750 First St. NE • Ste. 900 • Washington, D.C. 20002 Office: 202-384-1520 • Website: www.wmsc.gov

WMSC Commissioner Brief: W-0293 – Improper Door Operation – Archives Station – May 26, 2023

Prepared for Washington Metrorail Safety Commission meeting on May 14, 2024

Safety event summary:

On Friday, March 26, 2023, a Train Operator inadvertently opened train doors on the opposite side of the platform while servicing Archives Station and did not follow operating and reporting procedures during the event.

After stopping Train 514 at Archives Station on track 1 in preparation to service the station, data analysis shows the Train Operator incorrectly opened the train's doors on the side of the train that was not facing the station's platform. Six seconds later, the Train Operator closed the doors on the incorrect side and opened the doors on the correct side to service the station. The Train Operator continued on, operating the train toward the next station stop. Metrorail procedures require that a train operator report this type of improper door operation to the Rail Operations Control Center (ROCC) and perform a ground walkaround inspection to ensure that no passenger or personnel had fallen to the roadway. The Train Operator did not perform these tasks.

An Office of Systems Maintenance Automatic Fare Collection Technician reported the improper door operation to a Rail Supervisor at Gallery Place-Chinatown Station, who notified the Radio Rail Traffic Controller in the ROCC. The Radio Rail Traffic Controller contacted the Train Operator via radio and asked if the train had a good door operation at Archives Station. The Train Operator provided the Rail Traffic Controller with false information, confirming a good door operation.

During an interview, the Operator stated that they had to sneeze and opened the cab window to do so. While sneezing they mistakenly pressed the door open button on the non-platform side. Review of video footage shows the operator sneezing and spitting out the window of the Operator's cab. The Train Operator also stated that because they did not immediately hear from the ROCC, they thought the doors did not open, and that is why when questioned by the ROCC minutes later, they indicated they had a good door operation at Archives station.

The Train Operator was allowed to continue operating the train in service for 11 station stops and was removed from service when the train arrived at Greenbelt Station for post-event toxicology testing. The train was removed from service for post-incident inspection. There were no injuries reported during this event, however, improper door operations create the risk for serious injury including, fractures, electrocution and death.

Probable Cause:

The probable cause of this event was noncompliance with written operational rules and procedures.

Corrective Actions:

The Train Operator received a 30-day suspension and attended refresher training.

Metrorail is implementing corrective action plans (CAP C-0181) associated with the WMSC's Rail Operations Audit issued in April 2022. Metrorail has committed to completing this CAP in October 2024. This CAP addresses consistent supervisory oversight, effective training, safety promotion, "just culture," and other elements Metrorail has committed to in its Public Transportation Agency Safety Plan (PTASP). Metrorail has revised its Safety Management System

related to Rail Operations. This has included implementing new methods of hazard and risk reporting, training of personnel on reporting and implementation of a new data collection system for those issues so they can be properly evaluated and addressed. The WMSC is currently reviewing this CAP to ensure the deliverables meet the intended actions of the CAP.

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

FINAL REPORT OF INVESTIGATION A&I E23358

Date of Event:	May 26, 2023
Type of Event:	Improper Door Operations
Incident Time:	23:06 hours
Location:	Archives Station, Track1
Time and How received by SAFE:	11:46 hours, Mission Assurance Coordinator (MAC)
WMSC Notification Time:	00:12 hours
Responding Safety Officers:	N/A
Rail Vehicle:	Train 514 – [L3250-51x3003-02x3030-31x3012-13T]
Injuries:	N/A
Damage:	N/A
Emergency Responders:	N/A
SMS I/A Incident Number:	20230527#108807MX

Archives Station – Improper Door Operations

May 26, 2023

Table of Contents

Abbreviations and Acronyms

AIMS	Advanced Information Management System
AFC	Automatic Fare Collection
ARS	Audio Recording System
CCTV	Closed-Circuit Television
COMR	Office of the Chief Mechanical Officer
IIT	Incident Investigation Team
MSRPH	Metrorail Safety Rules and Procedures Handbook
NOAA	National Oceanic and Atmospheric Administration
OAP	Operations Administrative Policy
RTC	Rail Traffic Controller
RTRA	Office of Rail Transportation
ROCC	Rail Operations Control Center
ROQT	Office of Rail Operations Quality Training
SAFE	Department of Safety
SMS	Safety Measurement System
SMNT	Office of Systems Maintenance
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 Friday, May 26, 2023, at 23:06 hours, Train Operator of Train ID 514 [L3250-51x3003-02x3030-31x3012-13T] stationed at Archives-Navy Memorial-Penn Quarter (Archives) Station, track 1, inadvertently opened the train doors on the non-platform side, subsequently closed them, and then correctly opened the doors on the platform side to service the station. The Train Operator failed to report the event to the Rail Operations Control Center (ROCC) and neglected to perform a ground walkaround before departing the station. There were no resulting damages or injuries from this incident. A review of Closed Circuit Television (CCTV) showed the Train Operator open the right-side Operator's cab window (off-platform side) and expectorate out of the window before depressing the Door Open Pushbutton on the off-platform side.

At 23:12 hours, an Office of Systems Maintenance (SMNT) Automatic Fare Collection (AFC) Technician notified a Rail Supervisor at Gallery-Place Chinatown Station about the event. Subsequently, the Rail Supervisor informed the Radio Rail Traffic Controller (RTC) of the incident. In adherence to Standard Operating Procedure 102-1, which outlines the protocol for Removing an Employee from Service for involvement in an operational safety event, the Radio RTC dispatched a Rail Supervisor to relieve the Train Operator from duty for post-incident testing.

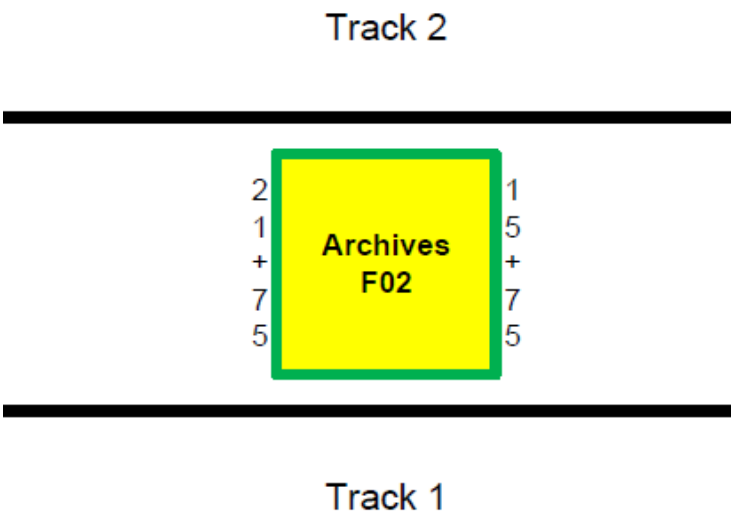
In accordance with the Office of the Chief Mechanical Officer (CMOR) Incident Investigation Team (IIT) Operations Administrative Policy (OAP) 102.06, the Rail Operations Control Center (ROCC) promptly initiated the removal of Train ID 514 from revenue service for post-incident investigative measures. This action adhered to the Rail Vehicle Event Investigation Policy, ensuring a comprehensive examination of the incident.

The probable cause of the Improper Door Operation event on May 26, 2023, is the Train Operator's failure to adhere to established procedures. Specifically, the Operator erred by pressing the door open push button prior to opening the cab window and verifying they were on the platform side by looking for three-five seconds. A Contributing Factor to the event was the Train Operator being distracted by a sneezing episode and expectorating out of the off-platform side cab window, which led to the inadvertent activation of the door open push button.

Incident Site

Archives Station - a center platform station, Track 1

Field Sketch/Schematics



The above depiction is not to scale.

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

The investigative methodologies included the following:

- Site Assessment through video and document review.

- Formal Interviews – SAFE interviewed one individual as part of this investigation. The interview included persons present at, during, and after the incident, those directly involved in the response process, and representatives from the Washington Metrorail Safety Commission (WMSC). SAFE interviewed the following individual:
    - Train Operator

- Informal Interviews – Collected through conversations with individuals during the investigation to provide background and supporting information. Written statements were reviewed from personnel present during the event.
    - AFC Technician

- Documentation Review – Collection of relevant work history information and process documentation contained in WMATA systems of record. These records include:
    - Train Operator Training Records
    - Train Operator Certifications
    - Train Operator 30-Day work history review
    - Metrorail Safety Rules and Procedures Handbook (MSRPH)
    - National Oceanic and Atmospheric Administration (NOAA)
    - Rail Managerial Incident Investigation Report

- 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 Friday, May 26, 2023, at 23:06 hours, the Train Operator of Train ID 514 [L3250-51x3003-02x3030-31x3012-13T] located at Archives Station, track 1 opened the train doors off the platform side, closed the doors, and then opened the door on the correct side of the platform, servicing the station. The Train Operator did not report the event to ROCC or perform a ground walkaround. There was no damage or injuries resulting from this event.

Archives Station is a center-platform station that accommodates eight railcars.

Figure 1 - Train ID 514 door signal lights illuminated, indicating train doors are open along consist. (Door closed on platform side)

According to the ARS playback, at 23:12 hours, an AFC Technician reported to the Rail Supervisor at Gallery-Place Chinatown Station that Train ID 514 opened the train door off the platform side. The Rail Supervisor then reported the event to the Radio RTC.

A Rail Supervisor was dispatched from Gallery-Place Chinatown to Greenbelt Terminal to remove the Train Operator from service for post-incident testing. The train was removed from service for post-incident inspection.

The Advanced Information Management System (AIMS) playback confirmed Train ID 514 opening the train door off the platform, displaying a yellow square instead of a grey square (See Figure 4).

The Train Operator reported in their written statement and interview that they were sneezing and spitting out of the Operator's control-side cab window as they stopped at the eight-car marker and mistakenly pressed the Door Open pushbutton.

Figure 2 – Depicts the Train Operator pressing the door open button on Train ID 514 opening the train doors off-platform.

Figure 3 – Depicts the Train Operator's head out of the operator cab window on the off-platform side closing the train door.

The Train Operator immediately realized their error and pressed the Door Closed pushbutton. When they looked down the platform, they did not see the doors open off the platform side, so they believed the doors didn't actually open.

Chronological Event Timeline

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

Time	Description
23:05:36 hours	Train ID 514 lead car entered the platform at Archives. [SPOTS]
23:06:06 hours	Train ID 514 right door open push button was activated. (Off platform side) [SPOTS]
23:06:12 hours	Train ID 514 right door close push button was activated. (Off platform side) [SPOTS]
23:06:19 hours	Train ID 514 left door open push button was activated [SPOTS]
23:06:35 hours	Train ID 514 left door close push button was activated [SPOTS]
23:07:02 hours	Train ID 514 trailing car cleared Archives platform. [SPOTS]
23:12:02 hours	RTRA Supervisor #1: Contacted the Buttons RTC to inform them that an AFC Technician reported that Train ID 514 opened the train door off the platform at Archives Station. [Phone/OPS3]
23:21:11 hours	Radio RTC: Requested Rail Supervisor #1 to landline ROCC. [Radio, OPS 3]
23:21:30 hours	Radio RTC: Requested confirmation if the train had a good door operation at Archives Station. Train ID 514: Acknowledged and confirmed a good door operation. [Radio, OPS 3]
23:22:26 hours	Radio RTC: Requested Rail Supervisor #2 to landline ROCC [Radio, Ops3]
23:29:51 hours	Radio RTC: Requested Train ID 514 lead car number Train ID 514: Confirmed lead car 3250 [Radio, OPS 3]
23:35:56 hours	Radio RTC: Dispatched Rail Supervisor #1 from Gallery-Place Station to relieve the Greenbelt Terminal Supervisor. Rail Supervisor #1: Acknowledged. [Radio, OPS3]
23:46:40 hours	MAC: Notified SAFE Director on Call of Improper Door Operation. [Phone/MAC]

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

Advanced Information Management System (AIMS)

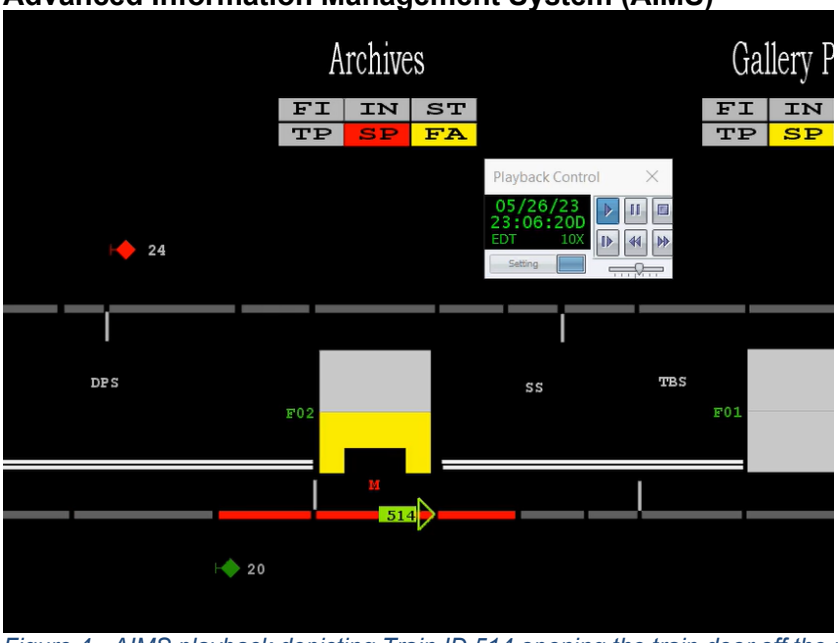


*Figure 4 - AIMS playback depicting Train ID 514 opening the train door off the platform. (*yellow square indicates train door open on the wrong side)*

Office of the Chief Mechanical Officer, Incident Investigation Team (IIT)
Adopted from CMOR IIT report with minor formatting and grammatical edits:

"IIT completed the data analysis of the incident below. Based on the data, Train 514 stopped at Archives (Archives are a Center Platform; hence the left doors face the Platform); after stopping at Archives, a Right Door Operation was Performed (Doors Opened off the platform side). A second after the doors opened off the platform, the right doors close button was depressed, and the doors closed. The right doors were opened or transitioned to the closed position for 4 seconds. The doors were opened on the platform side, and the station was serviced after the improper door operation. Based on the VMS data, no mechanical failure could have contributed to this incident; the doors responded to the commands that the door push buttons entered."

See timeline of events below:

Time	Description of Events
23:04:20	Train 514 stopped at Archives track 1.
23:04:23	Right Door Open Push Button was depressed.
23:04:23	Right Doors Opened
23:04:24	Right Door Close Push Button was depressed.

23:04:27	Right Doors Closed

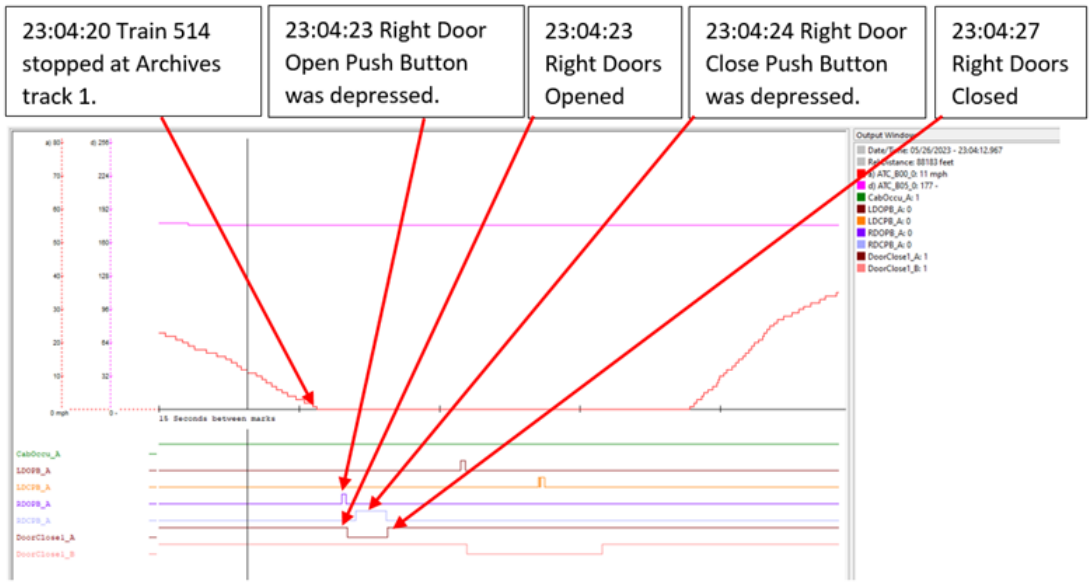


Figure 5 - Data Analysis from the lead railcar 3250.

ROCS SPOTS REPORT

ROCS SPOTS REPORT

based on up-to-the-second operational performance data from the Rail Operations Control System

Current date/time: Mon Jun 5 12:28:39 2023

Select Platform: F02-1 **and/or Select ID:** 514 Leave blank to remove criteria

and/or Select 4-digit car number: Leave blank to remove criteria

Select Date: May 26 2023 **Select Times (0-24HRS): From** 22:00 **To** 24:00

Generate Report

ID	Platform	length	dcode	Right door open	Right door close	dwell	Left door open	Left door close	dwell	Head Arrived	Tail cleared	cars	Travel Time door open to door open
514	F02-1	8	44	23:06:06	23:06:12	6	23:06:19	23:06:35	16	23:05:36	23:07:02	3250-3251.3003-3002.3030-3031.3012-3013	-

Figure 6 - ROCS SPOTS Report depicting right side and left side door operations of Train ID 514.

Office of Rail Transportation (RTRA)
Adopted from RTRA report:

The Train Operators actions relative to this incident were inappropriate, violated major safety/operational rules, and were extremely unsafe for passengers. The Train Operator mistakenly pressed the door open button on the non-platform side of the station, resulting in the doors opening inappropriately. This action deviated from the standard practice of verifying the

platform side of the train by observing the platform from the cab window with hands at your side before initiating the door-opening process. Operational/Safety rules indicate that a train operator in revenue service, when their train is otherwise with the limits of a station platform, shall not manually operate the open doors control on the side of the train opposite the platform. Based upon the VMS, Oracle Report, and TWC report, the Train Operator manually opened the door opposite the platform side at approximately 11:04:23. Operators are required to always be aware of their surroundings and of their actions. In this case, the Train Operator accidently opened the doors on the opposite platform side, and you put the safety of our customers at risk, particularly when not immediately reporting the occurrence and conducting a ground walkaround inspection.

The Train Operator in this event received a thirty (30) day suspension and will attend a refresher training with the Office of Rail Operations Quality Training (ROQT).

Interview Findings

As part of the investigation launched into the event, SAFE interviewed one person. The interview 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

- The Train Operator stated they were operating their second to last trip when the incident occurred.
- The Train Operator stated they had to sneeze and opened the cab window to sneeze out of; in doing so, they mistakenly pressed the door open push button on the non-platform side.
- The Train Operator stated they realized they had opened the train doors on the non-platform side of the station and quickly closed them.
- The Train Operator stated they serviced the station and waited to hear from ROCC. The Train Operator said that because ROCC did not call them, they thought the train doors did not open.
- The Train Operator stated that as they were operating after the event, the RTC contacted them and asked if they had a good door operation at Archives Station, to which they confirmed a good one.

Weather

On May 26, 2023, at the time of the incident, NOAA recorded the temperature as 61°F. The weather did not contribute to this incident (Weather source: NOAA) – Location: Washington, D.C.)

Related Rules and Procedures

SOP 40 – 6.1.5

-D. Verify the platform side of the train by placing their head out of the cab window and first look and identify the platform.

-E. Look at the doors on the platform side of the train to observe any activity in front of the doors, with hands to their side for five (5) seconds.

-F. Depress the Car's Open Doors button on the platform side of the train.

Metro Operating Rulebook (MOR)

8.18.4 In the event train doors are opened outside the platform limits or on the side opposite the platform, Rail Vehicle Operators shall close doors, notify the Rail Traffic Controller, and conduct a ground walk around inspection. The Rail Traffic Controller will determine if the train is to be taken out of service and if it is safe to discharge customers at that station.

Human Factors

Training and Certifications

The Train Operator was last certified in their position on July 2022. They passed with a QL-2, which is the minimum rating for certification. They received this rating because they exceeded the allotted troubleshooting time to rate QL-1.

Evidence of Fatigue

Evidence of fatigue was evaluated conditions at the time of the incident to distinguish whether evidence of fatigue was present. The available data indicated no sign of fatigue. The employee reported feeling Fully Alert at the time of the incident. The employee reported experiencing no symptoms of fatigue in the time leading up to the incident.

Fatigue Risk

Fatigue risk was evaluated incident data for fatigue risk factors. No significant risk was identified. The incident time of day did not suggest an increased risk of fatigue-related impairment. The employee reported a regular sleep schedule in the days leading up to the incident. The employee worked the evening shift in the days leading up to the incident. The employee was awake for 15 hours and 6 minutes at the time of the incident. The employee reported 9 hours of sleep in the 24 hours preceding the incident. The off-duty period was 15 hours, providing an opportunity for 7-9 hours of sleep. This was 1 hour more than the employee's usual workday sleep duration. The employee reported no issues with sleep. The employee worked the evening shift in the days leading up to the incident.

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.

Findings

- The Train Operator admitted that they pushed the door open push button on the off-platform side of the station.

- There were no mechanical issues identified with the train.
- The Train Operator did not complete a ground walkaround after opening the doors off the platform.
- The Train Operator did not initially report the Improper Door Operations event to ROCC. An AFC Technician reported the event to a Rail Supervisor.

Immediate Mitigation to Prevent Recurrence

- The incident train was removed from service for post-incident inspection.
- The Train Operator was removed from service for post-incident testing.
- Rail Transportation took administrative action related to the failure to report the event and procedural deviation.

Probable Cause Statement

The probable cause of the Improper Door Operation event on May 26, 2023, is the Train Operator's failure to adhere to established procedures. Specifically, the Operator erred by pressing the door open push button prior to opening the cab window and verifying they were on the platform side by looking for three-five seconds. A Contributing Factor to the event was the Train Operator being distracted by a sneezing episode and expectorating out of the off-platform side cab window, which led to the inadvertent activation of the door open push button.

Recommended Corrective Actions

Corrective Action Code	Description	Responsible Party	Estimated Completion Date
108807_SAFECAPS_RTRA_001	Train Operator attend ROQT refresher training – SOP 40	RTRA SRC	Completed
108807_SAFECAPS_RTRA_002	Based upon the nature of the incident, established discipline for the type of violation, and failing to report the incident – The train Operator will be suspended for Thirty (30) days.	RTRA SRC	Completed

.

Drafted By: SAFE 710 – 07/07/2023
Reviewed By: SAFE 704 – 07/12/2023
Approved By: SAFE 71 – 07/25/2023

Appendices

Appendix A – Interview Summary

The below narratives summarize the incident and represent the statements made by the involved individual. As such, times and details may present a conflict with the data contained in systems of record.

Train Operator

The Train Operator has been a WMATA employee for eleven years and in their current position for six years. The Train Operator is currently RWP Level 2 certified with an expiration date of August 2023, with a QL-2 (troubleshooting exceeded the allotted time for QL-1 status)

The Train Operator stated they were operating their second to last trip, and upon arriving at the eight-car marker of Archives Station, they had to sneeze. They sneezed out of the right-side window, mistakenly pressed the door open button, and immediately pressed the door close button. The Train Operator stated that the doors did not open as he looked with his head out of the window. The Train Operator said they opened the platform side's train doors and waited to hear from Central. They said they did not receive a call from ROCC, so they continued to the next station.

The Train Operator stated that ROCC contacted them when they arrived at Fort Totten Station and asked three times if they had a door problem at Archives Station. Once they arrived at Greenbelt Station, the Terminal Supervisor asked what happened on the line and informed them they were being removed from service.

The Train Operator stated they thought they must not have opened the train doors off the platform because ROCC did not call them. The Train Operator said they know that if the train doors are opened off the platform, they are to notify ROCC.

WMATA/RTRA Incident/Acci[illegible]t Report (Other than Motor Vehic! Page ___ of ___

Incident Information: This page must be completed for all incidents

Date: 5-26-23	Incident Time:	Time Reported:	Reported by: Customer ❑ Employee ❑ ROCC ❑ Other ❑ _____

Location

Station: ARCHIVE	Mezzanine #	Track #/Destination: 1 GREEN BELT	Chain Marker/Signal Number

TYPE OF INCIDENT

❑ Property Damage	❑ Smoke	❑ Fire	❑ Customer Complaint
❑ Customer injury	❑ Customer Illness	❑ Employee Injury	❑ Employee Illness
❑ Criminal Activity	❑ Elevator Entrapment	❑ Rail Vehicle Incident	❑ Other (Explain in description of incident)

WEATHER	LIGHT CONDITIONS (natural lighting)	LIGHTING (artificial lighting)
Clear ☒ Rain ❑	Dawn/Dusk ❑ Daylight ❑	Lights On ☒ Lights Off ❑
Snow ❑ Sleet/Ice ❑	Dark ❑ Tunnel/Underground ☒	Lights Not Working ❑

STATION INCIDENTS: Always include equipment number you use for MCC/AFC/EOC

Elevator/Escalator#:	AFC #:	Room Number/Location:

Failure Number(s): N/A

Parking Lot ❑ Paid Area ❑ Free Area ❑ Garage ❑ Station Entrance ❑ Stairway # ____❑ Platform ❑ Ancillary Room ❑

Injury/Illness reported aboard Train ❑ Other ❑ _____

Name of Responding Supervisor:	Name/Department of PLNT/AFC or other WMATA responder

TRAIN INCIDENTS

Train ID: 514	Destination: GREENBELT	Car Numbers(list all cars in consist):	Lead Car: 3250

Name of Responding Supervisor:	Name/Department of CMNT/TRST or other WMATA responder

DESCRIBE THE INCIDENT: Include what you did to correct the problem and who you notified and when.

Describe any property damage and the extent of any injuries.

Sneezing coughing + spitting out the window. Archives as I was putting my head out the window my hands hitting the buttons

MAY 27 PM 1:12

Employee Completing Report

[redacted] Date: 5-26-23

Division: BRANCH AVE	Run #: 501	Block #: SECOND	Assigned Days: SUNDAY - MONDAY

To Be Completed By Reviewing Manager

Supervisor Name:(print)	Supervisor Signature	Employee #	Date:

Action taken/needed

SMS Number:

50.753A 04/12 White Copy: Division or Supervisor Yellow Copy: For any incident involving escalators or elevators; remains in kiosk for use of elevator/escalator inspectors

Figure 7 - Employee statement

Washington Metropolitan Area Transit Authority

Office of Rail Transportation: Managerial Incident Investigation Report

Incident Status: **PRELIMINARY**

GENERAL INCIDENT INFORMATION

Incident Type:	Doors opened off the platform	Delay (Minutes):	8 minutes
Incident Date:	Friday, May 26, 2023	Vehicles Involved:	L3250*3003*3030*3012
Incident Time:	23:04 pm	First Reported By:	ROCC
Location:	Archives #1		

BRIEF DESCRIPTION:

At approximately 11:43pm Operator of Train #514 failed to report doors opened off the platform. Train and operator removed from service, resulting in a no dispatch.

Key Employees Involved & Employee Statements:

Train Operator [redacted] - wrote in his incident report and was interviewed by Assistant Superintendent [redacted] During this interview, Train Operator stated the following:

(Verbal) "I accidently bumped the doors off the platform side at Archives and ROCC didn't contact me about it until I reached Ft Totten."

(Incident Report) "Sneezing, coughing and spitting out of the window. Archives I was putting my head out the window my hands hitting the button."

Figure 8 - RTRA Managerial Incident Investigation Report 1 of 3.

Washington Metropolitan Area Transit Authority

Office of Rail Transportation: Managerial Incident Investigation Report

Post Incident Testing & Employee History:

Operator [redacted] was removed from service and transported for Post Incident Testing.
Operator [redacted] has been a WMATA employee since Mar 4, 2013.
Operator [redacted] has been on the Rail since Feb 25, 2018.
Operator [redacted] last certified as a Train Operator on Jul 12, 2022 (QL-2).
Operator [redacted] has had one (4) safety violation that occurred on,

- Dec 2, 2022 failing to remain on duty.
- Apr 24, 2018 Station overrun.
- May 19, 2018 Station overrun.
- Mar 16, 2018 Station overrun.
- Mar 12, 2018 Station overrun.

SIGNIFICANT INCIDENT TIMELINE:

Time	Description of Events
23:04:20	Train 514 stopped at Archives track 1.
23:04:23	Right Door Open Push Button was depressed.
23:04:23	Right Doors Opened
23:04:24	Right Door Close Push Button was depressed.
23:04:27	Right Doors Closed

SIGNIFICANT FINDINGS & PENDING ISSUES:

- The operator failed to follow OR 3.18 and GR 1.46, which caused the operator to inadvertently open the doors on the opposite side of the platform at Archives station track #1.

Office of Rail Transportation: Managerial Incident Investigation Report Page 2 of 3

Figure 9 – RTRA Managerial Incident Investigation Report 2 of 3.

Washington Metropolitan Area Transit Authority

Office of Rail Transportation: Managerial Incident Investigation Report

CORRECTIVE ACTIONS:

The operator has been placed on post incident investigation pending disciplinary action. Refresher Training with ROOT to review SOP 40, also Station Overrun procedures, will also be requested.

INCIDENT PHOTOS: ATTACH ANY SIGNIFICANT PHOTOS BASED ON THE INITIAL INCIDENT INVESTIGATION.

Report Prepared by: Assistant Superintendent [redacted] 4/29/2023

Report Reviewed by:

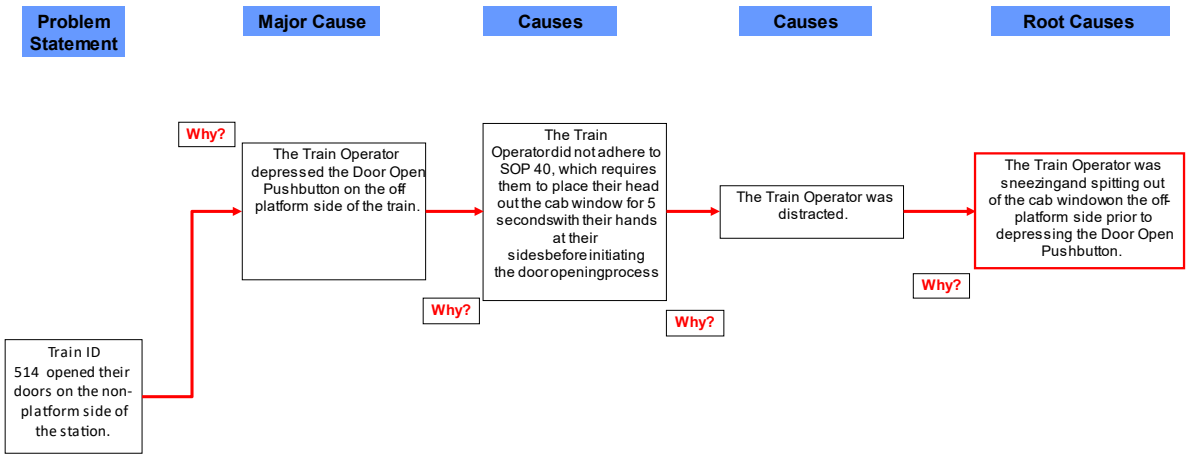
Office of Rail Transportation: Managerial Incident Investigation Report Page 3 of 3

Figure 10 - RTRA Managerial Incident Investigation Report 3 of 3

Appendix C – Scene Photographs

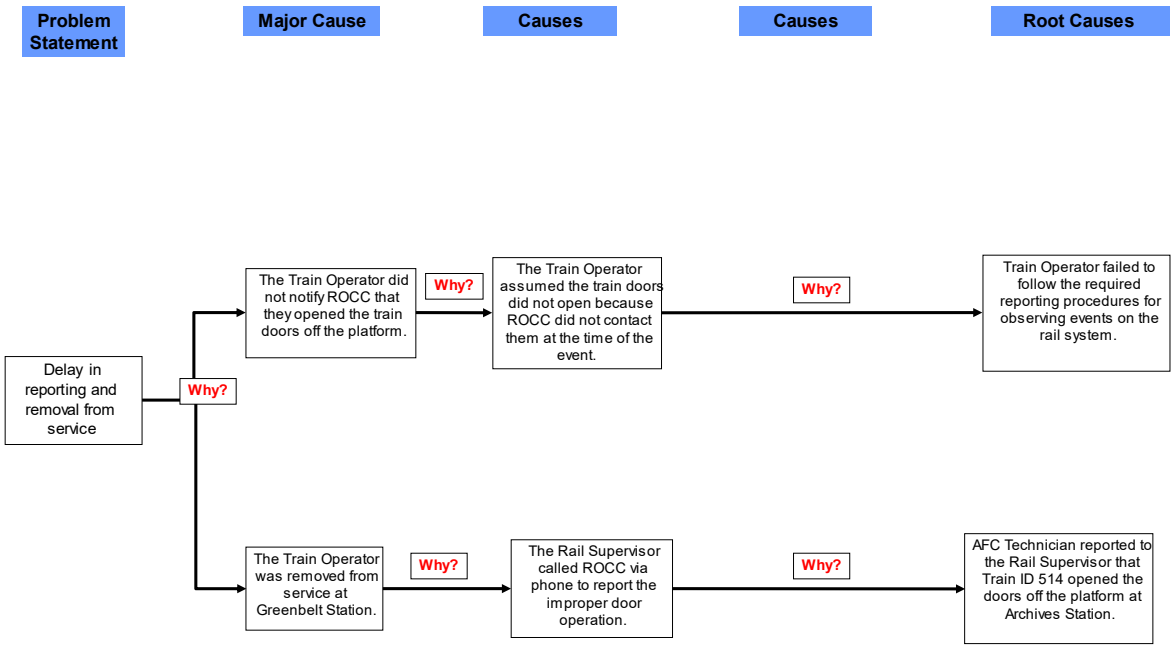

3251

Appendix D – Why-Tree Analysis



Root Cause Analysis

Figure 11 - Root Cause Analysis 1 of 2.



Root Cause Analysis

Figure 12 - Root Cause Analysis 2 of 2.