



W-0305 Train Operator Removed for Fatigue, Drug and Alcohol – Orange Line – September 10, 2023

Document Purpose

This WMSC written report on WMATA Metrorail's safety event investigation and review of Metrorail's findings in accordance with the WMSC Program Standard, in conjunction with the attached Metrorail investigation report that has undergone WMSC staff review, feedback, and Metrorail revision, describes the investigation activities, identifies factors causing or contributing to the accident, and sets forth ongoing, additional, or upcoming corrective actions and further oversight work (such as inspections and audits) as necessary or appropriate. The WMSC's ongoing oversight during the investigative process, including safety event reporting and verification, participation in investigative interviews, data review, consistent communication with the Metrorail investigations team, and feedback on Metrorail's reports leads to further improvements prior to consideration of the reports by WMSC Commissioners for adoption. The WMSC's safety event investigation oversight assures the sufficiency and thoroughness of Metrorail's investigations. The WMSC Commissioners are considering these documents (the WMSC review and Metrorail's investigation report) as a unified item for adoption at the Washington Metrorail Safety Commission meeting on August 6, 2024.

WMSC staff recommend adoption of this investigation.

Safety event summary:

A Train Operator who was fatigued and who had consumed alcohol prior to their shift operated a train through multiple stations without allowing passengers on and off, stopped the train at improper locations, stopped for extended periods with no actions, and did not respond to radio communications. These actions occurred over the course of approximately two hours before the train operator was removed from service. After being removed from service, the Train Operator refused to cooperate with a required drug and alcohol test, left the presence of Rail Supervisors, became combative with Rail Supervisors, and later became combative with Metro Transit Police and was therefore handcuffed.

The causes and contributing factors include:

- Metrorail personnel demonstrating a culture of noncompliance with written operational rules, procedures, and manuals.
- Metrorail's insufficient fitness for duty checks prior to and during shifts as required by APTA Standard.
- Metrorail's insufficient action on available data, including data available to the control center and others, that the train did not service stations as required and moved through stations at excessive speed.
- No one in stations or on the train identifying and communicating to personnel other than the train operator that the train was not properly stopping and servicing stations until after 9:14 a.m.
- The operator's fatigue.
- The operator's intoxication¹.
- The operator's expectation that this overtime shift would not include train operation
- Metrorail not proactively identifying through its physical exams or other standard industry practices the operator's difficulty with sleeping to allow for effective mitigations
- Metrorail's lack of effective fatigue self-reporting system

¹ In accordance with federal regulation, a refusal to test is treated as a positive test.



Corrective actions:

As a result of this investigation and associated WMSC follow-up, Metrorail developed the following corrective actions (expected completion dates July 31, 2024, after development of this document):

- Metrorail's Safety Department to review and report on Rail Transportation's compliance with post-incident testing requirements
- Metrorail is distributing information on the steps to be followed when personnel refuse to participate in required post-incident drug and alcohol testing
- Due to the WMSC's follow-up, the Metro Integrated Command and Control Center is evaluating with IT the previously used train "holding" screen that identified to Rail Traffic Controllers when a train was stopped for longer than expected. This screen was previously displayed on the "big board" at the front of the room, and was optional for controllers to open on their computers.

Metrorail is in the process of implementing related corrective action plans (CAPs) including:

- C-0120 addressing the finding that Metrorail ignores the minimum daily release period (rest period) requirements in its Fatigue Risk Management Policy.
- C-0121 addressing the finding that Metrorail does not have adequate access to, documentation of, or compilation of data for WMATA to assess compliance with its hours-of-service requirements.
- C-0129 addressing the finding that WMATA does not have a documented procedure for and training to carry out fitness for duty checks prior to or during shifts on a regular basis for all covered employees as specified in the APTA Fitness for Duty Standard.
- C-0130 addressing the recommendation that Metrorail collect fitness for duty data in a manner that allows for identification, tracking, and trending of issues.
- C-0181 addressing the finding that elements of Metrorail have a culture that accepts noncompliance with written operational rules, instructions, and manuals.
- C-0182 addressing the finding that Metrorail does not effectively identify, track, communicate, and address operational hazards as required by its Agency Safety Plan.

Metrorail has completed implementation of other corrective action plans, including corrective action plans related to post-event drug and alcohol testing. Metrorail properly in accordance with its procedures determined in this case that the Train Operator refused the test. Therefore, the test is treated as positive.

In addition to frequent inspections, regular corrective action plan oversight, and other activities, the WMSC is scheduled to conduct in-depth audits over the next year of Fitness for Duty and Occupational Health, the Metro Integrated Command and Control Center, Rail Operations, and other areas.

Event Details

The Train Operator operated the train through stations without stopping beginning at 7:50 a.m. at McPherson Square Station on Track 2 and continuing through 9:18 a.m. at Federal Center SW Station on Track 1. The investigation demonstrates that this Train Operator had earlier stopped at Eastern Market Station at 7:35 a.m., serviced the station, then did not move for four minutes without any communication to or from the control center. The Train Operator similarly



stopped the train at Virginia Square Station at 8:49 a.m. for six minutes without any communication to or from the control center. In each case, the train should have been stopped at the station for less than one minute. The control center took no action on the train operating in an unusual fashion. Further, the investigation demonstrates that the train operator stopped beyond the platform limits at other stations.

In all, the Train Operator passed through six stations without stopping, stopped at multiple other stations in an improper position and opened train doors (despite the improper positioning of the train to ensure it, the doors opened on the platform), had several instances of sudden braking, and did not respond to multiple radio communications. None of the improper and unsafe operations were reported by the Train Operator.

Station video shows that riders were present on and off the train when the train did not properly service stations including McPherson Square Station at 7:50 a.m. In that case, the train stopped at the station for about 90 seconds, but the Train Operator did not open the doors. The Train Operator then improperly turned off the lights in the passenger area of the train, and moved the train toward Farragut West Station. At 7:53 a.m., a Metrorail employee reported to the control center that the train was in service with its lights off. When contacted by the Radio Rail Traffic Controller, the Train Operator stated the lights were now back on.

At 9:07 a.m., the Vienna Terminal Supervisor requested a rail supervisor check on this train operator. The train had been late arriving to Vienna Station.

At 9:20 a.m., Metro Transit Police got a text message indicating that the operator had not serviced Foggy Bottom-GWU and Smithsonian Station, and suddenly applied brakes at L'Enfant Plaza Station (later investigation showed the train stopped approximately halfway into the platform at Smithsonian Station, then continued on without stopping at the proper location and without opening the doors). This was communicated by MTPD to the Button Rail Traffic Controller at 9:23 a.m. At 9:27 a.m., a Rail Traffic Controller directed a Rail Supervisor to meet the train at Deanwood Station and take over operations. The Radio Rail Traffic Controller attempted to contact the Train Operator on the radio multiple times as the train continued to Potomac Avenue and Stadium-Armory stations but got no response. Rail Traffic Controllers took no action to remove speed commands, remove power, or otherwise stop the train. The Train Operator communicated on the radio at 9:34 a.m. that they were at Stadium-Armory Station.

In the investigative interview, the Train Operator acknowledged drinking alcohol prior to their shift, and stated they believed they had stopped drinking alcohol before midnight (the operator's shift began at 5:45 a.m.), but said they could not be sure if they were under the influence when operating the train. The Train Operator also reported getting very little sleep before coming to work for this overtime shift, roughly 1-2 hours. The Train Operator reported normally getting about 5 hours of sleep, that they were jetlagged from a vacation that they had returned from a few days earlier, and that they have issues with sleep.

The Train Operator agreed to the gap assignment as an overtime shift, which they believed would mean they were not likely to be expected to operate trains on mainline. The Train Operator was provided with a trip assignment when they arrived at work, as they were an on-duty train operator available to be put into service. The Train Operator stated in an investigative interview that they thought a Yard Train Operator would get the assignment, and that the Gap person would not need to operate a train at that time as they would be the last to be assigned work.

In the investigative interview, the Train Operator stated that they did not recall the day's operation.



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The Train Operator stated that they could not recall not servicing stations, so they must have fallen asleep. After 9 a.m., they stated that they did not hear the multiple radio attempts to contact them, but heard a Rail Supervisor being sent to meet their train.



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

FINAL REPORT OF INVESTIGATION A&I E23636

Date of Event:	September 10, 2023
Type of Event:	Operator Removed from Service (Fatigue – Drug & Alcohol) - Failure to Service Stations
Incident Time:	07:50 Hours
Location:	Multiple Stations
Time and How received by SAFE:	09:30 Hours – SAFE/MAC
WMSC Notification Time:	11:12 Hours
Responding Safety Officers:	None
Rail Vehicle:	Train ID 909 (L7690/91x7639/38x7372/73x7399/98T)
Injuries:	None
Damage:	None
Emergency Responders:	MTPD (Metro Transit Police Department)
SMS I/A Number	20230910#111280

**Foggy Bottom Station – Operator Removed from Service
(Fatigue – Drug & Alcohol) - Failure to Service Stations**

September 10, 2023

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Abbreviations and Acronyms

AIMS	Advanced Information Management System
AOM	Assistant Operations Manager
ARS	Audio Recording System
CCTV	Closed-Circuit Television
CMOR	Office of Chief Mechanical Officer
CMNT	Office of Car Maintenance
COO	Chief Operating Officer
DER	Designated Employer Representative
DOT	Department of Transportation
FTA	Federal Transit Administration
IIT	Incident Investigation Team
MOR	Metrorail Operating Rulebook
MTPD	Metro Transit Police Department
NOAA	National Oceanic and Atmospheric Administration
OAP	Operations Administrative Policy
OM	Operations Manager
RTC	Rail Traffic Controller
RTRA	Office of Rail Transportation
ROCC	Rail Operations Control Center
SAFE	Department of Safety
SMS	Safety Measurement System
SOCC	Security Operations Control Center
SPOTS	System Performance On-Time System
WMATA	Washington Metropolitan Area Transit Authority
WMSC	Washington Metrorail Safety Commission

Washington Metropolitan Area Transit Authority
Department of Safety – Office of Safety Investigations

Executive Summary

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

On Sunday, September 10, 2023, at 09:23 hours, a Metro Transit Police Department (MTPD) Communications Technician contacted the Rail Operations Control Center (ROCC) Button Rail Traffic Controller (RTC) and reported receiving a tip via the Security Operations Control Center (SOCC) notification system that Train ID 909 (L7690/91x7639/38x7372/73x7399/98T) failed to service Foggy Bottom Station and Smithsonian Station. The Button RTC notified the Assistant Operations Manager (AOM) of the report.

At 09:27 hours, the Radio RTC instructed Office of Rail Transportation (RTRA) Rail Supervisor #1, located at Deanwood Station, to report to Minnesota Avenue Station to intercept Train ID 909. The Radio RTC attempted to contact Train ID 909 numerous times via radio without a response from the Train Operator. At 09:34 hours, the Train Operator responded to ROCC and was advised that Rail Supervisor #1 would meet the train at Minnesota Avenue Station.

At 09:35 hours, the Radio RTC inquired if the Train Operator had serviced Foggy Bottom Station, but there was no response. At 09:38 hours, Rail Supervisor #1 took over operating Train ID 909 to New Carrollton Station.

At 09:42 hours, the AOM advised the New Carrollton Station Terminal Supervisor that the Train Operator would be removed from service. At 09:56 hours, Rail Supervisor #1 was instructed by the Button RTC to transport the Train Operator for post-incident testing due to failure to service multiple stations. The Radio RTC contacted Rail Supervisor #2 and instructed them to meet Rail Supervisor #1 to transport the Train Operator.

At 10:19 hours, while en route to the testing site, Rail Supervisor #1 and the Train Operator arrived at Stadium-Armory Station aboard Train ID 912. Rail Supervisor #1 contacted ROCC and reported that the Train Operator exited the train and refused to attend the post-incident testing. At 10:23 hours, the Train Operator boarded Train ID 902 on track 1 (towards New Carrollton Station). Rail Supervisor #2 was already aboard, and they both exited the train at Minnesota Avenue Station. The Train Operator walked away and out of the line of sight of Rail Supervisor #2.

At 11:17 hours, MTPD contacted the Button RTC and requested a Rail Supervisor to respond to Minnesota Avenue Station. At 11:20 hours, the Button RTC instructed Rail Supervisor #2 to return to Minnesota Avenue Station. At 11:57 hours, Rail Supervisor #2 reported that the Train Operator was observed being combative with an MTPD Officer and was restrained with handcuffs.

MTPD spoke with the Train Operator, and they agreed to be transported for post-incident testing; however, the Office of Health and Wellness (OHAW) personnel declined to perform the testing since the Train Operator refused to test and deviated from the post-incident testing procedures.

The train consist was removed from service for post-incident inspection.

A review of the available video and recorded train data indicated that fatigue may have been a factor in the Train Operator's failure to service the stations. They were observed with several signs of fatigue and reported not sleeping the night before the event. In addition to failing to service the

station, the Train Operator experienced multiple Station Stop Misalignments, where the train overran the eight-car marker, but all doors remained aligned with the platform.

The probable cause of the Operator Removed from Service (Fatigue – Drug & Alcohol) – Failure to Service Stations event on September 10, 2023, was the Train Operator failing to service six stations due to non-work related issues preventing them from getting sleep the night before.

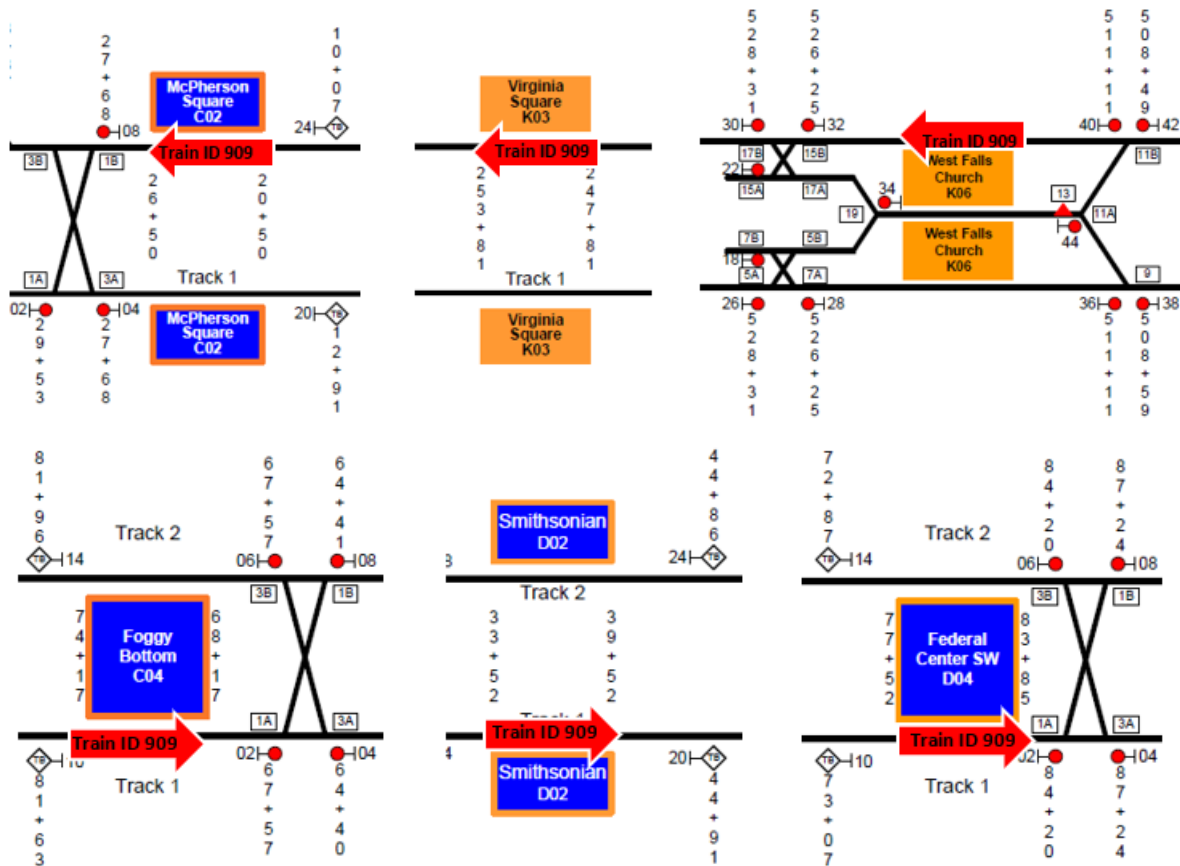
Incident Site

- Stations that were not serviced:** 07:50 hours – McPherson Square Station, track 2
 08:03 hours – Virginia Square Station, track 2
 08:19 hours – West Falls Church Station, track 2
 09:03 hours – Foggy Bottom Station, track 1
 09:14 hours – Smithsonian Station, track 1
 09:18 hours – Federal Center SW Station, track 1

Misalignments at Stations:

- 07:29 hours – Stadium-Armory Station, track 2, overran by five feet
 07:32 hours – Potomac Avenue Station, track 2, overran by seven feet
 07:51 hours – Farragut West Station, track 2, overran by two feet
 08:49 hours – Virginia Square Station, track 1, overran by six feet

Field Sketch/Schematics



The above depictions are 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 three individuals as part of this investigation. Interviews 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). The following individuals have completed interviews as of the time of this report:
 - Train Operator (Train ID 909)
 - RTRA Supervisor #1
 - RTRA Supervisor #2
- Informal Interviews – Collected through conversations with individuals during the investigation to provide background and supporting information. Written statements were reviewed by personnel present during the event.
 - Terminal Supervisor – Vienna Station
 - As-Directed Train Operator – Vienna Station
- Documentation Review – A collection of relevant work history information and process documentation contained in Metro systems of record. These records include:
 - Metrorail Operating Rulebook (MOR)
 - National Oceanic and Atmospheric Administration (NOAA)
 - Train Operator Written Statement
 - Train Operator 30-Day Work History
 - Train Operator Manifest
 - RTRA Supervisors Incident Reports
- System Data Recording Review – A collection of information contained in Metro Data Recording Systems. This data includes:
 - Audio Recording System (ARS) playback, [Radio and Landline Communications]
 - Closed-circuit television (CCTV)
 - System Performance On-Time Summary (SPOTS)
 - Office of the Chief Mechanical Officer, Incident Investigation Team (IIT) Analysis

Investigation

On Sunday, September 10, 2023, at 09:23 hours, an MTPD Communications Technician contacted the ROCC Button RTC and reported receiving a tip via the SOCC notification system that Train ID 909 overran Foggy Bottom Station and Smithsonian Station on track 1. The Button RTC notified the AOM of the report.

The System Performance On-Time Summary (SPOTS) revealed that at 07:14 hours, Train ID 909 departed New Carrollton Station on track 2. At 07:35 hours, Train ID 909 arrived at Eastern Market Station. The Train Operator serviced the station, then held at the station for four minutes without instruction from ROCC and departed at 07:39 hours.

At 07:50 hours, Train ID 909 arrived at McPherson Square Station, stopped within the platform limits, did not service the station, and continued to Farragut West Station.



Image 1 - Train ID 909 stops at McPherson Square Station at 07:50 hours for approximately 90 seconds and fails to service the platform, track 2, dimming the lights and then moving towards Farragut West Station.

The Audio Recording System (ARS) revealed that at 07:53 hours, an unknown employee contacted ROCC and reported that Train ID 909 was operating with the interior lights turned off. The Radio RTC questioned the Train Operator regarding the report, and the Train Operator advised that the interior lights were turned back on.

At 08:03 hours, Train ID 909 arrived at Virginia Square Station, stopped within the platform limits, did not service the station, and continued to Ballston Station.



Image 2 - Train ID 909 stops at Virginia Square Station at 08:03 hours for approximately two minutes and fails to service the platform, track 2.

At 08:19 hours, Train ID 909 arrived at West Falls Church Station, stopped within the platform limits, did not service the station, and continued to Dunn Loring Station. The Vienna Terminal Supervisor contacted the AOM and advised that Train ID 909 was late arriving at Vienna Station. The AOM responded that Train ID 909 held at Eastern Market for six minutes.



Image 3 - Train ID 909 stops at West Falls Church Station at 08:19 hours for approximately two minutes and fails to service the platform, track 2.

At 08:31 hours, Train ID 909 arrived at Vienna Station. The Vienna Terminal Supervisor instructed the Train Operator to remain aboard Train ID 909 on the now-trailing end. An As-Directed Train Operator was standing on the platform to operate the new lead end back towards New Carrollton immediately after alighting and boarding passengers. The As-Directed Operator operated the train from Vienna Station to Dunn Loring Station, track 1, where they turned the train over to the Train Operator at that location.

At 08:49 hours, Train ID 909 arrived at Virginia Square Station. The Train Operator serviced the station, then held at the station for six minutes without instruction from ROCC and departed at 08:55 hours.

At 09:03 hours, Train ID 909 at Foggy Bottom Station stopped within the platform limits, did not service the station, and continued to Farragut West Station.



Image 4 - Train ID 909 stops at Foggy Bottom Station at 09:03 hours for approximately two minutes and fails to service the platform, track 1.

At 09:07 hours, the Vienna Terminal Supervisor contacted the AOM and requested a Rail Supervisor to check on the Train Operator of Train ID 909 because the train was later than normal.

At 09:14 hours, Train ID 909 arrived at Smithsonian Station, stopped within the platform limits, did not service the station, and continued to L'Enfant Plaza Station.



Image 5 - Train ID 909 rolls through Smithsonian Station at 09:14 hours, failing to stop and failing to service the platform, track 1.

At 09:18 hours, Train ID 909 arrived at Federal Center Station, stopped within the platform limits, did not service the station, and continued to Capitol South Station.



Image 6 - Train ID 909 stops at Federal Center Station at 09:18 hours for approximately 90 seconds and fails to service the platform, track 1.

At 09:23 hours, an MTPD Communications Technician contacted the ROCC Button RTC and reported receiving a tip via text that Train ID 909 overran Foggy Bottom Station and Smithsonian Station. The Button RTC notified the AOM of the report.

At 09:27 hours, the Radio RTC instructed an RTRA Rail Supervisor #1 located at Deanwood Station to report to Minnesota Avenue Station to intercept Train ID 909. The Radio RTC attempted to contact Train ID 909 at 09:27 hours, two times within the same minute, at 09:28 hours, at 09:30 hours, and at 09:31 hours, two times within the same minute without a response from the Train Operator.

At 09:31 hours, the Radio RTC instructed an Office of Car Maintenance (CMNT) Road Mechanic to intercept Train ID 909 at Stadium-Armory Station for a radio check. Train ID 909 left the station before the CMNT Mechanic arrived. At 09:34, the Train Operator responded to ROCC that the train was located at Stadium-Armory Station. The Radio RTC advised the Train Operator that Rail Supervisor #1 would meet the train at Minnesota Avenue Station. At 09:38 hours, the Rail Supervisor took over operating Train ID 909 to New Carrollton Station.

At 09:42 hours, the AOM advised the New Carrollton Station Terminal Supervisor that the Train Operator would be removed from service. At 09:56 hours, Rail Supervisor #1 was instructed by the Button RTC to transport the Train Operator for post-incident testing due to failure to service multiple stations. The Radio RTC contacted Rail Supervisor #2 and instructed them to meet Rail Supervisor #1 to transport the Train Operator.

At 10:19 hours, while en route to the testing site, the Rail Supervisor #1 and Train Operator arrived at Stadium-Armory Station aboard Train ID 912. Rail Supervisor #1 contacted ROCC and reported that the Train Operator exited the train and refused to attend the post-incident testing. Rail Supervisor #1 advised the Train Operator a refusal would result in an automatic positive test. At 10:23 hours, the Train Operator boarded Train ID 902 on track 1 (towards New Carrollton Station). Rail Supervisor #2 was already aboard, and they both exited the train at Minnesota Avenue Station. The Train Operator walked away and out of sight of Rail Supervisor #2.

At 11:17 hours, MTPD contacted the Button RTC and requested a Rail Supervisor to respond to Minnesota Avenue Station. At 11:20 hours, the Button RTC contacted and instructed Rail Supervisor #2 to return to Minnesota Avenue Station. At 11:57 hours, Rail Supervisor #2 reported that the Train Operator was observed being combative with an MTPD Officer and was restrained with handcuffs.

MTPD transported the Train Operator for post-incident testing; however, OHAW declined to perform the testing since the Train Operator deviated from the post-incident testing procedures.

During their interview, the Train Operator reported they were tired and had not slept the night before. They became upset because they felt they were being treated unfairly by the Supervisor and were not told why they were being removed from service.

Chronological Event Timeline

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

Time	Description
07:14:48 hours	Train ID 909 departed New Carrollton Station on track 2. [SPOTS]
07:29:41 hours	Train ID 909 overran Stadium-Armory Station by five feet. [VMDS]
07:32:16 hours	Train ID 909 overran Potomac Avenue Station by seven feet. [VMDS]
07:35:22 hours	Train ID 909 arrived at Eastern Market Station. [SPOTS]
07:39:40 hours	Train ID 909 departed Eastern Market Station. [SPOTS]
07:49:55 hours	Train ID 909 arrived at McPherson Square Station. [VMDS] (Stopped on the platform; Station not serviced.)
07:51:35 hours	Train ID 909 overran Farragut West Station by two feet. [VMDS]
07:53:55 hours	<u>Train Operator of Unknown Train ID:</u> Advised the Radio RTC that Train ID 909 was operating with interior lights off. <u>Radio RTC:</u> Acknowledged and requested from the Train Operator of Train ID 909 if their EV was on. <u>Train Operator of Train ID 909:</u> Acknowledged and advised that the EV was on and that they turned the lights back on. <u>Radio RTC:</u> Acknowledged. [Radio Ops. 2]
08:03:30 hours	Train ID 909 arrived at Virginia Square Station. [SPOTS] (Stopped on the platform; Station not serviced.)
08:05:44 hours	Train ID 909 departed Virginia Square Station. [SPOTS]
08:19:59 hours	Train ID 909 arrived at West Falls Church Station. [SPOTS] (Stopped on the platform; Station not serviced.)
08:20:46 hours	<u>Vienna Terminal Supervisor:</u> Contacted the AOM about Train ID 909 because they were due at 8:26 hours. <u>AOM:</u> Informed them that it appeared that Train ID 909 was at Eastern Market Station for six minutes. [Phone]
08:21:50 hours	Train ID 909 departed West Falls Church Station. [SPOTS]
08:31:22 hours	Train ID 909 arrived at Vienna Station. [SPOTS]
08:33:56 hours	Train ID 909, same Train Operator, departed Vienna Station on track 1. [SPOTS]

Time	Description
08:35:02 hours	<u>Button RTC</u> : Contacted New Carrollton Terminal to inquire whether Train ID 909 was a new operator. <u>New Carrollton Terminal Supervisor</u> : Advised they did not get a put-in sheet but were trying to reach the Tower to obtain the operator's information. [Phone]
08:36:51 hours	<u>Vienna Terminal Supervisor</u> : Informed the AOM of Train ID 909 Operator's information and that they were a veteran operator. [Phone]
08:49:56 hours	Train ID 909 arrived at Virginia Square Station and overran the platform by six feet. [SPOTS]
08:55:07 hours	Train ID 909 departed Virginia Square Station. [SPOTS]
09:03:56 hours	Train ID 909 arrived at Foggy Bottom Station. [SPOTS] (Stopped on the platform; Station not serviced.)
09:06:18 hours	Train ID 909 departed Foggy Bottom Station. [SPOTS]
09:07:35 hours	<u>Vienna Terminal Supervisor</u> : Contacted the AOM to have a Rail Supervisor ride with Train ID 909 ASAP to check them out because something was happening. [Phone]
09:10:08 hours	<u>New Carrollton Terminal Supervisor</u> : Provided Button RTC with Train ID 909 Operator information and informed them Train ID 909 got to Vienna Station nine minutes late. [Phone]
09:14:26 hours	Train ID 909 arrived at Smithsonian Station. [SPOTS] (Stopped on the platform; Station not serviced).
09:15:36 hours	Train ID 909 departed Smithsonian Station. [SPOTS]
09:18:51 hours	Train ID 909 arrived at Federal Center Station. [SPOTS] (Stopped on the platform; Station not serviced).
09:20:38 hours	Train ID 909 departed Federal Center Station. [SPOTS]
Unknown	<u>MTPD</u> : Received a tip that Train ID 909 overran two stations. [TEXT]
09:23:06 hours	<u>MTPD Communications Technician</u> : Contacted Button RTC to report they received a complaint that Train ID 909 overran two stations, Foggy Bottom, then Smithsonian, and had a hard braking at L'Enfant Plaza. [Phone]
09:25:31 hours	<u>Button RTC</u> : Contacted the AOM to inform them they received a call from MTPD that Train ID 909 overran two stations. [Phone]
09:27:20 hours	<u>Radio RTC</u> : Contacted RTRA Supervisor #1 for their location and to landline Central. [Radio Ops. 2]
09:27:42 hours	<u>AOM</u> : Contacted Vienna Terminal to inform them that Train ID 909 overran two stations and will be removed from service. [Phone]
09:27:50 hours	<u>Button RTC</u> : Informed Rail Supervisor #1 it was reported that Train ID 909 failed to service several stations. Instructed them to intercept the train and take over operations. [Phone]
09:27:58 hours	<u>Radio RTC</u> : Made first two attempts to reach Train ID 909 on approach to Potomac Avenue Station, but there was no response. [Radio Ops. 2]
09:28:55 hours	<u>Radio RTC</u> : Made the third attempt to reach Train ID 909, but there was no response. [Radio Ops. 2]
09:30:01 hours	<u>Radio RTC</u> : Made the fourth attempt to reach Train ID 909, but there was no response. [Radio Ops. 2]
09:31:00 hours	<u>Radio RTC</u> : Made the fifth attempt to reach Train ID 909 while approaching Stadium-Armory, but there was no response. [Radio Ops. 2]
09:31:52 hours	<u>Radio RTC</u> : Made the sixth attempt to reach Train ID 909 while approaching Stadium-Armory, but there was no response. [Radio Ops. 2]

Time	Description
09:31:59 hours	<u>Radio RTC</u> : Requested a Road Mechanic to meet Train ID 909 at Stadium-Armory Station for a radio check. [Radio Ops. 2]
09:32:44 hours	<u>OM</u> : Instructed the AOM to have Rail Supervisor #1 cushion from Deanwood Station to Minnesota Avenue Station to intercept Train ID 909. [Phone]
09:33:24 hours	<u>Rail Supervisor #1</u> : Advised the Radio RTC they were boarding the train and headed towards Minnesota Avenue Station. [Radio Ops. 2]
09:34:00 hours	<u>Train ID 909</u> : Informed Radio RTC they were at Stadium Armory. <u>Radio RTC</u> : Advised to continue, check speed commands, and Rail Supervisor #1 would intercept at Minnesota Avenue Station. [Radio Ops. 2]
09:34:09 hours	<u>Button RTC</u> : Informed the New Carrollton Terminal Supervisor that Train ID 909 did not service Foggy Bottom Station and will be removed from service. [Phone]
09:34:30 hours	<u>OM</u> : Instructed the AOM to ensure Rail Supervisor #1 keeps the Train Operator with them. [Phone]
09:35:10 hours	<u>Radio RTC</u> : Inquired Train ID 909 serviced Foggy Bottom Station, but there was no response. [Radio Ops. 2]
09:38:39 hours	Train ID 909 arrived at Minnesota Avenue Station. [SPOTS]
09:38:55 hours	<u>Radio RTC</u> : Confirmed with Rail Supervisor #1 that they were taking over operating Train ID 909. [Radio Ops 2]
09:39:01 hours	<u>New Carrollton Terminal Supervisor</u> : The New Carrollton Terminal Supervisor inquired if Train ID 909 could still be used. <u>Button RTC</u> : Confirmed. [Phone]
09:39:13 hours	<u>Radio RTC</u> : Instructed Rail Supervisor #1 to stay with the Train Operator. [Radio Ops. 2]
09:39:18 hours	<u>OM</u> : Contacted the AOM to confirm Rail Supervisor #1 will operate the train and the Train Operator will stay with them. <u>AOM</u> : Confirmed [Phone]
09:40:37 hours	<u>OM</u> : Contacted the AOM to inquire if Train ID 909 left Vienna on time. <u>AOM</u> : Advised Train ID 909 arrived at Vienna Station seven minutes late due to dragging the line and departed Vienna Station late. <u>OM</u> : Inquired what was done when it was identified they were dragging the line. Was a Rail Supervisor dispatched? <u>AOM</u> : Informed the OM that the RTC never dispatched a Rail Supervisor and they reiterated that to the RTC. [Phone]
09:42:53 hours	<u>AOM</u> : Contacted the New Carrollton Terminal Supervisor to inform them that the Train Operator of Train ID 909 would be removed from service. [Phone]
09:46:32 hours	<u>Radio RTC</u> : Contacted Rail Supervisor #1 to inquire about any abnormalities operating Train ID 909. <u>Rail Supervisor #1</u> : Confirmed the train was operating as intended. [Radio Ops. 2]
09:47:24 hours	<u>AOM</u> : Advised OM that Rail Supervisor #1 reported the train was operating normally. [Phone]
09:47:34 hours	<u>Button RTC</u> : Advised New Carrollton Terminal Supervisor that Train ID 909 was a no-dispatch. [Phone]
09:51:42 hours	<u>AOM</u> : Contacted the OM to confirm the report came from MTPD. [Phone]
09:56:04 hours	<u>OM</u> : Inquired if the Vienna Terminal Supervisor advised that the Train Operator operated Train ID 909 when it arrived at Vienna Station and when it departed. [Phone]

Time	Description
09:56:36 hours	<u>Rail Supervisor #1</u> : Contacted the Button RTC to inquire about what to do with the Train Operator. <u>Button RTC</u> : Informed them the Train Operator needed to be transported for post-incident testing. [Phone]
09:57:56 hours	<u>AOM</u> : Contacted the Vienna Terminal Supervisor to confirm that the Train Operator operating Train ID 909 to Vienna Station was the same operator operating the train from Vienna. <u>Vienna Terminal Supervisor</u> : Confirmed it was the same operator. [Phone]
09:59:02 hours	<u>Rail Supervisor #1</u> : Contacted the Button RTC to inquire where Rail Supervisor #2 was so they could transport the Train Operator. <u>Rail Supervisor #2</u> : Advised they were at Eastern Market. [Phone]
10:03:37 hours	<u>Rail Supervisor #1</u> : Contacted the Button RTC to clarify the violation so they could include the correct information in their report. <u>Button RTC</u> : Advised the Train Operator failed to service the stations. [Phone]
10:05:55 hours	<u>OM</u> : Instructed the AOM to confirm with RTCs that no one instructed the Train Operator to express the stations. [Phone]
10:19:19 hours	<u>AOM</u> : Informed the New Carrollton Superintendent of the event and that the Train Operator was being removed from service. [Phone]
10:19:20 hours	Train ID 912 arrived at Stadium-Armory Station on track 2. [SPOTS]
10:19:47 hours	<u>Rail Supervisor #1</u> : Contacted the Button RTC to inform them that the Train Operator exited the train and advised that they were sick. [Phone]
10:20:43 hours	Train ID 912 departed Stadium-Armory Station. [SPOTS]
10:20:43 hours	<u>Rail Supervisor #1</u> : Contacted the OM and informed them that the Train Operator exited the train at Stadium-Armory Station and refused to test. <u>OM</u> : Advised Rail Supervisor #1 to explain to the Train Operator that a refusal is an automatic positive result. [Phone]
10:23:53 hours	Train ID 902 arrived at Stadium-Armory Station on track 1. The Train Operator boarded this train. [SPOTS]
10:31:47 hours	Train ID 902 arrived at Minnesota Avenue Station. [SPOTS]
10:41:00 hours	<u>AOM</u> : The Vienna Terminal Supervisor confirmed that the incident train would be removed. [Phone]
11:01:33 hours	<u>OM</u> : Contacted the AOM to confirm that the train on track 2 at Vienna Station was the incident train to be removed from service and transported to West Falls Church Yard. <u>AOM</u> : Confirmed. [Phone]
11:17:54 hours	<u>Button RTC</u> : Received a call that MTPD requested a Rail Supervisor at Minnesota Avenue Station. [Phone]
11:19:26 hours	<u>Button RTC</u> : Contacted Rail Supervisor #1 to respond but was advised they were at OHAW completing paperwork. [Phone]
11:20:32 hours	<u>Button RTC</u> : Contacted Rail Supervisor #2 and was advised they were already en route to Minnesota Avenue Station. [Phone]
11:57:32 hours	<u>Rail Supervisor #2</u> : Informed the Button RTC that they met with MTPD; the Train Operator was combative with MTPD and was placed in handcuffs. MTPD transported the Train Operator to Medical. [Phone]
12:05:46 hours	<u>COO</u> : Contacted the OM for an update on the situation and asked for a summary. [Phone]

Time	Description
12:08:36 hours	<u>OM</u> : Contacted the SOCC to inquire how the incident was reported and who reported it to the ROCC. <u>SOCC</u> : Advised it was a text tip and told them it was an MTPD Communication Technician who reported it to the ROCC. [Phone]
12:13:04 hours	<u>OM</u> : Contacted the MTPD Communication Technician to inquire if the text tips were anonymous. <u>MTPD Communication Technician</u> : Confirmed messages were anonymous. [Phone]

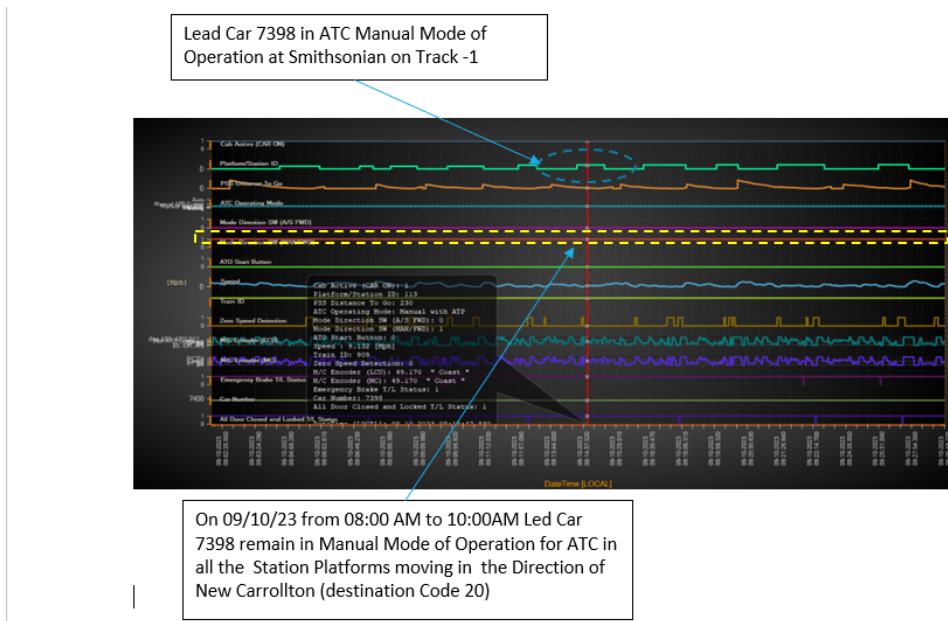
***Note: Times above may vary from other systems' timelines based on clock settings and reporting sources*

The Office of Chief Mechanical Officer (CMOR) / Vehicle Monitoring and Diagnostic System (VMDS)

Adopted from CMOR IIT report with minor formatting and grammatical edits:

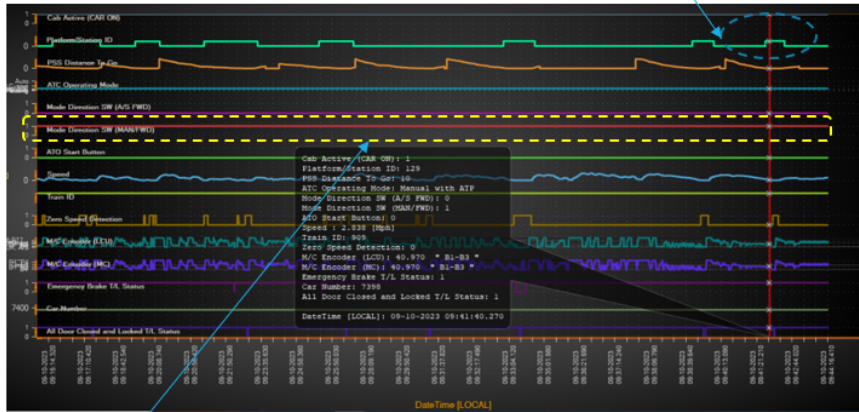
"IIT reviewed the ER Data for this incident. The ATC Operation remained in Manual Mode before, during, and after the reported incident at 9:30 AM. IIT did not see any faults in the Logs that would have contributed to this incident. At no time was the ATO Start push button depressed, and at no time was the Lead Car 7398 operated or configured for ATO mode of operation."

Lead Car 7398 ER Analysis Graph #1 / Lead Car 7398 remained in Manual Mode of operation before, after, and at Smithsonian on Track-1



Lead Car 7398 ER Analysis up to Deanwood Station Platform (TWC (129) on Track-1 with Lead Car 7398 operating in Manual Mode

09:41:40 Train in Manual Mode of Operation at DeanDeanwood on Track-1



Train remained in Manual Mode of operation before, during and after the Incident reported Time

First trip from New Carrollton track 2 to Vienna.

Time entered platform	Lead Car	Train ID	Station	Doors Open	Overran Station	ATO operation	Sequence of events.
07:13.31.340	7690	909	New Carrollton D13-2	Yes	No	No	Train serviced New Carrollton Track 2.
07:15:59.610	7690	909	Landover D12-2	Yes	No	No	Train Serviced Landover Track 2. Train speed entered station 37.5Mph.
07:19:17.520	7690	909	Cheverly D11-2	Yes	No	No	Train serviced Cheverly Track 2. Train speed entered station 40.8 Mph.
07:22:03.860	7690	909	Deanwood D10-2	Yes	No	No	Train Serviced Deanwood Track 2. Train speed entered station 23Mph.
07:24:29.760	7690	909	Minnesota Ave D09-2	Yes	No	No	Train Serviced Minnesota Ave Track 2. Train speed entered station 34.7Mph.
07:29:41.970	7690	909	Stadium Armory D08-2	Yes	Yes	No	Train Serviced Stadium Armory Track 2. Train speed entered station 13Mph. Overran Station by 5Feet.
07:32:16.530	7690	909	Potomac Ave D07-2	Yes	Yes	No	Train Serviced Potomac Ave Track 2. Train Speed entered Station 28Mph. Overran Station by 7Feet.
07:35:10.210	7690	909	Eastern Marker D06-2	Yes	No	No	Train Serviced Easter Marker Track 2. Train speed entered Station 35Mph
07:39:55.640	7690	909	Capital South D05-2	Yes	No	No	Train Serviced Capital South Track 2. Train speed entered Station 37Mph.
07:41:48.550	7690	909	Federal Center D04-2	Yes	No	No	Train Serviced Federal Center Track 2. Train speed entered Station 17.5Mph.
07:43:00.140	7690	909	L'Enfant Plaza D03-2	Yes	No	No	Train Serviced L'Enfant Plaza Track 2. Train speed entered Station 38Mph.
07:44:53.220	7690	909	Smithsonian D02-2	Yes	No	No	Train Serviced Smithsonian Track 2. Train Speed entered Station 31Mph.
07:46:48.050	7690	909	Federal Triangle D01-2	Yes	No	No	Train Serviced Federal Triangle Track 2. Train Speed entered Station 37Mph.

07:48:18.440	7690	909	Metro Center C01-2	Yes	No	No	Train Serviced Metro Center Track 2. Train Speed entered Station 35Mph.
07:49:55.940	7690	909	McPherson Sq C02-2	No	No	No	Train did not Serviced McPherson sq Track 2. Train Speed entered Station 19.8Mph.
07:51:35.450	7690	909	Farragut West C03-2	Yes	Yes	No	Train Serviced Farragut West Track 2. Train Speed entered Station 38.9Mph. Overran Station By 2feet.
07:54:17.140	7690	909	Foggy Bottom C04-2	Yes	No	No	Train Serviced Foggy Bottom Track 2. Train Speed entered Station 33.5Mph.
07:56:45.550	7690	909	Rosslyn C05-2	Yes	No	No	Train Serviced Rosslyn Track 2. Train Speed entered Station 33Mph.
08:00:01.260	7690	909	Court House K01-2	Yes	No	No	Train Serviced Court House Track 2. Train Speed entered Station 27.7Mph.
08:01:49.000	7690	909	Clarendon K02-2	Yes	No	No	Train Serviced Clarendon Track 2. Train speed entered Station 36Mph.
08:03:23.360	7690	909	Virginia Sq K03-2	No	No	No	Train did not Serviced Virginia Sq Track 2. Train Speed entered Station 30Mph.
08:06:11.050	7690	909	Ballston MU K04-2	Yes	No	No	Train Serviced Ballston Track 2. Train Speed entered Station 33.9Mph.
08:12:57.070	7690	909	East Falls Church K05-2	Yes	No	No	Train Serviced East Falls Church Track 2. Train Speed entered Station 29.49Mph.
08:19:53.350	7690	909	West Falls Church K06-2	No	No	No	Train did not Serviced West Falls Church Track 2. Train Speed entered Station 14Mph.
08:26:01.390	7690	909	Dunn Loring K07-2	Yes	No	No	Train Serviced Dunn Loring Track 2. Train Speed entered Station 28Mph.
08:31:15.360	7690	909	Vienna K08-	Yes	No	No	Train Serviced Vienna Track 1. Train Speed entered Station 16Mph.

Second Trip from Vienna Track 1 to New Carrollton.

Time entered platform	Lead Car	Train ID	Station	Doors Open	Overran Station	ATO operation	Sequence of events.
08:33:28.360	7398	909	Vienna K08-1	Yes	No	No	Train reversed at Vienna Track 1. Lead car 7398. Direction Inbound track #1.
08:36:21.100	7398	909	Dunn Loring K07-1	Yes	No	No	Train Serviced Dunn Loring Track 1. Train Speed entered Station 35.7Mph.
08:40:23.940	7398	909	West Falls Church K06-1	Yes	No	No	Train Serviced West Falls Church Track 1. Train Speed entered Station 32Mph.
08:43:23.170	7398	909	East Falls Church K05-1	Yes	No	No	Train Serviced East Falls Church Track 1. Train Speed entered Station 34.5Mph.
08:47:11.880	7398	909	Ballston MU K04-1	Yes	No	No	Train Serviced Ballston MU Track 1. Train Speed entered Station 18.7Mph.
08:49:46.580	7398	909	Virginia Sq K03-1	Yes	YES	No	Train Serviced Virginia Sq Track 1. Train speed entered Station 28.Mph. Overran Station by 6Feet.
08:55:15.870	7398	909	Clarendon K02-1	Yes	No	No	Train serviced Clarendon Track 1. Train Speed entered Station 36.7Mph.
08:57:23.800	7398	909	Court House K01-1	Yes	No	No	Train serviced Court House Track 1. Train Speed entered Station 30.6Mph.
09:00:25.380	7398	909	Rosslyn C05-1	Yes	No	No	Train Serviced Rosslyn Track 1. Train Speed entered Station 21.7Mph.
09:03:48.480	7398	909	Foggy Bottom C04-1	No	No	No	Train did not Serviced Foggy Bottom Track 1. Train Speed entered Station 14.7Mph.
09:06:40.010	7398	909	Farragut West C03-1	Yes	No	No	Train Serviced Farragut West Track 1. Train Speed entered Station 35Mph.
09:08:00.500	7398	909	McPherson Sq C02-1	Yes	No	No	Train Serviced McPherson Sq Track 1. Train Speed entered Station 34Mph.
09:09:41.870	7398	909	Metro Center C01-1	Yes	No	No	Train Serviced Metro Center Track 1. Train Speed entered Station 31Mph.

09:11:26.940	7398	909	Federal Triangle D01-1	Yes	No	No	Train Serviced Federal Triangle Track 1. Train Speed entered Station 14.7Mph.
09:14:15.330	7398	909	Smithsonian D02-1	NO	Yes	No	Train did not Serviced Smithsonian Track 1. Train stop 261feet short from the 8-car marker, after stop train continue without stopping at the 8-car marker.
09:16:11.830	7398	909	L'Enfant Plaza D03-1	Yes	No	No	Train Serviced L'Enfant Plaza Track 1. Train Speed entered Station 12Mph.
09:18:43.270	7398	909	Federal Center D04-1	NO			Train did not Serviced Federal Center SW track 1. Train Speed entered Station 18. 6Mph. Train stop at the 8-Car Marker but continue without opening any doors.
09:21:14.340	7398	909	Capital South D05-1	Yes	No	No	Train Serviced Capital South Track 1. Train speed entered Station 16.9Mph.
09:25:16.160	7398	909	Eastern Marker D06-1	Yes	NO	NO	Train Serviced Easter Marker Track 1. Train Speed entered Station 17Mph.
09:29:40.580	7398	909	Potomac Ave D07-1	Yes	No	No	Train Serviced Potomac Ave Track 1. Train Speed entered Station 27.64Mph.
09:32:39.390	7398	909	Stadium Armory D08-1	Yes	NO	NO	Train Serviced Stadium Armory Track 1. Train Speed entered Station 21Mph.
09:38:29.980	7398	909	Minnesota Ave D09-1	Yes	No	No	Train Serviced Minnesota Ave Track 1. Train Speed entered Station 34Mph.
09:41:13.390	7398	909	Deanwood D10-1	Yes	No	No	Train Serviced Deanwood Track 1. Train Speed entered Station 25.8Mph.
09:45:40.100	7398	909	Cheverly D11-1	Yes	No	No	Train Serviced Cheverly Track 1. Train Speed entered Station 22.6Mph.
09:49:00.080	7398	909	Landover D12-1	Yes	No	No	Train Serviced Landover Track 1. Train Speed entered Station 30Mph.
09:52:21.770	7398	909	New Carrollton D13-2	Yes	No	No	Train Serviced New Carrollton Track 2. Train Speed entered Station 14Mph.

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

Interview Findings

As part of the investigation launched into the event, SAFE interviewed three people. The interviews identified the following key findings associated with this event. The findings detailed below include reported information from involved personnel and may conflict with other data sources in the report.

Train Operator (Train ID 909)

- They were on vacation and returned from Hawaii on September 7, 2023, six hours behind local time.
- They worked on Saturday, September 9, 2023.
- They worked overtime on September 10, 2023, and were assigned as the Gap Person.
- They could not recall failing to service any stations.
- They reported consuming alcohol the night before.
- They stated they stopped drinking before midnight.
- They reported not getting any sleep before coming to work.
- They reported requesting sick leave when they were initially transported to New Carrollton station but were denied because they had to complete a post-incident test.
- They got off the train at Stadium-Armory station because another RTRA Supervisor was supposed to meet them.
- RTRA Supervisor #2 was reportedly unprofessional, which upset them, and they walked away from the Supervisor at Minnesota Avenue station.
- They reported that they asked the MTPD Officer to handcuff them because they were getting frustrated.

Rail Supervisor #1

- They took over train operations at Minnesota Avenue Station.
- They operated the train to New Carrollton Station.
- Once at New Carrollton Station, they were notified that the Train Operator needed to be transported for post-incident testing.
- Initially, there were no issues with the Train Operator.

- While transporting the Train Operator, the Train Operator alighted at Stadium-Armory Station and refused to be transported.
- While talking to the Division Superintendent, the Train Operator attempted to take the cell phone from them.
- They contacted the ROCC OM and informed them of the situation.
- The ROCC OM and RTRA Supervisor #1 advised the Train Operator if they did not go to Medical, it would be considered a refusal and automatic positive result.
- They continued to Medical to complete the paperwork since the Train Operator refused to be tested.

Rail Supervisor #2

- They arrived at Stadium-Armory Station but were advised to get back on the train.
- They walked to the trailing car and located the Train Operator.
- They were receiving instructions from the Division Superintendent.
- When they informed the Train Operator, the Division Superintendent requested them to complete an incident report upon their return to New Carrollton Station, and the Train Operator became irate.
- They informed the Division Superintendent the Train Operator alighted at Minnesota Avenue Station and was advised not to follow the Train Operator.
- They continued to New Carrollton Station, then were instructed to return to Minnesota Avenue Station because MTPD requested an RTRA Supervisor.
- When they returned to Minnesota Avenue Station, they witnessed the Train Operator being combative with MTPD Officers.
- MTPD Officers placed handcuffs on the Train Operator but later removed them and transported the Train Operator to Medical.

Weather

On September 10, 2023, at the time of the incident, NOAA recorded the average temperature as 76°F, with minor cloud cover, winds averaging 3.0 mph, and 83% humidity. The weather did not contribute to this incident (Weather source: NOAA) – Location: Washington, DC.

Related Rules and Procedures

General Rule 1.24: Employees found consuming, possessing, or under the influence of an alcoholic beverage, narcotic drug, depressant, stimulant, hallucinogenic drug, prescription drug labeled for someone other than the employee, or other controlled substance while on duty, on Metro property, or on-call duty, will be subject to the terms and conditions of existing Authority policies and procedures at the time of the incident.

Policy Instruction 7.7.3/7 Section 3: 3.27 Refusal to Test – constitutes a verified positive test result and occurs when a selected or required employee or contractor:

- Fails to appear for any test (except a pre-employment test) within a reasonable time, as determined by Metro, after being directed to do so by Metro;
- Fails to remain until the testing process is complete;
- Possesses/wear a prosthetic or other device used to tamper with the testing process;
- Fails to provide the required urine or breath specimen for any drug or alcohol test;
- Fails to remain readily available for a post-accident or Metro post-incident test, as determined by the Designated Employer Representative (DER), or notify supervisor of whereabouts until testing is complete;

- Provides MRO-verified adulterated or substitute specimen;
- Refuses to cooperate with any part of the testing process, e.g., refusal to empty pockets when directed by collector or displays behavior in confrontational way that disrupts the collection process.

Policy Instruction 7.7.3/7 – Post Incident Testing may be performed on employees and contractors whose performance cannot be "completely discounted" (applying 49 CFR 655.44 post-accident standard to Metro's post-incident policy) as the cause or contributing factor to an accident. A post-incident test may be triggered when the employee or contractor is not designated as Department of Transportation (DOT) Federal Transit Administration (FTA) Safety-Sensitive or where the incident failed to meet the criteria of a DOT/FTA post-incident test.

Alcohol Testing

- Employees and contractors who perform Safety Sensitive Functions may not consume alcohol under the following circumstances:
 - Four (4) hours before performing safety-sensitive functions
 - While performing any safety-sensitive function; and
 - After an accident, until the employee/contractor has been tested or eight (8) hours have elapsed, whichever occurs first.

Human Factors

Fatigue

Signs and Symptoms of Fatigue

Conditions at the time of the incident were evaluated to distinguish whether evidence of fatigue was present. Video of the incident was reviewed for behaviors suggesting fatigue. The Train Operator demonstrated possible signs of fatigue, including rubbing their eyes, delayed reactions, and opening and closing the Operator's cab window for air. The Train Operator reported they were fighting sleep at the time of the incident and reported experiencing symptoms of fatigue, including feeling sluggish, falling asleep, and having difficulty concentrating in the time leading up to the incident.

Fatigue Risk

Incident data was evaluated for fatigue risk factors. Risk factors for fatigue were identified. The incident time of day does not suggest an increased risk of fatigue-related impairment. The employee worked day shift the day leading up to the incident. The employee reported a total of 2 hours of sleep in the last sleep period preceding the incident and was awake for 5 hours at the time of the incident. The off-duty period preceding the incident was 14.6 hours, which provided the opportunity for 7-8 hours of sleep. The employee reported usual workday sleep durations of 5 hours and issues with sleep, though these were unspecified.

A biomathematical fatigue modeling application (SAFTE-FAST WebSFC) was used to evaluate further fatigue risk factors that may have been present in the Train Operator's schedule. The analysis was based on the Train Operator's work schedule, reported sleep from the day before the incident, and reported habitual sleep durations. The estimated performance effectiveness at the time of the incident was 79.2%. Specifically, the analysis identified short sleep duration in the last 24 hours as a factor contributing to an increased risk of fatigue at the time of the incident.



Modeling analysis output shows estimated performance effectiveness during the incident work shift and for the week leading up to the work shift, based on the employee work and reported sleep schedule. Estimates were based on the Train Operator's work schedule, reported sleep from the day preceding the incident, and reported habitual sleep durations (7 hours a day). Bold portions of the modeled curve show work (in black) and sleep times (in blue). Effectiveness is shown on the vertical axis, with colored fields in the chart background signifying ranges of effectiveness scores, including high effectiveness (>90%) in green and low effectiveness (<65%) in red. Time is shown on the horizontal axis. Markers for work and sleep times are shown in the lanes above the time of day on the horizontal axis.

Post-Incident Toxicology Testing

WMATA's Drug and Alcohol Program determined that the Train Operator refused to comply with the Drug and Alcohol Policy and Testing Program 7.7.3/7 resulting in a positive test

Findings

- The Vienna Terminal Supervisor notified the ROCC of Train ID 909 delay.
- The Vienna Terminal Supervisor advised the ROCC to have an RTRA Supervisor check the Train Operator.
- MTPD notified the ROCC that they received an anonymous text tip that Train ID 909 failed to service two stations and had a hard braking at L'Enfant Plaza Station.
- The Train Operator failed to service six stations.
- The Train Operator serviced four stations even though they passed the 8-car marker. All doors remained on the platform when they were opened.
- The Radio RTC attempted several times to contact Train ID 909 but was unsuccessful.
- The Radio RTC dispatched Car Equipment personnel to intercept Train ID 909 and conduct a radio check.
- Rail Supervisor #1 took over train operations at Minnesota Avenue Station.
- As Rail Supervisor #1 was transporting the Train Operator for their post-incident test, the Train Operator alighted at Stadium-Armory Station and refused to test.
- The Train Operator became irate with Rail Supervisor #2 and alighted at Minnesota Avenue Station.
- Rail Supervisor #2 did not follow the Train Operator when they alighted at Minnesota Avenue Station.
- The Train Operator was combative with MTPD Officers and had to be temporarily restrained with handcuffs.
- MTPD Officers transported the Train Operator to Medical but was denied testing.
- The Train Operator retired from the Authority soon after this event.

Immediate Mitigation to Prevent Recurrence

- 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 IIT Operations Administrative Policy (OAP) 102.06, the ROCC removed Train ID 909 from revenue service for post-incident investigative measures. This action adhered to the Rail Vehicle Event Investigation Policy, ensuring a comprehensive incident examination.

Probable Cause Statement

The probable cause of the Operator Removed from Service (Fatigue – Drug & Alcohol) – Failure to Service Stations event on September 10, 2023, was the Train Operator experienced non-work-related issues that prevented them from getting sleep the night before.

Recommended Corrective Actions

Corrective Action Code	Description	Responsible Party	Estimated Completion Date
111280_SAFE CAPS_OSO_0 01	Monitor compliance with RTRA's post-incident testing SOP and produce a report with findings.	OSO SRC	07/31/2024
111280_SAFE CAPS_OHAW 001	Company-wide communication on the steps to be followed when an employee refuses to conduct post-incident testing.	OHAW SRC	07/31/2024
111280_SAFE CAPS_MICC_ 001	The MICC will collaborate with IT to evaluate the accuracy of the “holding” screen before re-implementing.	MICC SRC	07/31/2024

Appendices

Appendix A – Interview Summaries

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 is a WMATA employee with 22 years of service, including 12 years as a Train Operator. The Train Operator previously worked as a Bus Operator and Station Manager. The Train Operator is RWP Level 2 certified and must recertify in October 2023. The Train Operator was last certified as a Train Operator in October 2022. The Train Operator was asked how alert they felt leading up to the incident, and they said they were fighting sleep. The Train Operator mentioned feeling sluggish, falling asleep, and difficulty concentrating, leading to the incident.

The Train Operator mentioned they had just returned to work from vacation in Hawaii, six hours behind the local time. The Train Operator was working a new schedule at New Carrollton, and on the day of the incident, the Train Operator was working overtime. The Train Operator contacted the Clerk at New Carrollton to ask for overtime and was assigned a gap run on Sunday, September 10. A gap run is when a train stored on a pocket or tail track is inserted into the schedule if another train is removed from service or if additional service is required. The Train Operator said they were tired when they arrived on duty at 05:45 hours because they did not get any sleep the night before due to non-work-related issues. The Train Operator acknowledged that they made a bad decision by going to work because they did not get any rest the night before. The Train Operator said they were given a run when they arrived at work and were under the impression the run was supposed to go to the Yard person first. The Train Operator said they thought the Gap person was the last to be assigned work when a run opened.

The Train Operator mentioned being tired and not 100 percent mentally focused as they left New Carrollton to start their shift. The Train Operator said they could not recall failing to service any stations. The Train Operator said they would not have purposely not serviced a station, so they must have fallen asleep. The Train Operator said their handheld radio was off. They did not hear ROCC make multiple attempts to contact them, but they heard when ROCC told them a Rail Supervisor would intercept their train, and they responded. The Train Operator said when the Rail Supervisor boarded the train, they took over the train operations and informed them that it was alleged that they did not service a couple of stations. When they arrived at New Carrollton station, the Train Operator said they tried to take sick leave while the Rail Supervisor was trying to figure out what the ROCC wanted them to do with the Train Operator.

The Train Operator said the Rail Supervisor informed them they had to go for a post-incident test, and the Operator said they were going sick, and the Rail Supervisor informed them they couldn't delay the process. The Train Operator said they stepped off the train at Stadium-Armory station. The other Rail Supervisor arrived and was unprofessional when they asked if they were talking to the Division Superintendent. The Train Operator said they walked downstairs at Minnesota Avenue station to escape the unprofessional Rail Supervisor and then returned to the platform, where an MTPD Officer met them. The Train Operator said they never refused to take the post-incident test. The Train Operator said they asked the MTPD Officers to put handcuffs on them because they were getting frustrated because the MTPD Officers arrived without an explanation. The Train Operator did mention they had been drinking alcohol the night before and was not 100 percent sure if they were under the influence when the incident occurred. They believed they stopped drinking before midnight the night before the incident.

Rail Supervisor #1

Rail Supervisor # 1 is a WMATA employee and has been a Rail Supervisor for the last 18 years. They have supervised the Orange Line for the last four to five years. On the day of the incident, Rail Supervisor #1 had a special assignment as an event coordinator for the Washington Commanders' football game. When the ROCC contacted RTRA Supervisor #1 about taking over the train operation of Train ID 909, they were located at Deanwood Station. Before taking over operations, the ROCC informed Rail Supervisor #1 that it was suspected that the Train Operator had run through a couple of stations. Rail Supervisor #1 was supposed to intercept Train ID 909 at Deanwood Station. Still, the Train Operator was not responding to the radio, so they were cushioned to Minnesota Avenue Station to intercept Train ID 909. Rail Supervisor #1 said the Train Operator's demeanor seemed normal when they boarded the train. Rail Supervisor #1 said they saw and sat next to the Train Operator that morning at New Carrollton Division and did not see any signs of fatigue or impairment. Rail Supervisor #1 said the Train Operator never requested to go out sick while en route to New Carrollton Station. Once Rail Supervisor #1 arrived at New Carrollton Station, they were advised the Train Operator needed to be transported for a post-incident test.

While on the train to the post-incident testing site, Rail Supervisor #1 contacted Rail Supervisor #2 to meet them at Eastern Market Station so they could transport the Train Operator. Rail Supervisor #1 stated as they arrived at Stadium-Armory Station, the Train Operator said, "I'm going sick". The Rail Supervisor said they explained to the Train Operator that they could not go sick or it would be considered a refusal. This was the first time the Train Operator told Rail Supervisor #1 they wanted to go sick. The Train Operator alighted the train at Stadium-Armory Station, and Rail Supervisor #1 followed him. While on the platform at Stadium-Armory Station, the Train Operator attempted to take the cell phone out of Rail Supervisor #1 hands. The Train Operator boarded an outbound train, and Rail Supervisor #1 proceeded to Medical to complete the refusal paperwork at Medical.

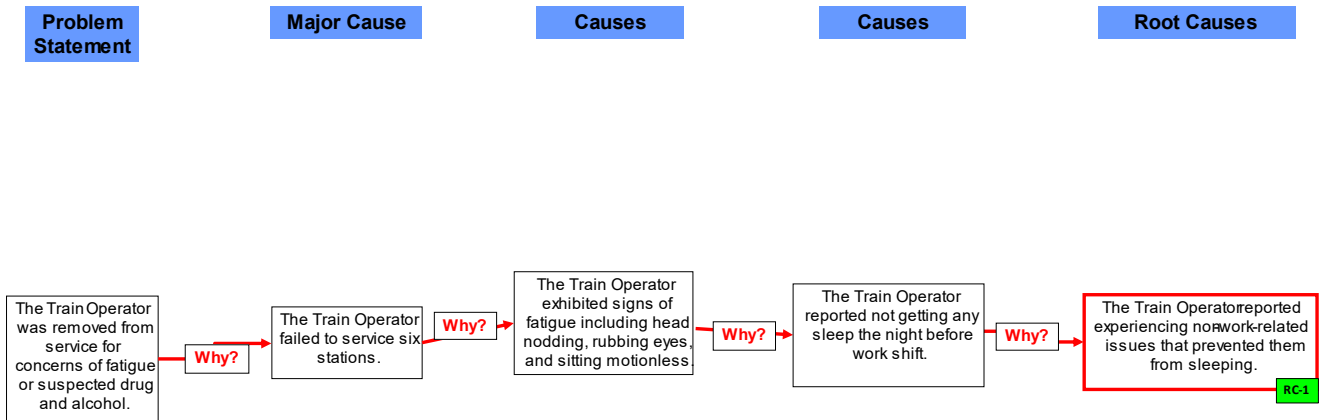
Rail Supervisor #2

Rail Supervisor #2 is a WMATA employee with 32 years of service, including six years as a Rail Supervisor. Rail Supervisor #2 will have to recertify as an RTRA Supervisor in June 2024. The Rail Supervisor stated this was their second time working on the Orange Line. On the day of the incident, Rail Supervisor #2 started their workday at 06:00 hours and had no special assignments. They were performing their normal work duties. While they were on the line, Rail Supervisor #1 contacted them directly. When Rail Supervisor #2 was contacted, they were located at Eastern Market Station. RTRA Supervisor #1 contacted Rail Supervisor #2 because they had a special assignment for the day. Since Rail Supervisor #2 was assigned to the roadway that day, Rail Supervisor #1 contacted them so they could meet and Rail Supervisor #2 could transport the Train Operator to Medical for their post-incident testing. They never met the Rail Supervisor or Train Operator at Eastern Market Station. Rail Supervisor #2 boarded a train to meet the two at Stadium Armory Station.

When Rail Supervisor #2 arrived at Stadium-Armory Station, as they were alighting, Rail Supervisor #1 went over the radio and told Rail Supervisor #2 to get back on the train. Rail Supervisor #2 thought the two were on the trailing car, so they walked through the train, but once they got to the trailing car, it was only the Train Operator. At that point, Rail Supervisor #2 called Rail Supervisor #1 about what was going and that's when they were informed that they had to go to Medical to complete paperwork since the Train Operator refused the testing. Rail Supervisor #2 called their Superintendent for instructions on what to do with the Train Operator. The Superintendent instructed Rail Supervisor #2 to advise the Train Operator they needed to conduct

an incident report. When Rail Supervisor #2 informed the Train Operator what the Superintendent said, the Train Operator became irate because they attempted to contact the Superintendent several times and they did not answer.

Appendix B – Why Tree



Root Cause Analysis

