Involved Person or Witness)

[redacted] ta.com

Incident Information

Date	Incident Time	Date/Time Reported	Location
12/11/2022	7:37am	12/n/a/22	Anacostia Station

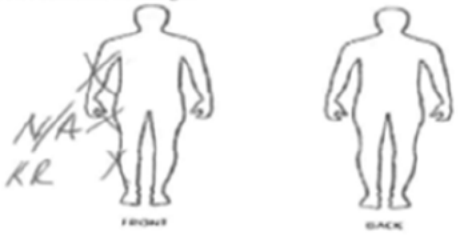
Incident ID# (from OCC) – Completed by Supervisor | SMS Incidents/Accidents Report# Completed by Supervisor

What happened prior to the incident/accident?
Prior to the incident I was operating the train from Navy Yard to Anacostia track 2.

Describe the incident/accident
A black male jumped in front of my train as I was entering the Anacostia Station track 2 side. I immediately placed the master controller in emergency to stop the train. I heard the person make contact with the train when he jumped from the platform.

What happened after the incident/accident?
I contacted the ROCC to inform them of the jumper. I walked all the passengers through the bulkhead doors of the train toward the front to exit the train. I then waited in the cab area of the train I was interviewed by transit and checked on by Supv. Little and [redacted]

Please indicate the area of the injury by placing an X on the corresponding body parts below. To specify which side of the body is involved, please use "L" for left and "R" for right.



Turn Over to Complete Employee and Injury Information

Witness or Employee Statement Form

Washington Metropolitan Area Transit Authority

TO BE COMPLETED AND DISTRIBUTED WITHIN 24 HOURS

Complete all Fields (Write *N/A* if field does not apply)

Involved Personnel (Use this Block for WMATA Employees and Contractors)

[redacted]	Witness? (Yes) No	[redacted]	
[redacted]	Job Title: Train Operator	Department/Division (Company): RTRA	Union: Local 689
Last Day Worked (Prior to): 12/10/2022	Hours Worked (in last 24 hours): 11 hours	Date/Time Shift Began: 12/11/2022 6:11am	
On Overtime? (Yes) No	Personal Protective Equipment used (list)		

Secondary Employment (Write *None* if employee does not have secondary employment)

Name of Secondary Employer: NONE	Full Time / Part Time	Work Hours
Secondary Employer Full Address		
Date of Hire	Supervisor	Phone Number

Injury Information (Complete for all involved People. If there is no injury, write *None* in Date of Injury)

Date of Injury: NONE	Time of Injury	Date/Time Injury Reported	Body Part(s) Injured:
Location (Address) where injury occurred (check one: MD VA DC)			
Witness Information (Name, Phone Number, Email, address)			
Did Another Person Cause this Injury? Yes No		Name of Responsible Party	
Responsible Party Insurance Carrier/Agent		Phone Number	
Are you able to Continue Work? Yes No		Name/Address of facility where you will seek treatment	
Doctor's Phone Number		Date you will see your doctor	

Employee, please read before signing:

(1) This form is only to be used for Employees who are injured on the job.

(2) All persons having a workers' compensation claim that was caused by the act of another is required to have the written approval of the Authority before agreeing to or signing any settlement for the injuries or lost wages that were paid as part of the whole by the Authority or its insurer to the employee as workers' compensation benefits.

(3) Any Employee who willfully makes any materially false or misleading statements or representations for the purpose of obtaining any benefits under workers' compensation or leave provisions of the Authority may be subject to prosecution, disciplinary action up to and including dismissal and may adversely affect the employee's rights to workers' compensation benefits.

THIS IS TO CERTIFY THAT I HAVE READ THE ABOVE GUIDELINES AND UNDERSTAND THEM FULLY AND THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT.

Employee Signature: [redacted] Date: 12/11/2022

Original: RISK Copy: (1) SMS Incidents/Accidents (SAFE) (2) Employee File (3) Employee

Appendix C – Training and Certification

TRAIN OPERATOR AND ROAD SUPERVISOR JOB TASK PROFICIENCY EVALUATION

Name:	[redacted]	Emp.No:	[redacted]	Division:	Branch Ave	Date:	5/20/21

Reason for Certification: *Please place a check in an area below.*

☐ Certification: Student ☐ Pre-certification: Student ☐ Division Request

☑ Re-Certification ☐ Return to Duty ☐ Other_____

Training Time Received: *Please record training time in an area below.*

Rail Training: Weeks: ____ Days: ____ Hours: ____ OJT: ____

Division Training: Weeks: ____ Days: ____ Hours: ____ OJT: ____

NOTE: OJT time is not separate from Weeks/Days/Hours.

Exam Administered		Score	Date Taken
MSRPH	version #:	90 %	5/20/21
TVOIM/TOIM		90 %	5/20/21
Supervisor Combination		n/a %	
Practical	attempt #: 1	QL- 1	5/20/21

Equipment *(current/working condition)*	Yes	No
MSRPH	✓	
Perm/Temp/Special Orders	✓	
Troubleshooting Guide	✓	
Flashlight	✓	
Safety Vest	✓	
Footwear	✓	
Identification (One Badge, RWP)	✓	

Corrective Actions Required	Date Due	Complete	Initials

Forwarded to: QA/QC Group & Div. Mgmt Date: 5/20/2021

Certification Information: *To be completed by QA/QC Staff*

Emp. No: [redacted] Date of Birth:

Date Last Qualified: Certification Class:

Due Date Next Qualification: Corrective Lenses:

Date Qualification Expires: Restrictions:

Signatures:	Date:
[redacted]	5/20/2021
Reviewed by:	5/20/21

Rev. June 5, 2020 - RTRA QA/QC TRAIN OPERATOR AND ROAD SUPERVISOR JOB TASK PROFICIENCY EVALUATION Page 1

[redacted] 5/20/21

TRAIN OPERATOR AND ROAD SUPERVISOR JOB TASK PROFICIENCY EVALUATION (continuation sheet)

CATEGORIES / SUBCATEGORIES	QUALITY LEVEL	REMARKS (*Remarks are required for a quality level score of 2 or 3*) – ALL TIMES (*are in minutes*)
I. Preparation for Service	QL-1	Cars Used: 7206/07 • 7539/38
1. Exterior Inspection	1	7207 - R Truck C/O, 7207 - BPTCO C/O, 7539 - Elec. Rot. Drum
2. Interior Inspection - Trailing Cab	1	7206 - Horn C/O
3. Interior Inspection - Each Car	1	7207 - T/m Light TLCB, 7539 - ELV C/B tripped
4. Interior Inspection – Oper. Cab	1	7538 - ATP C/O
5. Rolling Test / Rolling Brake Test	1	
		Time Allotted: 35:00 / Actual Time: 22m : 42s
II. Mainline Operation	QL-1	
6. Communications	1	
7. Door Oper. & Station Stopping	1	
8. Use of Horn	1	
9. Speed Adherence/Manual Oper.	1	
10. Turn Back Moves	1	Location: Time Allotted: 02:00 / Actual Time: :
11. Manual Route Selection	1	Location: Branch Ave
12. EV Shutoff	1	Time Allotted: 00:30 (01:00) / Actual Time: 0m : 30s
III. Yard Operation	QL-1	
13. Communications	1	
14. Yard Movements	1	
15. Coupling	1	Time Allotted: 08:00 (12:00) / Actual Time: 5m : 13s Cars Used: 7719 + 7597
16. Uncoupling	1	Time Allotted: 05:00 (07:30) / Actual Time: 3m : 42s Cars Used: < 7596 > 7206
17. Isolation (Self-Recovery)	1	Time Allotted: 15:00 (22:30) / Actual Time: 12m: 1s Cars Used: Bad Quad 7206 & 7539
18. Manual Switch Operation	1	Switch #101
IV. Miscellaneous	QL-1	
19. Recovery Train Operation	1	Time Allotted: 12:00 (18:00) / Actual Time: 10m :08s Cars Used: 7206 + 7596
20. Troubleshooting	1	

① ATC Power Supply tripped on 7596 5m:21s QL-1

② Stuck Holding Brake 7597 6m:38s QL-1

Appendix D – Incident Report

Washington Metropolitan Area Transit Authority

Incident Number
20221211#104803MX

OVERVIEW

Department	RTRA RSTO Greenbelt
Incident Date	12/11/2022 07:37 AM
Incident Report Date	12/11/2022 09:43 AM
Maximo #	8639817
Was anyone transported from the scene for medical attention?	No
Was the facility or vehicle evacuated as a result of the incident?	Yes
Incident Type	Rail Vehicle Struck Person on Track
Incident Description	Customer struck by a train., 0/0, F06, PUB, JUMP, 506
People Impact	Fatalities or life threatening injuries.
Asset Impact	Asset temporarily removed from service.
Preferred Phone	301-955-2029
Response Level	Level 1
Recommended Response	CSO will identify team to include subject matter experts, line organization, safety and a facilitator. Team must dedicate 100% of their time for 72 hours in the initial fact finding, document collection and initial analysis.

DETAILS

Environmental Factors

Immediate Mitigation Response	N/A
Lighting	Lights On
Light Conditions	Artificial Lighting
Weather	Clear

Location Information

Rail Station/Yard	ANACOSTIA STATION
Mezzanine or Other Asset	ANACOSTIA, SOUTH MEZZANINE (106)
Address/Nearby Address	1101 HOWARD ROAD SE
Region	WASHINGTON
State	DC
Latitude	38.86324305
Longitude	-76.99519563

OCC Information

Problem Description	Customer struck by a train., 0/0, F06, PUB, JUMP, 506
Response Code	PUB
Trouble Code	JUMP
Asset	R7256
Asset Description	7256, RAIL CAR, KAWASAKI, 7000 AC, A CAR
Asset Type	RAIL CAR
Asset ID	R7256
Vehicle Id	506
Rail Line	GRN
Serial Number	7256
Model	A CAR
Year	2016
Make	KAWASAKI
Reporting Time	12/11/2022 9:43:22 AM

PROPERTY

WMATA Rail Vehicle - R7256

WMATA Asset ID	R7256
Vehicle License State	
Service Type	
Preventability Rating	Not Rated
Make	
Model	
Year	
Asset Type Code	
Vendor Code	
Serial Numbe	
Body Damages	
Collision Factors	

PEOPLE

WMATA Personne

Name	
Employee	
Department Cod	
Department Name	
Email	
Age Range	
Was this person inju	

Medical Transport	[redacted]
Transport Location	
Injury Class	
Body Part	
Injury Type	
Injury Cause	
Was a drug test required?	
What was the Justification?	
Is this person a witness?	
What happened before the incident?	on 12/11/2022. As he track #2, a man jumped train and notified ROCC engers through the train sn't completely on the platform.
What happened after the incident?	The operator was transported for Post Incident Testing b The customer was removed from und signs of life.
Was this person driving?	Yes
Driver's License Number	N/A
License Issuing State	MD
License Expiration Date	
Occupant of Vehicle	WMATA Rail Vehicle - R7256
Personal Protective Equipment (PPE) Usage	
OSHA Recordable	
OSHA Injury Code	
Job Title	
Where Event Occurred	
OSHA Location	
Days Away from Work	
Days Restricted	
Private	Yes

FATIGUE INFORMATION

What was the employee's bed time, for the sleep period preceding the incident?	12/10/2022 07:30 PM
What time did the employee's wake up?	12/11/2022 04:00 AM
Was this the employee's	Yes

sleep schedule in the last seven days, including days off?	
How alert was the employee's immediately prior to the incident?	Fully Alert
Were there any behaviors suggestive of fatigue?	None Observed

SUMMARY OF FATIGUE FACTORS

Length of employee's last sleep	8 hours 30 minutes
Short prior sleep	No
Hours spent awake at time of incident	3 hours 37 minutes
Long wake period	No
Circadian effects on alertness at time of incident (incident between 02:00 am and 05:00 am?)	No
Circadian effects on time of sleep in week before incident	Yes
Employee alertness at incident	No
Observed fatigue behaviours	No

INVESTIGATION

General

Equipment Involved	Rail Car
Known Facts	Customer struck by a train., 0/0, F06, PUB, JUMP, 506
DriveCam Event #	N/A
Key Factors	Criminal Activity
Root Causes	

ATTACHMENTS

Original Name	File Name
Supervisor Report 12_11_22.pdf	20221211_104803MX_48767.pdf
Workers Comp Form.pdf	20221211_104803MX_48768.pdf
Operator Interview Questions.pdf	20221211_104803MX_48769.pdf
Post Incident Testing Form.pdf	20221211_104803MX_48770.pdf
Manifest.pdf	20221211_104803MX_48771.pdf
Incident Report.pdf	20221211_104803MX_48772.pdf
20221211 Incident.pdf	20221211_104803MX_48773.pdf

Appendix E - Root Cause Analysis