Recommendation(s) Status: Train departed with doors open, Warren Street, Victoria Line, London

This report is based on information provided to the RAIB by the relevant safety authority or public body.

The status of implementation of the recommendations, as reported to us, has been divided into six categories:

Key to Recommendation Status

Implemented:	All actions to deliver the recommendation have been completed.
Implemented by alternative means:	The intent of the recommendation has been satisfied in a way that was not identified by the RAIB during the investigation.
Implementation ongoing:	Work to deliver the intent of the recommendation has been agreed and is in the process of being delivered.
In-progress:	The relevant safety authority has yet to be satisfied that an appropriate plan, with timescales, is in place to implement the recommendation; and work is in progress to provide this.
Non-implementation:	Regulation 12(2)(b)(iii) = recommendation considered and no implementation action to be taken.
Awaiting response:	Awaiting initial report from the relevant safety authority or public body on the status of the recommendation.

RAIB concerns on actions taken by organisations in response to recommendations are reflected in this report and are indicated by one of the following:

▲ The red triangle shows recommendations where the RAIB has concerns that no actions have been taken in response to a recommendation.

▲ The blue triangle shows recommendations where the RAIB has concerns that the actions taken, or proposed, are inappropriate or insufficient to address the risk identified during the investigation.

△ The white triangle shows recommendations where the RAIB notes substantive actions have been reported, but the RAIB still has concerns.

Note: The tables which follow, report the status of recommendations on 31 December 2015. In some other cases the end implementer has already sent information to the relevant safety authority about the actions it has taken, or proposes to take and the safety authority is considering whether it is satisfied that those actions and the associated timescales are accepted.

Number/ Date/ Report No/ Inv Title / Current Status	Safety Recommendation	Summary of current status (based on latest report from the relevant safety authority or public body)
1 11/07/2011 13/2012 Train departed with doors open, Warren Street, Victoria Line, London Status: Implemented	The intention of the recommendation is that train operators should be issued with clear instructions on the action that they should take in the event of an activation of the sensitive edge system and should be briefed on their content. In the light of the Warren Street incident, LUL should review the current instructions on the action that train operators should take in the event of the sensitive edge system being activated. This should include, in particular: l the options available to train operators for dealing with activations of the sensitive edge system and which option should be used first in specific circumstances; l under what circumstances the sensitive edge override should be used; and l the information provided by the TCMS to see whether there is suitable and sufficient information to train operators about using the override. Any necessary changes to the instructions should be implemented, and train operators briefed and/or trained, as appropriate, on the changes made (paragraph 131c)	London Undergroun Ltd has reported that it has taken actions in response to this recommendation. Office of Rail Regulation (ORR) proposes to take no further action unless they become aware that the information provided becomes inaccurate.
2 11/07/2011 13/2012 Train departed with doors open, Warren Street, Victoria Line, London Status: Implemented	The intention of the recommendation is to identify why LUL did not follow good practice for the introduction of the sensitive edge override modification and why this was not detected. In relation to the sensitive edge override modification, LUL should review how its process for managing engineering change and the associated management controls was not followed, and why it did not adequately identify the risks associated with the design modification. The review should include: l why good and established practice in engineering change management was not followed during the design and introduction of the sensitive edge override modification with particular reference to the specification of requirements and the risk assessment of the proposed changes; and l why the management system and controls did not identify or correct the design deficiencies relating to the sensitive edge override modification. LUL should implement any necessary changes to its process for managing engineering change and associated management	LUL has outlined the actions to be taken in response to the recommendation. Office of Rail Regulation (ORR) proposes to take no further action unless they become aware that the information provided becomes inaccurate.

Number/ Date/ Report No/ Inv Title / Current Status	Safety Recommendation	Summary of current status (based on latest report from the relevant safety authority or public body)
	controls (paragraph 131d.ii).	
3 11/07/2011 13/2012 Train departed with doors open, Warren Street, Victoria Line, London Status: Implemented	The intention of the recommendation is that LUL's competence management arrangements for train operators should: a) identify those who are unable to reliably and correctly respond to out-of-course events (including faults and failures); and b) incorporate arrangements designed to eliminate or resolve the competence deficiencies identified. In the light of the findings of this investigation, LUL should review those elements of its competence management system that relate to the ability of train operators to respond to out-of-course events, faults and failures. This should take into account: • how the evidence from train operators' performance in practical training and instruction is captured and dealt with by the competence management system; • how the evidence from train operators' performance in incidents in service is captured and dealt with by the competence management system (paragraph 124); and • how LUL acts on any deficiencies identified from the above, relating to a train operator's ability to recognise and correctly respond to an out-of-course event, with the aim of eliminating any competence deficiencies identified, including how corrective action plans are developed, implemented and monitored to successful conclusion. LUL should implement any necessary changes to the competence management system (paragraph 131d.iii).	London Underground Ltd has reported that it has taken actions in response to this recommendation. Office of Rail Regulation (ORR) proposes to take no further action unless they become aware that the information provided becomes inaccurate.
4 11/07/2011 13/2012 Train departed with doors open, Warren Street, Victoria Line, London Status: Implemented	The intention of the recommendation is that train operators should be aware that operational or technical advice is available when required and they should know how to obtain it so that they can effectively resolve faults and failures and avoid mistakes which could reduce safety. LUL should review how and in what circumstances train operators should request assistance following defects in service and implement any changes found necessary. This should include the adequacy of the competence management system and competence assessment of train operators in requesting assistance when needed. In addition: l train operators should be reminded of the availability of operational and technical advice when they are unable to resolve train defects and how they can obtain it; and l service controllers should be reminded that they should challenge train operators if they believe them to be acting outside LUL's mandatory instructions (paragraph 131d.vi).	LUL has reported that it has taken actions in response to this recommendation. Office of Rail Regulation (ORR) proposes to take no further action unless they become aware that the information provided becomes inaccurate.